Addendum #2: Q&A and Revisions

RESPONSE TO WRITTEN INQUIRIES AND REVISIONS TO RFP DOCUMENTS
Request for Proposals # 3000011953
Louisiana Medicaid Managed Care Organizations

LOUISIANA DEPARTMENT OF HEALTH
BUREAU OF HEALTH SERVICES FINANCING
APRIL 5, 2019

PART 1: QUESTIONS AND ANSWERS

Question No.	Document Reference	Section Number	Section Heading	Page	Question	Answer
1	RFP	1.1.7	Purpose	4	Please provide: 1. The rate development cadence and timeline under this new contract 2. The base data expected to be used for a given rate period for non-expansion and non-expansion populations 3. The risk adjustment cadence and timeline	The timeline for rate development is to be determined; however, LDH and its contracted actuary aim to publish draft rates by October 1, 2019.
2	RFP	1.1.7	Purpose	4	For RFP development purposes, it would be helpful for proposers to understand the capitation rates for this contract. Can LDH please provide these rates to proposers prior to the RFP submission deadline?	See response to question #1. However, Proposers may refer to the data books located in the procurement library for relevant background information.
3	RFP	1.1.7	Purpose	4	Would the state consider sharing the timing of when the capitation rates will be released to the MCOs?	See response to question #1.
4	RFP	1.1.8	Purpose	4	This section states the Medicaid managed care program is "also impacted by a section 1115 waiver for substance use disorder services." In regards to the waiver, please see the following questions. 1. In the approved waiver, the state's objectives are stated as follows. "During the demonstration period, Louisiana seeks to achieve the following: • Increase enrollee access to and utilization of appropriate OUD/SUD treatment services based on the ASAM Criteria; • Decreased use of medically inappropriate and avoidable high-cost emergency department and hospital	1a) Louisiana already covers all of the critical levels of care, including outpatient, intensive outpatient, medication-assisted treatment (MAT), residential, inpatient, and withdrawal management services. Additional services or population coverage expansion hinges upon legislative appropriation. Regarding program changes, effective April 1, 2019, residential SUD providers shall provide MAT onsite or facilitate access to MAT offsite which includes coordinating with the enrollee's MCO for referring to available MAT provider and arranging Medicaid non-emergency medical

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					services by enrollees with OUD/SUD; • Increased initiation of follow-up after discharge from emergency department for alcohol or other drug dependence; and • Reduced readmission rates for OUD/SUD treatment." Please provide some insight on: a) The program changes and service expansions expected to be implemented in the coming months and years to meet these objectives b) Expected utilization, costs and trend estimates for such programs and services c) The role the MCOs can play in helping the state achieve these objectives 2. Also in the approved waiver document, in the budget neutrality test section, the below table is included. It shows the "trend rates and per capita cost estimates for each EG for each year of the demonstration." Please provide detail on how the trend and costs shown are developed and which MEGs are addressed by the estimate. 3. Can the state provide emerging experience for any of the expanded benefits under the approved SUD waiver (for example, increased utilization of IMDs for purposes of SUD treatment)?	transportation if other transportation is not available for the patient. 1b) The SUD Monitoring Protocol will describe the data collection and reporting for performance measures identified by CMS and the State. For each performance measure, the protocol will identify a baseline, a target to be achieved by the end of the demonstration, and an annual goal for closing the gap between baseline and target (expressed as percentage points where applicable). Results from demonstration year one will be used for baselines. Targets will be reflected as directional targets (e.g., increase, decrease), rather than values. The Monitoring Protocol is currently pending approval by CMS. 1c) The MCO's role related to the 1115 waiver is incorporated throughout the contract and appropriate appendices and attachments. This includes, but is not limited to, enrollee outreach, provider education and training, and provider monitoring. 2) The information presented in the table referenced in this question is subject to change based on ongoing discussions with CMS and refinement of the data.

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						3) Louisiana is still awaiting approval of the SUD Monitoring Protocol. Once approved, the quarterly and annual reports will discuss any relevant metric trends and analysis.
5	RFP	1.6	Schedule of Events	6	Will the state consider releasing answers to written inquiries sooner than April 5, 2019 or consider releasing answers on a rolling basis as they are ready?	LDH intends to release answers to the written inquiries according to the published schedule. Any changes to the schedule will be posted as an addendum to the RFP.
6	RFP	Part 2	Proposals	8	Can LDH confirm organizational charts may be submitted on 11” x 17” paper?	Proposers may submit organizational charts on 11" x 17" paper.
7	RFP	2.2	Proposal Response Format	9	Please confirm that Section 2.2.2.2 is asking for the name and address of the Proposer’s principal office location registered with the Louisiana Secretary of State and that it is not asking for a list of the individuals who serve as principal officers, as such individuals would not have website URLs.	Confirmed. **Please refer to revision #1 in Part 2 below.**
8	RFP	2.2	Proposal Response Format	9	Would LDH allow for any requested attachments larger than 10 pages to be submitted electronically? Proposers can provide a placeholder to indicate where the attachments would otherwise have been placed to inform reviewers where to find the materials in the electronic submission.	Proposers may include the following attachments as part of the electronic copy submission (see RFP Section 2.3.1) in lieu of hard copy: • Financial Statements (RFP Section 2.9.5.1.1) • Medicaid Ownership and Disclosure Form (RFP Section 2.9.6.3), as a scanned copy of the original signature (no digital signatures accepted) • CHW Pilot Response (RFP Section 2.10.4.5) • Provider Network Listing Response (RFP Section 2.10.7.1)

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						• Provider Network Capacity Response (RFP Section 2.10.7.2) • NCQA Ratings/Quality Response (RFP Section 2.10.11.6) **Please refer to revision #9, 10, 14, and 17 in Part 2 below.** Please note that these attachments are also exempt from section-specific and total page limits.
9	RFP	2.2.1	Proposal Response Format	9	Please clarify what constitutes a section. For example, should a tabbed page be inserted after RFP level 3 headings (i.e., after Sections 2.9.1, 2.9.2, 2.9.3, etc.)?	Each Level 3 heading in the Business Proposal Requirements and Technical Proposal Requirements sections introduces a distinct section. For example, a tabbed page should preface each of the following sections: 2.9.1., 2.9.2,…,2.10.1, 2.10.2, etc.
10	RFP	2.2.2	Cover Letter	9	In response to this section, should the Proposer be defined as the bidding entity or should the definition include parent and affiliates as applicable?	A Proposer is defined as a bidding entity for the purposes of this requirement.
11	RFP	2.2.3	Proposal Response Format	9	Please confirm the response to the Business Proposal and Technical Proposal may be included in the same hard copy binder.	Proposers may provide the Business Proposal and the Technical Proposal in the same or separate hard copy submission. LDH will accept either format.
12	RFP	2.2	Proposal Response Format	10	In the MCO_RFP, it states, “The Proposer must adhere to page limits wherever specified. Proposals shall not exceed two hundred and fifty (250) pages in total, inclusive of attachments and appendices, unless explicitly exempted.” Do the questions in the RFP count towards this page limit or are they exempted?	The proposal should be comprised of responses to the RFP questions and is subject to the 250-page limit. If the Proposer chooses to restate the RFP questions in the proposal, it will be counted toward the 250-page limit. Please note that LDH reserves the right not to evaluate any proposal content which exceeds the stated page limits.

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						Please refer to revision #3 and 5 in Part 2 below.
13	RFP	2.2	Proposal Response Format	10	RFP Section 2.2.2.12 requires "[a] brief statement of the Proposer ever having had" specified types of contract terminations. (emphasis added) This limitless lookback period is beyond the document retention policies prescribed by most state and federal regulations; and therefore, most organizations will not be able to provide the requested information if documents relating to it have been destroyed in compliance with such retention policies. Even if such information were available, the number of contracts a company has been party to during the entire time it has been in existence, coupled with the fact that some companies may have acquired other companies or have been acquired, makes it extremely difficult to track contract terminations for an undefined time period. Would the Department be amenable to Proposers applying a 10-year lookback period to this section? This approach is consistent with Section 2.9.1.9, which also addresses contract terminations, and Section 2.2.2.11, regarding litigation.	LDH will accept a 10-year lookback period as it pertains to RFP Section 2.2.2.12. This requirement is only applicable to Medicaid managed care contracts. **Please refer to revision #2 in Part 2 below.**
14	RFP	2.2	Proposal Response Format	10	Should the business proposal be broken out into its own binder separate from the technical proposal?	See response to question #11.
15	RFP	2.2.2.10	Proposal Response Format	10	Please confirm “graphical summary” means a table or chart that indicates the MCO’s compliance with the mandatory and preferred requirements.	The graphical summary may be a table or chart that indicates whether the Proposer meets mandatory and preferred qualifications to propose.

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16	RFP	2.2.2.12	Proposal Response Format	10	Please confirm that MCOs should use the timeframe of the last ten (10) years when submitting a listing of contracts terminated or not renewed for non-performance or poor performance.	See response to question #13.
17	RFP	2.2.2.14	Proposal Response Format	10	Is the "positive statement of compliance" intended to be an agreement to comply with the terms of the Model Contract?	Yes.
18	RFP	2.2.4	Proposal Response Format	10	May attachments over 10 pages in length be submitted in digital form only?	See response to question #8.
19	RFP	2.2.4	Proposal Response Format	10	Section 2.2.4 of the RFP states that "Proposals should not exceed 250 pages in total…" Several questions (e.g.: 2.10.2.3, 2.9.5) indicate that the requested attachments are exempt from total page limits. Please confirm that such attachments are also excluded from the 250-total page limit.	Attachments that are requested in a section that is explicitly exempt from the total page limit are also exempt from the 250-page total limit. For example, the financial statements requested in RFP Section 2.9.5 will not be counted toward the 250-page limit. Please note that in some cases, requirements are exempt only from section-specific page limits and not the total page limit. For example, organizational charts and resumes are exempt from the 6-page limit for RFP Section 2.10.2.2, but will be counted against the total page limit of 250 pages. Also note that LDH reserves the right not to evaluate any proposal content which exceeds the stated page limits. **Please refer to revision #3 and 5 in Part 2 below.**

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20	RFP	2.5	Confidential Information, Trade Secrets, and Proprietary Information	11	Please confirm the "Confidential" marking should only be applied to pages within the redacted copy.	If the proposal contains confidential data, each page of the unredacted version (hard and electronic copies) that contains confidential data shall be specifically identified and marked “CONFIDENTIAL.” The redacted electronic copies, which should be clearly marked "REDACTED COPY", shall have all confidential data removed.
21	RFP	2.3.2	Number of Copies of Proposal	11	RFP Section 2.3.2 states, "The Proposer must certify that all copies are correct and complete." Where would LDH like this certification located? Will a statement included in the cover letter suffice?	This provision will be updated in this addendum. **Please refer to revision #4 in Part 2 below.**
22	RFP	2.5	Confidential Information, Trade Secrets, and Proprietary Information	12	Do Proposers need to submit a physical copy of the redacted version of the response?	No.
23	RFP	2.9.1.1	Mandatory Qualifications	14	Does the LDI Certificate of Authority qualify as demonstration of meeting the federal definition of an MCO?	No. The Proposer must affirm that it meets the federal definition of an MCO as defined in the CFR in addition to having a license or certificate of authority issued by LDI.
24	RFP	2.9.1.3	Mandatory Qualifications	14	How would LDH prefer the Proposer demonstrate non-exclusion in compliance with 42 CFR § 438.808? If additional documentation is requested, may this be included as separate attachments that do not count toward the total page limits?	The Proposer may attest or include a statement that they are not an excluded entity. This information will count towards the page limit.
25	RFP	2.9.1.5	Mandatory Qualifications	15	How would LDH prefer the Proposer demonstrate compliance with LDI standards? If additional documentation is requested, may this be included as	The Proposer must demonstrate evidence of solvency. Documentation of this and other LDI applicable standards may be included in separate attachments and will not count towards the business proposal

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					separate attachments that do not count toward the total page limits?	and total page limits. **Please refer to revision #6 in Part 2 below.**
26	RFP	2.9.1.7	Mandatory Qualifications	15	[Redacted], a holding company, will respond to the Louisiana Medicaid RFP, by creating a wholly owned subsidiary that will be locally domiciled and licensed as an HMO in Louisiana. [Redacted] wholly owns and currently operates, two MCOs that service the Medicaid populations in [Redacted]. Will [Redacted] satisfy RFP Section 2.9.1.7 where its affiliate, [Redacted], is engaged in a contract as a Medicaid MCO in the State of [Redacted], which has a Medicaid population greater than that of Louisiana?	Yes. **Please refer to revision #7 in Part 2 below.**
27	RFP	2.9.1.9	Mandatory Qualifications	15	Will LDH please confirm that contract termination referenced in 2.9.1.9 is related specifically to the Proposer and not its parent company or affiliate organizations?	This requirement has been removed. **Please refer to revision #7 in Part 2 below.**
28	RFP	2.9.2.2	Conflict of Interests	15	Will the state provide a list of LDH's Enrollment Broker, External Quality Review Organization Contractor, and both of their subcontractors for the proposed contract period?	LDH's current contract with Maximus for enrollment broker services ends 7/3/2021. Subcontractors include CSG BI, Inc, Franklin Associates, and AltaRecruit, LLC. LDH's current contract with Island Peer Review Organization (no subcontractors) for EQRO services ends 8/31/2019. LDH plans to contract with a new EQRO via a competitive bidding process. As the EQRO vendor during the term of the MCO

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						contract is to be determined, this component of the provision will be removed. **Please refer to revision #8 in Part 2 below.**
29	RFP	2.9.4.1	Material Subcontractors	16	In the business proposal, Section 2.9.4.1 asks the Proposer to list material subcontractors who will provide a function that "…relates to the delivery or payment of MCO covered services." For the "payment" portion of this request, please confirm that LDH is expecting Proposers to list only subcontractors that are adjudicating/paying claims, rather than listing subcontractors that, for example, perform payment-related support services such as identification/recovery of third party liability?	Please refer to the definition of a material subcontract [emphasis added]: **Material Subcontract** - Any contract or agreement by which the Contractor procures, re-procures, or proposes to subcontract with, for the provision of all, *or part*, of any program area or function that relates to the delivery or payment of MCO covered services including, but not limited to, behavioral health, claims processing, care management, utilization management, transportation, or pharmacy benefits, including specialty pharmacy providers. Payment-related support services such as identification/recovery of third party liability meet the definition of a material subcontract and shall be included in the response.
30	RFP	2.9.4.2.1	Material Subcontractors	16	Please confirm that vendors that supplement or enhance existing core functions are not considered "Material Subcontractors" in light of the language "relates to the delivery or payment of MCO covered services." (For example, a vendor that supplements claims review but the ultimate responsibility remains	See response to question #29.

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					with the MCO would not be considered a Material Subcontractor.)	
31	RFP	2.9.5	Financial Condition	16	Financial statements are voluminous documents (generally, each statement is over 300 pages in length). Please confirm the Department will allow MCOs to submit their financial statements electronically on flash drive only.	See response to question #8.
32	RFP	2.10.	Technical Proposal Requirements	17	Does LDH prefer attachments and appendices to be included after the subsection (e.g., Subsection 2.10.2.1) they are requested or in order by section at the end of the main section (e.g., Section 2.10.2)?	LDH prefers attachments and appendices to be included at the end of the proposal, in the order of the respective sections.
33	RFP	2.9.5	Financial Condition	17	The requirement asks for audited financial statements for each of the last three years. Keeping in mind the large size of the documents, can the financials be submitted electronically instead of printed?	See response to question #8.
34	RFP	2.9.5.1.1	Financial Condition	17	If a Material Subcontractor would prefer not to release its audited financial statements, will the Department allow some other documentation (i.e. certified statement) that demonstrates they are in sound financial condition?	No. The proposal shall include audited financial statements of all material subcontractors.
35	RFP	2.9.5.1.1	Financial Condition	17	Are audited financial statements to be provided exclusively for the material subcontractors referenced in Section 2.10.2.3 of the Technical Proposal?	See response to question #34.

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36	RFP	2.9.6.3	Required Forms and Certifications	17	The instructions for Appendix E indicate every field should be completed and every question must be answered or you will be rejected. Appendix E asks for a National Provider Identifier (NPI) number. Please confirm Proposers who may not have or are not required to obtain an NPI number, may leave this field blank and not be rejected. If not, please provide additional direction for filling out this component.	An NPI number is required for completion of this form. Proposers that do not have an NPI number may apply for one at https://nppes.cms.hhs.gov/#/.
37	RFP	2.9.6.3	Required Forms and Certifications	17	In Appendix E, is the Provider Name field applicable to Proposer? If yes, please provide additional direction for filling out this component.	Yes. This field should be the same as the name used in the DBA Name field in Section I.
38	RFP	2.10.2.1	Proposer Experience	18	Total page limit is 250, yet the cumulative page limit of all questions only equals 162. Please confirm that for sections within the Technical Proposal that include a page limit, the page limit only applies to the written narrative response and not to any attachments that may be included as part of the response, which are not otherwise exempted by the RFP.	Attachments will be counted toward the section-specific and total page limit unless explicitly exempted. See response to question #19 for additional information.
39	RFP	2.10.2.2	Proposer Experience	18	Given the fact that LDH has accepted incumbent staffing, in the case where requirements have materially changed, should we assume that the previously accepted staff will be grandfathered?	No, all proposers, including incumbent MCOs, must comply with new or revised requirements.
40	RFP	2.10.2.2	Staff Experience and Organizational Structure	18	Will LDH consider allowing the org charts and resumes exempt from section-specific and from total page limit?	Organizational charts and resumes are exempt from the 6-page limit for Section 2.10.2.2, but will be counted against the total page limit of 250 pages. See response to question #19.

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41	RFP	2.10.2.2	Staff Experience and Organizational Structure	18	Question 2.10.2.2 requests Proposers to describe individuals' roles, the operating structure and how leadership reports to the governance structure, and description of the teams/units and how it reports to and informs leadership, and a description of qualifications for each team/unit, as well as the team/unit lead. Given the amount of information requested, please consider increasing the page limit from 6 to 15 pages to allow Proposers to adequately address the question.	LDH encourages concise descriptions in the Staff Experience and Organizational Structure response and maintains the 6-page limit. Please note that the organizational chart(s) and resumes are exempt from the 6-page limit.
42	RFP	2.10.2.2.1	Staff Experience and Organizational Structure	18	Can you please define "operating structure" vs. "governance structure" as you request it to be described in this section?	The governance structure provides strategic direction, policy, oversight, and evaluation to realize the organization's long-term vision. The operating structure defines the roles and responsibilities to support the organization's day-to-day activities.
43	RFP	2.10.2.2.2.4	Staff Experience and Organizational Structure	19	To determine the number of full time equivalent employees on each team/unit in the organization, should proposers assume total membership of 375,000?	Proposers may assume a total enrollment of 375,000 for this question. Proposers should also provide its plan to scale staffing levels based on increased or decreased enrollment. **Please refer to revision #11 in Part 2 below.**
44	RFP	2.10.2.2.2.4	Staff Experience and Organizational Structure	19	Should Proposers calculate the estimated FTEs based on the anticipated number of 375,000 Enrollees (similar to what is referenced in the requirement about providing an actuarial statement in support of Value Added Benefits valuation in Section 2.10.3.4)?	See response to question #43.
45	RFP	2.10.2.3	Material Subcontractors	19	Given the CVOs contractual relationship with the state, should Proposers consider them a Material Subcontractor (both for RFP and oversight)? If yes, please confirm	The CVO should not be considered a material subcontractor. A material subcontractor refers to an entity contracted by the MCO.

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					that Proposers may reach out to gather information.	
46	RFP	2.10.2.3	Material Subcontractors	19	Please confirm that proposers need to complete "Appendix F" only for Material Subcontractors that interface directly with enrollees, such as behavioral health, pharmacy, vision, transportation services and dental.	Appendix F should be completed for material subcontractors that provide behavioral health, pharmacy, vision or transportation services, or a value-added benefit.
47	RFP	2.10.2.4	Proposer Reference Contact Information	19	Please confirm there are no page limitations in meeting the requirements for 2.10.2.4 Proposer Reference Contact Information.	There is no section-specific page limit for Proposer Reference Contact Information. However, responses will be counted toward the total page limit of 250 pages. Please note that LDH is not requesting letters of recommendation. Any letters submitted will not be considered for evaluation purposes.
48	RFP	2.10.2.4	Proposer Reference Contact Information	19	To align with 2.10.2.4.1, should Proposers follow the same three (3) year timeframe when responding to the request for corrective action plans and/or monetary penalties for each reference.	For each reference, Proposers should include any compliance actions taken by the State or municipality during the entire term of its contract. **Please refer to revision #12 in Part 2 below.**
49	RFP	2.10.2.4	Proposer Reference Contact Information	19	If the Department is unable to reach or does not receive a reference, will the Department notify the Proposer to help obtain the reference? The requested Proposer Reference contact information appears in the Section 2.10.2 Proposer Organizational Experience, which can receive up to 120 points. What portion of those points is allocated to the Proposer Reference section?	LDH will make a reasonable attempt to contact references for each Proposer. It is the Proposer's responsibility to provide complete and accurate contact information for each reference. However, LDH reserves the right to seek clarification in accordance with RFP Section 3.4. LDH will not be providing point allocations beyond those specified in RFP Section 3.3.2.

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50	RFP	2.10.2.4	Proposer Reference Contact Information	19	There is no stated page limit for the Proposer Reference Contact Information. Should this be exempt from the page limits?	See response to question #47.
51	RFP	2.10.2.4	Proposer Reference Contact Information	19	Given that this request may require a considerable amount of pages, will LDH consider allowing the reference contact information exempt from section-specific and from total page limits?	LDH maintains that Proposer Reference Contact Information shall be counted toward the total page limit of 250 pages. Please see response to question #47.
52	RFP	2.10.2.4	Propose Reference Contact Information	19	Will LDH be outreaching to references? If so, can LDH provide additional detail as to timing and format of outreach in order to ensure the reference contact is aware and available?	Yes. LDH plans to make the initial outreach via e-mail, likely within two weeks following receipt of the proposal. However, it is the Proposer's responsibility to notify the references and make them aware that they may be contacted at any time during the evaluation process.
53	RFP	2.10.2.4	Proposer Reference Contact Information	19	There is no page limit specified for 2.10.2.4. Does the absence of a page limit reflect that the response is exempt from a page limit? If not, will you provide a page limit for 2.10.2.4 Proposer Reference Contact Information?	See response to question #47.
54	RFP	2.10.2.4	Proposer Reference Contact Information	19	Please confirm the disclosure period for items required by RFP Section 2.10.2.4.2 is three years, consistent with the disclosure period in RFP Section 2.10.2.4.1.	See response to question #48.
55	RFP	2.10.2.4	Proposer Reference Contact Information	19	RFP Section 2.10.2.4 asks the Proposer to submit information from Medicaid managed care contracts for comparable services. Proposers may have a significant number of references, and a response to this section may be extensive. Please confirm that we can exclude this section of the response from the total page limit.	See response to question #47.

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56	RFP	2.10.2.4.2	Proposer Reference Contact Information	19	Please confirm MCOs should use the RFP Release Date (2/25/19) as the look-back date when submitting the list of corrective action plans and/or monetary penalties.	Proposers may use the RFP release date as the start of the 3-year lookback period for the identification of contracts referenced in 2.10.2.4.1. However, for each reference, Proposers should include any compliance actions taken during the entire term of its contract. See response to question #48.
57	RFP	2.10.2.4.2	Proposer Reference Contact Information	19	RFP Section 2.10.2.4.2 asks for reference information about Medicaid managed care contracts for comparable services. For ease of review of the contract information, such as description of individuals served and key responsibilities, please confirm that Proposers can place information about compliance actions in an attachment that is excluded from the total page count.	This requirement will not be excluded from the total page count. See response to question #47.
58	RFP	2.10.2.5.1	NCQA Accreditation	19	Could LDH please confirm that the Proposer should provide a copy of all NCQA Accreditation certificates for each of the Proposer's organizations, including affiliates, Medicaid managed care contracts, nationwide?	The Proposer should provide a copy of all NCQA accreditation certificates for each of the Proposer's Medicaid managed care contracts nationwide. The Proposer is defined as a bidding entity. Certificates are not required for the parent organization or affiliates.
59	RFP	2.10.3	Enrollee Value-Added Benefits	20	Can a proposer submit additional Value-Added benefits above and beyond those listed? If so, will the proposer receive points towards the maximum allowed for this section?	Proposers should provide responses to the six optional value-added benefits listed. Any additional value-added benefits submitted will not be considered for evaluation purposes.
60	RFP	2.10.3	Enrollee Value-Added Benefits	20	Please confirm section 2.10.3.1 is intentionally omitted from the RFP document.	RFP Section 2.10.3.1 was omitted due to a numbering error. **Please refer to revision #13 in Part 2 below.**
61	RFP	2.10.3	Enrollee Value-Added Benefits	20	Can LDH further detail how value-added benefits will be evaluated? How are each of the six different options weighted?	LDH will not be providing point allocations beyond those specified in RFP Section 3.3.2.

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62	RFP	2.10.3	Enrollee Value-Added Benefits	20	Will LDH please clarify its intent in section 2.10.3.2, "LDH reserves the right to add additional options during the term of the Contract, and the selected Proposer may provide additional value-added benefits during the term of the Contract at its option"?	Currently, LDH has limited value-added benefits to the six listed in the RFP. In the future, LDH may expand the value-added benefit options, which the Contractor may choose to offer to its enrollees. Value-added benefits are optional; however, the proposed monetary value of any selected value-added benefit shall be considered a binding Contract deliverable.
63	RFP	2.10.3	Enrollee Value-Added Benefits	20	We note that the RFP has a section numbered 2.10.3.2 but not a section numbered 2.10.3.1. Was a section inadvertently omitted, or should the remaining sections be renumbered in sequence?	See response to question #60.
64	RFP	2.10.3	Enrollee Value-Added Benefits	20	RFP Section 2.10.3.2 outlines six value-added benefits that MCOs can elect to offer. In addition to the six optional benefits provided by LDH, we understand that MCOs can propose additional value-added benefits that fall outside of these six benefits.). Please clarify how these additional VABs will be scored. Will MCOs receive more points for offering additional VABs?	See responses to question #59 and 61.
65	RFP	2.10.3	Enrollee Value-Added Benefits	20	The first sub-level under 2.10.3 is 2.10.3.2. Is section 2.10.3.1 intentionally omitted?	See response to question #60.
66	RFP	2.10.3.2	Enrollee Value-Added Benefits	20	Please confirm that responses to section 2.10.3.2 should be limited to the six (6) value-added benefits specified?	See response to question #59.

Question No.	Document Reference	Section Number	Section Heading	Page	Question	Answer
67	RFP	2.10.3.2	Enrollee Value-Added Benefits	20	This section states that LDH reserves the right to "add additional options during the term of the Contract." Please provide more detail about: 1. What process LDH will follow to add more options once the contract is in place 2. What process and terms will be available for the selected MCOs to assess and determine whether to provide additional value adds that LDH might include once the contract is in place 3. If the cost of any additional benefits will be offset by the removal of benefit(s) with a similar actuarial value?	During the term of the contract, LDH will consider additional value-added benefits that align with departmental priorities. For each additional benefit, LDH will consider the populations who may receive the benefit, the scope of the benefit and how the scope compares to existing Louisiana Medicaid coverage, any proposed co-payments, how the benefit will be provided to enrollees, how the Contractor will provide oversight, and the PMPM actuarial value of benefits. Any formal process or guidelines beyond this, if developed by LDH, shall be added to the MCO Manual.
68	RFP	2.10.3.2	Enrollee Value-Added Benefits	20	How will the 60 points for the six Value-Added benefits be distributed?	See response to question #61.
69	RFP	2.10.3.2	Enrollee Value-Added Benefits	20	Is it expected that If bidders offer additional Value-Added benefits beyond the six included in this section, how will those items be scored?	See response to question #61.
70	RFP	2.10.3.2	Enrollee Value-Added Benefits	20	Please confirm only the six value-added benefits listed in Section 2.10.3 should be included in the response to this section.	See response to question #59.
71	RFP	2.10.3.3.2	Enrollee Value-Added Benefits	20	For each value-added benefit selected, the Proposer is to include a description of "how the scope compares to existing Louisiana Medicaid coverage." The respite care and non-Rx pain management benefits seem to not align with any benefits provided in existing Louisiana Medicaid. What services are currently included in the State plan that the State views are in the scope of these benefits?	By definition, value-added benefits are additional benefits that are not Medicaid covered services. Proposers should describe how the proposed benefit may align with or support Medicaid covered services, if applicable. For example, the Proposer should describe how its respite care model, if selected, aligns with or supports care management activities targeted to homeless individuals.

Question No.	Document Reference	Section Number	Section Heading	Page	Question	Answer
72	RFP	2.10.3.3.2	Enrollee Value-Added Benefits	20	Regarding the value-added benefit for respite care model targeting homeless persons with post-acute medical needs: Is there any historical data that tracks the number of members who have been identified as homeless?	No, LDH does not have historical data tracking the number of enrollees who have been identified as homeless.
73	RFP	2.10.3.4	Enrollee Value-Added Benefits	20	Please provide an assumed breakdown of the 375,000 members by Region and Rate Cell. We would expect the projected cost of these benefits to differ at this level of detail.	Proposers may use the Potential Enrollment data file located in the procurement library to determine membership mix.
74	RFP	2.10.3.4	Enrollee Value-Added Benefits	20	In the event the benefit is covered via a sub-capitation agreement with a 3rd party, should the PMPM submitted reflect the expected claims cost or the full value of the capitation premium?	Proposed value-added benefit PMPMs shall reflect the full cost of providing the proposed benefit(s) to enrollees.
75	RFP	2.10.3.4	Enrollee Value-Added Benefits	20	Is there a required format or any further content requirements for the actuarial certification of the value-added benefits?	No.
76	RFP	2.10.4.3	Population Health	21	Has the State developed any standardized screening tools for MCO's to screen for SDOH issues? Please discuss if any standardized tools will be used by MCO's to identify and report issues associated with housing, transportation, food security, utility needs, education, etc…	The State has not developed standardized screening tools for MCOs to screen for SDOH issues; however, LDH expects the Contractor to use a common Health Needs Assessment, to be developed by LDH as described in Model Contract Sections 2.7.2 and 3.1.15.
77	RFP	2.10.6.3	Case Scenarios	24	Please confirm that for the purpose of this response, Proposers should assume the 65 year old enrollee in Case 3 is eligible for Medicare.	Confirmed. Proposers should assume the 65 year old enrollee in Case 3 is eligible for Medicare. **Please refer to revision #15 in Part 2 below.**

Question No.	Document Reference	Section Number	Section Heading	Page	Question	Answer
78	RFP	2.10.7	Provider Network	24	Can the list of providers required by Section 2.10.7 be submitted as an electronic file, only, with no printed version? If a printed copy is required, in an attempt to help increase readability and ease the review process, will LDH permit Proposers to submit Provider Network documentation at the end of their response as an attachment with a placeholder where Section 2.10.7 would go, informing reviewers where to find the materials? We believe this approach will make it easier for reviewers to focus on the response narrative.	Proposers are not required to submit the response to RFP Section 2.10.7 in hard copy. See response to question #8.
79	RFP	2.10.7.1	Provider Network	24	To simplify the provider experience, please confirm executed Letters of Intent (LOI) to contract will be acceptable to demonstrate network build progress and capacity where applicable.	Letters of Agreement are synonymous with Letters of Intent.
80	RFP	2.10.7.1	Provider Network	24	Please confirm whether providers with a specialty of Licensed Clinical Social Worker and Psychiatry should be listed on both the Specialists & Outpatient BH Providers tabs of the Provider Network Listing Template.	No. Licensed behavioral health practitioners (e.g., LCSWs or psychiatrists) should only be listed under the "Outpatient BH Providers" tab.
81	RFP	2.10.7.1	Provider Network	24	Please confirm that the following Louisiana Medicaid provider types were intentionally left off the “Non-BH Providers & Specialties” tab: Physical Therapy, Durable Medical Equipment, Certified Nurse Midwife, Non-Emergency Medical Transportation, and Imaging Centers. If they instead should be included, would we include them under the “specialists” tab?	Proposers should use the provider types listed in the “Non-BH Providers & Specialties” tab. Not all provider types have been included.

Question No.	Document Reference	Section Number	Section Heading	Page	Question	Answer
82	RFP	2.10.7.1	Provider Network	24	Please clarify if Pediatric Allergists should be listed under the “Allergists” or the “Pediatrics” Specialists tab.	Pediatric Allergists should be listed in the "Specialists" tab.
83	RFP	2.10.7.1	Provider Network	24	It is our understanding that all specialists who are employed with a federally qualified health center (FQHC) or a rural health center (RHC) should be separately identified on the Specialists tab. As such, do RHCs who employ these specialists need to be listed as well? Do FQHCs that also employ these specialists need to be listed as well?	These providers should be listed separately in the “Specialists” tab. Additionally, fully licensed behavioral health specialists employed by FQHCs or RHCs should be listed on the "Outpatient BH Providers" tab. To avoid duplication, RHCs and FQHCs who employ these specialists should not be listed in the “Specialists” tab.
84	RFP	2.10.7.1	Provider Network	24	On the Provider Network Listing Excel file, if an Inpatient BH facility provides both inpatient and outpatient services, do both services go on the Inpatient BH Providers tab, or are they separately listed on both the Inpatient BH Providers tab and the Outpatient BH Providers tab?	The facility should be listed only on the "Inpatient BH Providers" tab.
85	RFP	2.10.7.1	Provider Network	24	Are providers who deliver value-added benefits only, such as dental, to be listed on the Specialists tab? If so, should general dentistry be included in addition to orthodontists? Orthodontists are the only dental providers currently included on the non-BH Providers and Specialties tab.	Value-added providers should not be listed in the Provider Network Listing Response.
86	RFP	2.10.7.1	Provider Network	24	Should the summary table be included in the state’s Provider Network Listing Response Template or as a separate file? If on the Provider Network Listing Response Template, should we revise the template to include the summary?	The Proposer may add an additional tab in the Provider Network Listing Response for the summary.

Question No.	Document Reference	Section Number	Section Heading	Page	Question	Answer
87	RFP	2.10.7.1, 2.10.7.2	Provider Network	24	Please confirm Proposers may submit the Provider Network Listing Response Template and the Provider Network Capacity Response Template in an electronic format only (on the required flash drives), rather than print them as part of the response submission.	See response to question #8 and 78.
88	RFP	2.10.9	Provider Support	26	Appendix B Model Contract Section 2.10.9 Provider Services and Support has 7 pages of requirements that must be addressed in the Proposer's response to be fully compliant with LDH instructions. Section 2.10.9 also asks 15 separate questions but the section only allows 10 pages in which to address both contract requirements and the questions. Please consider increasing the page limit to 14 pages for the total response.	This page limit has been increased. **Please refer to revision #16 in Part 2 below.**
89	RFP	2.10.9.1.3	Provider Support	26	Is there a set standard for identifying providers with high claims denial rate? In other words, if a provider experiences a 50% denial rate but has only submitted 2 claims, are they included? Or is there a standard threshold of volume that must be met to be included in the population of providers who could receive support for high denial rates?	LDH has not currently established a set standard for identifying providers with high claims denial rates. However, to comply with Act 710 of the 2018 Regular Session, LDH is establishing a reporting template for MCOs to submit listings of providers with a denial rate of 10% or greater, stratified by low, medium, and high claim volumes.

Question No.	Document Reference	Section Number	Section Heading	Page	Question	Answer
90	RFP	2.10.11	Quality/Attachment G	28	Quality Question 2.10.11.1 refers to the incentive-based quality measures identified in Attachment G to the Model Contract. RFP section 2.16.9.1 indicates these specific measures can be identified in Attachment G annotated with “$$”. Attachment G does not have "$$" but has a footnote of "*Selection of incentivized measures and related benchmarks is dependent on measurement year 2018 performance, clinical priority, validation of LDH agency-wide priorities and validation of technical specifications for state specific measures". Please clarify which measures are the incentive-based quality measures.	**Please refer to revision #17 in Part 2 below.** Attachment G will be updated to reflect incentive-based measures once the proposed performance measures set is finalized by Fall 2019. The incentive-based measures will be notated with "$$."
91	RFP	2.10.11	Quality	28	Will LDH please consider revising page limit requirement to include the NCQA rating attachments exempt from the total page limit as well as the section-specific page limit?	Rating information will be exempt from both section-specific and total page limits. Please note that this response, per the instructions in the Quality Response Template, should be a listing of NCQA Health Insurance Plan Ratings rather than a narrative response. However, this requirement has been clarified to include rating information of the parent organization and affiliates. **Please refer to revision #17 in Part 2 below.**
92	RFP	2.10.11	Quality	28	The RFP indicates the NCQA rating attachment is exempt from the section-specific page limit. Please confirm it is also excluded from the total page limit of 250.	See response to question #91.

Question No.	Document Reference	Section Number	Section Heading	Page	Question	Answer
93	RFP	2.10.11.3	Quality	28	Please clarify whether LHD wants the Proposer to respond to the sub-elements of this question (3.1 – 3.3) as a general description or should the Proposer answer the sub-elements using a specific data driven clinical initiative from the past 24 months.	The sub-elements of the question (3.1-3.3) should address how the proposer's QAPI Program addresses these functions through organization-wide initiatives to improve the health status of covered populations. In addition, the Proposer should describe in detail at least one (1) data-driven clinical initiative that the Proposer initiated within the past twenty-four (24) months that yielded improvements in clinical care for similar populations.
94	RFP	2.10.11	Quality	29	Please confirm that the requested sample of a clinical practice guideline does not count against the 20 page limit of the section?	The clinical practice sample guidelines will be excluded from the section-specific and total page limits. **Please refer to revision #17 in Part 2 below.**
95	RFP	2.10.11.5	Quality	29	Please confirm the list of clinical practice guidelines is excluded from both the Section and Total page limits of the response.	See response to question #94.
96	RFP	2.10.11.5	Quality	29	Considering the length of many clinical practice guidelines, would LHD accept a website link to the specific guideline? If not, please confirm that the sample clinical practice guideline is excluded from both the Section and Total page limits of the response.	See response to question #94.
97	RFP	2.10.11.5	Quality	29	Should the list of clinical practice guidelines be submitted as an attachment? If so, is it excluded from the 20 page section limit and 250 page total?	See response to question #94.
98	RFP	2.10.11.6	Quality	29	Please confirm the Quality Response Template attachment will not be counted toward the Section or Total page limits for the response.	See response to question #91.

Question No.	Document Reference	Section Number	Section Heading	Page	Question	Answer
99	RFP	2.10.12.1	Value-Based Payment	30	Sub-question 2.10.12.1 asks for, "The specific models and VBP arrangements the Proposer will implement to ensure that it meets the VBP thresholds for provider payments in such arrangements in 2020 as described in Part 2, Value Based Payment of the Model Contract, and the impact of the models on potential incentive earnings by providers;" Please clarify whether projecting the maximum dollars the provider is eligible to earn under each model satisfies the 'impact of the models'. If not, please define what LDH means by 'impact of the models.'	In terms of the impact of the VBP models on potential incentive earnings by providers, LDH expects proposers to estimate the expected and the maximum payment amounts that contracted providers are eligible to earn under each proposed model, and, if downside risk or penalties are applicable to the model, the expected and the maximum amount a provider might lose under each proposed model.
100	RFP	2.10.12.1	Value-Based Payment	30	Does LDH have requirements on the specific "impact on potential incentive earnings by providers" that must be provided by potential Contractors? For example, would an estimate of the dollars "at-risk" in the various VBP arrangements suffice?	See response to question #99.
101	RFP	2.10.13	Claims Management and Systems and Technical Requirements	30	In order to adequately address the 14 questions and sub-questions in this section, as well as 35 pages of contractual requirements, please consider expanding the page limit to 20 pages.	This page limit remains unchanged.
102	RFP	2.10.13	Claims Management and Systems and Technical Requirements	30	Please confirm that the data flows and charts requested in 2.10.13 are excluded from the RFP's 250 total page limit. Allowing the data flows and charts outside of the RFP's 250 page limit allows Proposers to more fully address the 35 pages of requirements.	Data flows and charts requested in RFP Section 2.10.3 will be excluded from the section-specific and total page limits. **Please refer to revision #18 in Part 2 below.**

Question No.	Document Reference	Section Number	Section Heading	Page	Question	Answer
103	RFP	2.10.13.2.3	Claims Management and Systems and Technical Requirements	31	Are “functions” synonymous with “systems that would be used to support the Contract (including enrollment, claims processing, customer service systems, utilization management/service authorization, care management/care coordination, and financial systems)” as outlined in 2.10.13.2.2?	This section is speaking to Systems and Technical Requirements. RFP Section 2.10.13.2.2 specifically asks the Proposer to speak to the hardware and system architecture for all systems so it is not synonymous with "functions".
104	RFP	2.10.13.2.5	Claims Management and Systems and Technical Requirements	31	Please clarify what is meant by “proposed resources.” Does this refer to staffing or technical resources?	This refers to both technical and staffing resources.
105	RFP	2.10.13.5	Claims Management and Systems and Technical Requirements	31	Please clarify if Proposers are to describe their overall capability to interface or solely the maximum amount (“capacity”) of their interfaces.	Proposers should describe both their capability and capacity to interface with multiple LDH vendors, even those with older technology that may require retro-fitting, as well as an enterprise architecture. **Please refer to revision #19 in Part 2 below.**
106	RFP	2.10.15	Veteran and Hudson Initiatives	32	This section of the Technical Proposal did not indicate a page limit, nor did it state that there are no page limits. Please confirm that there is no page limit for 2.10.15 Veteran Hudson Program Participation and that these pages do not count toward the overall 250 page limit.	There is no section-specific page limit for the Veteran and Hudson Initiatives response. However, responses will be counted toward the total page limit of 250 pages.
107	RFP	2.10.15	Veteran and Hudson Initiatives	32	Does this section have a page limit?	See response to question #106.

Question No.	Document Reference	Section Number	Section Heading	Page	Question	Answer
108	RFP	2.10.15	Veteran and Hudson Initiatives	32	Please define the denominator and numerator for the calculation of "net percentage of contract work".	The RFP states: 2.10.15.1.3 If the Proposer demonstrates its intent to use certified small entrepreneurship(s) in the performance of contract work resulting from this solicitation, the Proposer shall receive points equal to the net percentage of contract work which is projected to be performed by or through certified small entrepreneurship subcontractors, multiplied by the appropriate number of evaluation points. The formula for the RFP language is: (A/B) * C = D, where A = the eligible subcontracted work, B = the estimated value of the MCO contract, C = the number of reserved points, and D = points earned. The estimated value of each MCO contract is $7.24B. This value will be used for evaluation purposes only and is not a guarantee of contract value.
109	RFP	2.10.15	Veteran and Hudson Initiatives	32	It is our understanding that under La. R.S.39:2005(5), no more than 10% of the total evaluation points in a RFP may be awarded for the use of Hudson Initiative subcontractors. Based upon this provision of state law, please confirm that the 12% of the total number of evaluation points referred to in Section 2.10.15.1.4 of the RFP is a combination of Veterans Initiative and Hudson Initiative points, since no more than 10% of the total evaluation points in a RFP may be awarded solely for the use of Hudson Initiative subcontractors.	Confirmed. The 12% of the total number of evaluation points is a combination of Veterans Initiative and Hudson Initiative points.

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110	RFP	2.10.15	Veteran and Hudson Initiatives	32	Please provide examples of the scoring calculation and how "net percentage of contract work" impacts how a proposer will score for this section.	See response to question #108 for the formula. If a Proposer uses a certified Veteran Initiative small entrepreneurship for 10% of the proposed work, it would earn 1.2 points: 10/100 * 12 = 1.2 points. If a Proposer uses a certified Hudson Initiative small entrepreneurship for another 10% of the proposed work, it would earn an additional point: 10/100 * 10 = 1 point. In total, if a Proposer subcontracted with both a certified Veteran Initiative small entrepreneurship and a Hudson Initiative small entrepreneurship, the Proposer would score 2.2 points.
111	RFP	2.10.15	Veteran and Hudson Initiatives	32	RFP Section 2.10.15.5 refers to Appendix F (Hudson and Veteran Initiatives), however, the Appendix provided with the RFP is referenced as Appendix G. Please verify that Section 2.10.15.5 should reference Appendix G.	This reference will be corrected in this addendum. **Please refer to revision #20 in Part 2 below.**
112	RFP	2.10.15.1.3	Veteran and Hudson Initiatives	32	Can you define the denominator by which the percentage of total spend will be measured (i.e., will a uniform contract value be used for all Proposers)? Which category of expenditures, as defined in the instructions of the Financial Reporting Guide for FRR Income Statement Schedule C, will be used for calculating the percentage? Should medical spend to certified network providers be included in the calculation of the percentage of contract work	The denominator is the estimated value of the MCO contract. LDH will project the average contract cost and apply that amount uniformly across all proposers. Medical spend to certified network providers cannot be included in the numerator. There is no minimum percentage of the subcontracted work.

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					performed? Is the certified small entrepreneurship(s) expected to perform a minimum percentage of the subcontracted work (e.g., are they expected to not have subcontracted a certain percentage of their work to a subcontractor that is not a certified small entrepreneurship(s))? If yes, what percentage of work is that?	
113	RFP	2.10.15.1.3	Veteran and Hudson Initiatives	32	Please clarify how "contract work" is defined and will be calculated for the purposes of the Veteran Initiative and Louisiana Initiative for Small Entrepreneurships section.	See response to question #108.
114	RFP	2.10.15.1.3	Veteran and Hudson Initiatives	32	Please clarify how "net percentage of contract work" will be defined for Proposers that intend to use certified small entrepreneurship(s) in the performance of contract work.	See response to question #108.
115	RFP	2.10.15.1.3	Veteran and Hudson Initiatives	32	Please clarify how "appropriate number of evaluation points" will be assigned for Proposers that intend to use certified small entrepreneurship(s) in the performance of contract work.	See response to question #108.
116	RFP	2.10.15.1.3	Veteran and Hudson Initiatives	32	If possible, please provide a sample equation or example of how points will be assigned for Proposers that intend to use certified small entrepreneurship(s) in the performance of contract work.	See response to question #110.
117	RFP	2.10.15.1.3	Veteran and Hudson Initiatives	32	Please clarify if LDH will allot more points to specific types of proposed work to be performed by certified small entrepreneurship(s). For example, will LDH assign more weight to SEs that provide care management services, as	LDH will not allot more points to specific types of proposed work.

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					opposed to SEs that provide administrative/office services?	
118	RFP	2.10.15.1.3	Veteran and Hudson Initiatives	32	Will the Department clarify what denominator will be used in determining the "net percentage of contract work to be performed by or through certified [subcontractors]?" For example, the denominator may be the MCO's revenue from the contract OR the MCO's administrative spend OR the MCO's total dollars spent on subcontractors.	See response to question #112.
119	RFP	2.10.15.1.3	Veteran and Hudson Initiatives	32	How will the total value of the contract work be calculated for purposes of determining the percentage that is performed through certified small entrepreneurship subcontractors? Will a standard total contract work value be used for all respondents, will it be based on the values submitted by the respondents, or via some other mechanism?	See response to question #112.
120	RFP	2.10.15.3	Veteran and Hudson Initiatives	32	The list of certified Veterans Initiative or Hudson Initiative subcontractors requested in Section 2.10.15.3 is currently part of the 250 page proposal limit. To encourage detailed responses, such as descriptions of the scope of work to be performed (by each Hudson or Veterans Initiative subcontractor), would LDH consider exempting this section from the total page limit?	See response to question #106.

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121	RFP	2.10.15.3.3	Veteran and Hudson Initiatives	33	To develop the anticipated dollar value of the subcontract, may bidders assume a membership of 375,000?	Yes.
122	RFP	2.10.15.5	Veteran and Hudson Initiatives	33	The RFP indicates, “see Appendix F”, should this be “see Appendix G”?	See response to question #111.
123	RFP	2.10.15.5	Veteran and Hudson Initiatives	33	Please confirm Proposers should refer to Appendix G, Veteran and Hudson Initiative, instead of Appendix F.	See response to question #111.
124	RFP	4.2.1	General MCO Requirements - Ownership Interest	41	Please confirm that requirements stated in Section 4.2.1 do not apply to MCO's subcontractors, in that subcontractors are not required to submit separate disclosures. MCOs in their own disclosures would still comply with the requirement to indicate ownership interest in subcontractors.	Confirmed. The MCO must provide to LDH a completed Medicaid Ownership and Disclosure Form, which includes information about its subcontractors. A separate form is not required for each subcontractor. **Please refer to revision #42 in Part 2 below.**
125	RFP	2.5 and 2.3.1	Confidential Information, Trade Secrets, and Proprietary Information/ Number of Copies of Proposals	11-12, 10	Is the redacted copy of the proposal required to be printed as well as submitted via the two searchable flash drive copies?	Proposers should not submit printed hard copies of the redacted version. Proposers shall provide two (2) electronic copies of the redacted version, each on a separate flash drive, if applicable, based on RFP Section 2.5.
126	RFP	2.9.2, 2.9.4.1	Conflict of Interests, Material Subcontractors	15, 16	RFP Sections 2.9.2 and 2.9.4 each request submission of a signed Proposer’s Certification with specific attestations. Please confirm that Proposers should create Proposer’s Certification with the required attestations and submit with signature. Also, does the Department want a single Proposer’s Certification that combines Sections 2.9.2 and 2.9.4 or one for each section? Please confirm that, consistent with the other Required Forms and Certifications in Section 2.9.6, the Proposer’s Certification(s) for Sections	Proposers must create a certification statement with the required attestations and submit with signature. Proposers may combine these certifications. These certifications are not exempt from the business proposal page limit of 5 pages or the total page limit of 250 pages.

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					2.9.2 and 2.9.4 are excluded from business proposal and total page limits.	
127	RFP	2.9.2-.2.9.4	Business Proposal	15-16	May each of the "signed Proposer's attestations" referenced in the Business Proposal be included as separate attachments that do not count toward the final page limits?	The attestations in RFP Sections 2.9.2-2.9.4 are not exempt from the business proposal or total page limits.
128	RFP	2.10.2.4, 2.10.15	Veteran and Hudson Initiatives	19, 32	There are no page limits listed for Sections 2.10.2.4 and 2.10.15. Can LDH please confirm that these sections are exempt from page limits?	There are no section-specific page limits for the Proposer Reference Contact Information and Veteran and Hudson Initiatives response. However, these responses will be counted toward the total page limit of 250 pages.
129	Appendix B Model Contract	1.1	Glossary and Acronyms	11	The Model Contract defines Disease Management as "see Chronic Care Management"; however, Chronic Care Management is not included in the terms list. Please provide a definition for Chronic Care Management.	**Please refer to revision #21 in Part 2 below.**
130	Appendix B Model Contract	1.1	Glossary	20	For clarification purposes, are all health care professionals who are contracted with the Contractor to deliver health care services considered material subcontractors under the RFP/Scope of Work?	No.

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131	Appendix B Model Contract	Part 1. 1.1	Glossary	25	The definition of "Preventive Care" says that the term "refers to the treatment to avert disease/illness and/or its consequences. The term is used to designate prevention and early detection programs rather than restorative or treatment". However, this section defines tertiary preventive care as "aimed at restoring function after the disease has occurred." We understand that there are variances among experts as to defining preventive care tiers, but would you also consider tertiary prevention to include a slightly larger purview, such as to also "reverse, arrest, or delay the progression of disease" (similar to definition referenced in MEDPAC's Report to Congress, June 2014, Chapter 3. Medicaid and Population Health)	This definition has been revised to adopt the www.Medicaid.gov definition of preventive care. **Please refer to revision #24 in Part 2 below.**
132	Appendix B Model Contract	2.3.1.7	Administration & Contract Management	48	The Contractor shall remove or reassign, upon written request from LDH, any employee or subcontractor employee that LDH deems to be unacceptable. The Contractor shall hold LDH harmless for actions taken as a result hereto. Please define what constitutes unacceptable.	Employees and/or subcontractors may be found unacceptable due to a lack of professionalism, qualification(s), experience, knowledge and/or talent or any other reason affecting the fulfillment of contract requirements.
133	Appendix B Model Contract	2.4.1.2	Mandatory MCO Populations for All MCO Covered Services	60	Please confirm that the "TANF (FITAP) Program" is now the Family and Children (TANF) eligibility category as stated on page 4 of the Healthy Louisiana Data Book.	Confirmed.

Question No.	Document Reference	Section Number	Section Heading	Page	Question	Answer
134	Appendix B Model Contract	Section 2.4	Eligibility and Enrollment	60	The RFP states LDH may select up to four statewide MCO entities. Can LDH provide additional clarification on how membership will be distributed among the four MCOs?	LDH will host an Open Enrollment period for current and new enrollees to proactively select an MCO. Enrollees who do not select an MCO will be automatically assigned based on its algorithm. Enrollees will then have a 90-day period to change their MCO assignment before being linked to that MCO for the next 12 months.
135	Appendix B Model Contract	2.4.12.2.2.1	Effective Date of Enrollment	68	Will the impact of retroactive membership be analyzed periodically, with the results being used to adjust expected claims in the rate development process?	Retroactive enrollment is analyzed during the annual rate update.
136	Appendix B Model Contract	2.4.12.2.4	Administration & Contract Management	68	Is the capitation payment described in this section for the month of the eligibility date? For example, if the eligibility effective date is 1/5/2019, is the capitation payment for the month of January and if so, will it be included in the February capitation payment?	Capitation payments are paid beginning with the first month of an enrollee's eligibility. In the example given, and assuming timely enrollment, if an enrollee's eligibility begins in January 2019, the MCO will receive a capitation payment for the January service month in the month of February. Capitation payments for retrospective enrollment are also made monthly, going back to the first month of an enrollee's eligibility, subject to a limitation of 12 months of retrospective enrollment.
137	Appendix B Model Contract	2.4.13.3.5	Involuntary Disenrollment Requested by the MCO	71	It is our understanding the disenrollment forms are no longer in use and all disenrollment requests are submitted via LaMeds. If that is not accurate what types of disenrollments must be processed on the disenrollment forms?	Disenrollments are a process of MCO assignment managed by the Enrollment Broker and is not handled within LaMEDS. Disenrollment is a request to change from one MCO to another, either for or without cause. This process is automated.

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138	Appendix B Model Contract	2.4.13.4.1	Disenrollment Effective Date	72	Please provide an example of how the disenrollment date will be determined. If a disenrollment determination occurs in March with an effective date of May 1st, who is responsible for the claims payment between March and May?	A disenrollment is approved or denied by the first day of the second month after the month that a disenrollment is requested. Based on the example provided, the losing plan is generally responsible for claims until April 30. Provisions related to inpatient claims apply.
139	Appendix B Model Contract	2.5.2.1.9.6	Excluded Services	77	The requirement in the Model Contract states, "Narcotics other than those indicated for substance use disorder when treating narcotic addiction." This reads that narcotics are excluded except those narcotics indicated for substance use disorder when treating narcotic addiction. This reads that narcotics indicated for substance use disorder when treating narcotic addiction would be covered. Please clarify the intent of this requirement.	The intent was not to allow a recipient being treated for substance use disorder to fill narcotics other than the drugs indicated for the treatment. This will be taken out of the Model Contract and clarified in the MCO Manual. **Please refer to revision #26 in Part 2 below.**
140	Appendix B Model Contract	2.5.5.4	Value Added Benefits	78	In the event actual experience for a specific benefit comes in differently than what was anticipated in the actuarial estimates, is there a process in place for revised estimates to be submitted? Would that fall under "modifications"?	Aside from Model Contract Section 2.5.5.7, there is currently no other process in place for the Contractor to submit revised estimates, as the proposed monetary value of value-added benefits is binding and the Contractor is required to offer the value-added benefits proposed in its response.

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141	Appendix B Model Contract	2.7.2.3	Care Management	89	Section 2.7.2.3 of the Model Contract states that the Contractor shall conduct an HNA for enrollees with Special Health Care Needs within 30 days of identification. Please confirm that LDH will provide Contractors with previous claims, assessment and other critical data that will enable Contractors to quickly identify enrollees with Special Health Care Needs so that the HNA can be completed within the required timeframe.	Please note the provision in the Model Contract, which states [emphasis added]: 2.7.2.2 The Contractor shall develop, implement, and maintain procedures for completing an initial HNA for each enrollee, and *shall make best efforts to* complete such screening within ninety (90) calendar days of the enrollee's effective date of enrollment [42 C.F.R. §438.208(b)] and within thirty (30) calendar days of the date of identification for enrollees with special health care needs (SHCN), *following the protocol below*. (See 2.7.2.3.) While the Contractor shall make best efforts to meet these requirements, in accordance with 42 CFR 438.208(b)-(c), the State and/or the prior MCO are also responsible for sharing information with the new MCO to help identify persons with special health care needs.
142	Appendix B Model Contract	2.7.6	Tiered Case Management Based on Need	91	The model contract indicates that members must be stratified into three levels of risk for case management: High, Medium, Low. To address LDH's requirement accurately in our RFP responses, should proposers assume no case management is required for members identified with no risk? If not, then please clarify LDH's expectations for case management for members identified with no risk.	LDH does not require case management for enrollees classified as having no risk. Contractors shall use tools, such as predictive modeling and referrals, to identify enrollees with new or rising risk.

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143	Appendix B Model Contract	2.7.6.1	Tiered Case Management Based on Need	91	Please confirm that per section 2.7.6.1 Community Health Workers may complete in person visits within the community for Case Management required contacts under the support/direction of the assigned Case Management and as part of the multi-disciplinary team.	Community health workers may provide this service if they are supervised by the case manager and if the health needs assessment falls within the defined scope of practice approved by LDH, in accordance with Model Contract Section 2.6.3.4.1.
144	Appendix B Model Contract	2.7.6.1	Care Management	91	Tier 3 dictates monthly face-to-face collaboration with member / guardian (and quarterly for tier 2 members). For cases involving state custody of members (OJJ / DCFS / etc.) – would a face-to-face collaborative visit to the regional office for that member constitute as face-to-face coordination? If a member or guardian (state employee) requests to complete a monthly follow up by phone, teleconference etc. – can the frequency of outreaches or method of outreach be adjusted to meet the member's request?	For cases involving state custody of members, a face-to-face collaborative visit to the regional office would meet the monthly in-person meeting requirement if that is the enrollee's preferred setting. If requested by the enrollee, or the enrollee's parent or legal guardian, the frequency and/or method of outreach may be adjusted. **Please refer to revision #27 in Part 2 below.**
145	Appendix B Model Contract	2.7.7.2	Case Management for DOJ Individuals	93	Please confirm when LDH issued tools and methodology for conducting a survey for the DOJ population will be made available.	LDH anticipates the tools and methodology will be made available to the MCOs prior to the contract start date.
146	Appendix B Model Contract	2.9.6.1	Requests for Exceptions to Access Requirements	109	Please define "prevailing community standard".	This refers to the current known community network adequacy standard, such as with Applied Behavior Analysis.
147	Appendix B Model Contract	2.9.7.4	Overall Network Management	111	If the MCO is contracting with providers that were approved by the CVO, please confirm the MCO would not be responsible for validating that the provider meets minimum qualifications and requirements.	Confirmed. The MCO would not be responsible for validating that the provider meets minimum qualifications and requirements.

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148	Appendix B Model Contract	2.9.8.1.2	Provider Enrollment	111	Will providers already credentialed with MCOs have to be re-credentialed by the CVO before they can participate?	No.
149	Appendix B Model Contract	2.9.8.1.3	Provider Enrollment	111	Please elaborate on what is included in the State Screening, enrollment, and re-validation process which can take up to 120 days? Is this the CVO process? Currently, MCO's have 60 days to complete the provider credentialing.	Applications for high risk provider types may take up to 120 days because they are required by federal law to undergo fingerprint-based background checks and unannounced site visits when screened by the state. Current high risk provider types are Personal Care Services, Personal Care Attendant, Home Health Agencies, Mental Health Rehabilitation, and DME Agencies.
150	Appendix B Model Contract	2.9.8.3.2	Other Enrollment and Disenrollment Requirements	114	Please confirm the CVO will be responsible for re-credentialing.	Confirmed. The CVO will be responsible for re-credentialing.
151	Appendix B Model Contract	2.9.8.3.4	Other Enrollment and Disenrollment Requirements	114	The requirement that notice be given 15 days prior to the effective termination date could be read to prohibit immediately terminating a provider for-cause in cases of loss of credentials or licensure, criminal conviction, or exclusion from the Medicaid program, or risks to health, safety or welfare. Please confirm that the above scenarios will be exempt from the 15-day prior notice.	State law prohibits LDH from confirming the requested exemptions, except in cases of the provider's loss of state licensure. La. R.S. 46:460.72(C) permits immediate termination only if the provider commits fraud, waste, or abuse or loses a required license, and it requires 15 days' notice prior to the termination if the provider fails to satisfy "all Medicaid provider enrollment, credentialing, and accreditation requirements and all other applicable state or federal requirements for Medicaid reimbursement."
152	Appendix B Model Contract	2.9.1.2	General Provider Network Requirements	121	Please clarify whether existing MCOs should use their current membership file for Network Adequacy reporting or will LDH provide an alternate file?	All proposers, including incumbent MCOs, should use the Potential Enrollment data file located in the procurement library to complete the Provider Network Capacity Response and demonstrate that it meets or exceeds network standards.

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153	Appendix B Model Contract	2.9.14.2	Access to Medication Assisted Treatment	122	The Model Contract refers to the MCO Manual for the reporting frequency and format however, the MCO Manual does not include any specifics regarding reporting requirements for MAT. Please provide the relevant reporting requirements.	Reporting requirements are included in the Behavioral Health Provider Audit Tool, which can be found at http://ldh.la.gov/index.cfm/page/2974. The MCO Manual will be updated accordingly in future versions.
154	Appendix B Model Contract	2.9.24.7	Specialized Behavioral Health Providers	126	Please clarify whether Peer Support Services will be a billable service in the new contract cycle.	LDH fully supports the utilization of peers throughout the behavioral health system. Peer support as a standalone benefit is not currently in the Medicaid service benefit array. Any additions to MCO covered services will be dependent upon legislative appropriation.
155	Appendix B Model Contract	2.9.33.1	Pharmacy Network, Access Standards, and Reimbursement	133	Will the State provide the MCO with a list of pharmacies enrolled in State Medicaid and permitted by the Louisiana Board of Pharmacy?	LDH will provide enrolled pharmacies to the MCOs. Pharmacies enrolled in FFS already have a Louisiana permit.
156	Appendix B Model Contract	2.9.33.3.1	Pharmacy Network, Access Standards, and Reimbursement	134	Will an out-of-state pharmacy filling an emergency prescription be required to have a LA Board of Pharmacy permit?	An out-of-state pharmacy would need to have an expedited enrollment in order to pay the emergency claim. The pharmacy would not have to have a LA Board of Pharmacy permit.
157	Appendix B Model Contract	2.9.33.3.2	Pharmacy Network, Access Standards, and Reimbursement	134	Will an out-of-state pharmacy supplying a service not available in Louisiana as a network provider be required to have a LA Board of Pharmacy permit?	Yes.
158	Appendix B Model Contract	2.9.33.7.3	Out of state pharmacy providers	135	This timeframe will be difficult to meet. Would LDH consider pushing this back to five business days or at least 72 hours?	This provision will be updated in this addendum. **Please refer to revision #29 in Part 2 below.**
159	Appendix B Model Contract	2.10.1	Provider Advisory Council	136	Are there any requirements surrounding the provider advisory councils, such as a	No, LDH expects MCOs to apply their experience and best practices in provider

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					minimum of representatives from different provider groups?	engagement to guide the establishment of the Provider Advisory Council.
160	Appendix B Model Contract	2.10.3.6	Provider Relations	138	Does this provision encompass changes to provider handbooks/manuals?	Yes.
161	Appendix B Model Contract	2.10.3.10	Provider Relations	139	Please clarify types of issues that would constitute an "emergent provider issue".	This refers to any emergent patient issue being handled by the provider.
162	Appendix B Model Contract	2.10.5.3.3	Provider Website	140	Would having a downloadable roster template meet this requirement? How will this change with the implementation of the CVO?	Section 2.10.5.3.3 of Appendix B will be deleted. The CVO will credential MHR staff, and a roster would no longer be necessary. **Please refer to revision #30 in Part 2 below.**
163	Appendix B Model Contract	2.10.5.3.3	Provider Website	140	Please confirm the CVO will be responsible for reviewing and updating MHR rosters.	See response to question #162.
164	Appendix B Model Contract	2.11.1.3	Provider Reimbursement	145	An effective DRG methodology implementation requires build integration, testing, educating providers, training internal teams, etc. The DRG methodology implementation timeline could risk the quality of implementation. Please consider extending the stated timeline to more than 180 days after notification by LDH to ensure a successful implementation.	LDH will consider extending the timeframe if deemed appropriate during the development of the DRG methodology. LDH plans to provide advance notice to MCOs during the development of the DRG methodology and provide opportunities for MCO feedback prior to implementation. **Please refer to revision #32 in Part 2 below.**
165	Appendix B Model Contract	2.11.6.6	Claims Processing Requirements	147	Section 2.11.6.6 refers to a notification requirement of 90 days before implementing changes to claims, coding and processing guidelines. Section 2.11.1.1 (page 145) refers to the required quarterly CMS and NCCI updates. Would these quarterly CMS and NCCI edits require a 90 day notification?	No, a 90-day notification for the standard quarterly updates by CMS of NCCI state Medicaid edits is not required. These edits shall be in place no later than the first day of the second month of the new quarter.

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						Please note that a numbering error has been corrected in this addendum. **Please refer to revision #39 in Part 2 below.**
166	Appendix B Model Contract	2.11.10.1	Provider Preventable Conditions	149	The Model Contract provision implies that state specific criteria may be developed. If accurate, please provide the proposed criteria.	If state-specific criteria is developed, LDH will identify them in the MCO Manual.
167	Appendix B Model Contract	2.12.1.13	Utilization Management	153	This requirement states, "The Medicaid Director, in consultation with the Medicaid Medical Director, may require the Contractor to authorize services on a case-by-case basis." This provision would imply that these decisions would be made without involvement from the health plan. We recommend that LDH delete this provision as it conflicts with the Contractor's ability to apply medically necessary criteria to the authorization of services on a case-by-case basis.	This provision remains unchanged. However, the Medicaid Medical Director will typically consult with the MCO Medical Director to inform his/her decision.
168	Appendix B Model Contract	2.13.4.1	Welcome Calls	167	Please confirm proposers may contact enrollees via phone upon receipt of the ANSI ASC X12 834 file. If not, please confirm the earliest possible opportunity to make telephonic outreach to engage new enrollees?	Yes, the Contractor may reach out to the enrollee at any time following the receipt of the ANSI ASC X12 834 file. This can include making the welcome call. The intent of the guidance in Model Contract Section 2.13.4.1 is to ensure the Contractor makes a welcome call within a reasonable timeframe around the mailing of the welcome packet.

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169	Appendix B Model Contract	2.13.14.5	Interpretation and Written Translation Services	183	"…Written materials shall include taglines in the prevalent non-English languages in the state, as well as large print, and Braille explaining the availability of written translation or oral interpretation…" This section appears to combine two concepts: 1. the availability of written materials in alternative formats, and 2. taglines to comply with Section 1557 provisions the ACA The placement of Braille in the tagline portion of the section, rather than in the alternative formats portion, would require every piece of member material and marketing (including all standard correspondence like care management letters, health check reminders) to include a Braille tagline. This would significantly increase costs, and cause production delays and operational concerns across millions of pieces of correspondence each year. Section 1557 does not require Braille in document taglines (except, if it were one of the top two non-English languages in the state.). Please confirm that LDH will not require Braille taglines on all written materials in order to request Braille as an available alternative format.	LDH agrees that the inclusion of a Braille tagline on all printed items is unnecessary. Written materials should be made available in alternative formats, including Braille, upon request. But a tagline on every item is not necessary. **Please refer to revision #33 in Part 2 below.**

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170	Appendix B Model Contract	2.14.6.4	MCO Provider Marketing Guidelines	189	This section seems to prohibit distributing enrollee education on health reminders, covered benefits, transportation and other services available to members at a provider office, in collaboration with that provider. Please confirm that distribution of enrollee education materials at a provider's office will be permissible with provider consent and LDH approval.	Distribution of health education materials, whether it is branded or not, at a provider's office is permissible with provider consent. All marketing and enrollee materials must be approved by LDH. **Please refer to revision #34 below.**
171	Appendix B Model Contract	2.14.9.7	MCO Website Guidelines	193	This section states that the Contractor website shall be "functionally equivalent to the website maintained by the LDH FI." Please define functionally equivalent. The FI and MCO websites have different functional needs based on their differing roles. How would compliance with this section be determined?	This requirement has been removed. **Please refer to revision #31 and 35 in Part 2 below.**
172	Appendix B Model Contract	2.15.2	Process for Grievances	199	What is the timeline to file a grievance?	An enrollee may file a grievance at any time per Model Contract Section 2.15.2.1. There is no timeline.
173	Appendix B Model Contract	2.15.3.7	Standard Resolution of Appeals	202	The Model Contract indicates that "Appeals shall be resolved no later than stated timeframes and all parties shall be informed of the Contractor's decision." Please clarify whether this applies to provider/post service appeals, when the member is not financially liable for the inpatient stay.	This provision is applicable to enrollee appeals, including the case of an enrollee appealing a post-service claim that has been denied, despite the enrollee not being financially liable.
174	Appendix B Model Contract	2.15.6.3	Process for State Fair Hearings	203	The Model Contract states the Contractor shall submit an evidence packet to LDH and enrollee within 10 days of receiving notification of hearing. SFH Companion Guide was last revised 6/2014 and does not reflect this change or other changes in relation to time frames for filing a SFH. Please confirm when the SFH Companion	The State Fair Hearing Companion Guide has been revised and is in the final review phase.

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					Guide will be updated to reflect the model contract requirements.	
175	Appendix B Model Contract	2.16.2.3.3	Quality Assessment and Performance Improvement (QAPI) Program	206	Please clarify how LDH defines "Low Value Services" and "High Value Services" as referenced in 2.16.2.3.3 of the Model Contract.	High value services, as defined by the Institute of Medicine, represent the "best care for the patient, with the optimal result for the circumstances, delivered at the right price." Low-value services represent care that does not meet these criteria.
176	Appendix B Model Contract	2.16.8.3	Performance Measures	210	Please confirm MCOs will receive ethnicity, race and disability status on the 834 eligibility file.	The 834 eligibility file does include a handicap indicator, gender and race. Race/Ethnicity is a composite code on the 834 file.
177	Appendix B Model Contract	2.16.9.1	Incentive Based Performance Measures	211	The Model Contract states that IB performance measures can be identified in Attachment G annotated with "$$", however there are no measures with this notation. Please provide revised Attachment G with the "$$" notation.	See response to question #90.
178	Appendix B Model Contract	2.16.9.1	Incentive Based Performance Measures	211	Requirement 2.16.9.1 indicates that Incentive Based performance measures that may affect PMPM payments are annotated with "$$" in Attachment G; however, the draft Attachment G located in the RFP Appendices and Attachments site does not indicate "$$" for any of the measures. Please provide an updated, final version of Attachment G.	See response to question #90.

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179	Appendix B Model Contract	2.17.2-2.17.2.3.2	Value-Based Payment	219	MCO contract Sections 2.17.2 through 2.17.2.3.2 define the minimum VBP Threshold that the MCO must achieve beginning CY2020 through 2022 and beyond. For each year, the contract specifies that "Contractual arrangements linked to a VBP model account for at least X percent (X%) of total provider payments in the measurement year." How does LDH define "total provider payments"? Is this intended to mean the same thing as "Total Cost of Care (TCOC)," which is a defined term in the MCO Contract? Or is this intended to mean only total payments to the provider that participates in the APM? Please provide a definition.	The VBP Requirements appendix, located in the MCO Manual (see procurement library), provides VBP related definitions. Total Provider Payment, or Total Dollars, is the total estimated in- and out-of-network health care spend (e.g. annual payment amount) made to providers in the applicable payment period where provider includes all providers for which there is MCO health care spending. For the purposes of reporting APMs, this definition of provider includes medical, behavioral, pharmacy, DME, PCMH, dental, vision, transportation, and local health departments (e.g., lead screening) etc. as applicable.

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180	Appendix B Model Contract	2.17.2-2.17.2.3.2	Value-Based Payment	219	MCO contract section 2.17.2 through 2.17.2.3.2 define the minimum VBP Threshold that the MCO must achieve beginning CY2020 through 2022 and beyond. In the section titled "Minimum VBP Threshold and Qualifying VBP Arrangements," the model contract specifies that "Contractor's total potential provider incentive payments related to this measurement year exceed X (X) million dollars in total provider payments." How does LDH define "total potential provider incentive payments" in comparison to "total provider payments"? Additionally, the model contract specifies fixed dollar amounts for provider incentive payments in Sections 2.17.2.1 through 2.17.2.3. Given the potential variances in membership among selected proposers, these proposed fixed dollar amounts may unintentionally favor MCOs with the largest market share. Please provide additional clarification on the fixed targets, and how Proposers should address them for the purposes of the RFP.	See response to question #179. Total Potential Provider Incentive Payments represent the full amount of funding that a provider in an APM arrangement may earn during the identified 12 month period if the provider meets all applicable reporting, quality and/or cost-effectiveness benchmarks for APMs that include Category 2C, 3, and 4 payment models. This total includes both the actual/expected incentive payment earned by the provider and any unearned provider incentives under the APM agreement that vary based on performance. This total does not include downside or shared risk arrangements, only upside shared savings potential in Category 3 APMs. Total Potential Provider Incentive Payments also includes provider payments in Category 2A APMs or Category 4 APMs that vary based on attributed panel size. The purpose of the fixed targets is to ensure a significant amount of incentive dollars flow to providers. No changes will be made to the fixed targets.
181	Appendix B Model Contract	2.17.3.1	Qualifying VBP Arrangements	221	HCP-LAN Category 2B is a Pay for Reporting model similar to Category 2A Foundational, which could be useful as a component of a more advanced model as a means to move providers to readiness. Please confirm that LDH will consider and count as compliant (with Section 2.17.3) VBP models that include, as only one	Qualifying VBP arrangements exclude Category 2B payments.

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					component, a Category 2B: Pay for Reporting payment.	
182	Appendix B Model Contract	2.17.3.2	Qualifying VBP Arrangements	221	Will LDH read Section 2.17.3.2 as an "or" instead of "and", so that HCP-LAN Categories 2C OR 3 OR 4 will count as compliant with Section 2.17.3.2?	LDH agrees this should read "OR", not "AND," and will update the language. **Please refer to revision #36 in Part 2 below.**
183	Appendix B Model Contract	2.17.5.5	Qualifying VBP Arrangements	222	Does LDH have a required format or formula for evaluating the VBP return on investment?	LDH does not currently have a required format or formula for MCOs to evaluate the VBP return on investment. LDH will discuss the application of this provision with selected contractors after contract execution.
184	Appendix B Model Contract	2.17.6	Inventory of VBP Arrangements	223	Does LDH have a required format and/or set of information that must be included within a Contractor's inventory of providers within VBP arrangements?	LDH does not currently have a required format or set of information that must be included within a Contractor's inventory or providers within VBP arrangements. After contracts have been awarded, LDH will provide selected contractors a draft format and/or set of information to be included in the inventory. Selected contractors will have the opportunity to comment on the draft inventory format and minimum requirements prior to the initiation of MCO readiness reviews.
185	Appendix B Model Contract	2.17.9.1.1	Preferred VBP Arrangements	224	By using "and" instead of "and/or", did the state intend that the broader payment model must support integration of all three components (BH, SDOH, AND populations with special health care needs) for each participating PCMH to be considered a preferred VBP arrangement? In other words, must the payment model be limited to populations with special health care needs and incent integration of BH and SDOH for this population?	LDH did not intend the broader payment model to support integration of all three components for each participating PCMH to be considered a preferred VBP arrangement. LDH agrees this should read "AND/OR", not "AND," and will update the language. **Please refer to revision #37 in Part 2 below.**

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186	Appendix B Model Contract	2.17.13.1	Financial Benchmarks, Shared Savings Calculations and Risk Mitigation	226	Please confirm how feasibility and appropriateness (of risk-adjusting provider payments) will be determined and who will make this determination.	The Contractor is responsible for determining feasibility and appropriateness of risk adjusting provider payments.
187	Appendix B Model Contract	2.17.14.2.3	Accountable Care Organizations	227	What is LDH's definition of hospital based entities? (ER Physicians /Pathologists/ Radiologist)	In this context, LDH is referring to providers that are independent of/ not employed by hospitals or health care systems that operate hospitals. For example, a primary care provider that is not employed by a hospital or a health system that operates a hospital would be considered independent in this context.
188	Appendix B Model Contract	2.18.17.5.4	Pharmacy Claims Processing	232	It is in the "best interest of the state" to amend Section 2.18.17.5.4 to also require that any contract between the Contractor and a PBM for pharmacy services stipulate that the PBM has a fiduciary relationship with and obligation to the Contractor, LDH, and the State of Louisiana. Will LDH add this requirement for such contracts? A fiduciary duty is the legal obligation of one party to act in the best interest of interest of another. Including this requirement in contracts between the Contractor and a PBM would insure that the PBM acts first in the best financial interest of the Contractor, LDH, and the State; provide for greater transparency, and assure fewer inherent conflicts of interest.	LDH declines to make the suggested revision, as it is too broad to include as a contract requirement.

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189	Appendix B Model Contract	2.18.7.3	Timely Filing Guidelines	232	Are there any protections offered if a claim is filed erroneously with the wrong Managed Care Plan or LDH's FI? Enrollees often change plans or transition to LDH's FI which can lead to a claim being inadvertently filed with another plan. It may be beneficial to add language allowing the Contractor to process claims if a provider can produce documentation verifying that the initial filing of the claim occurred within the three hundred and sixty-five (365) Calendar Day period but was erroneously filed with another Managed Care Plan or LDH's FI.	The timely filing requirement is 365 days. Providers have this amount of time to ensure they file with the correct contractor or entity. LDH would not allow for an override to timely filing over 365 days if a provider only provided documentation that it initially tried to file the claim with another contractor. A provider must provide documentation that the enrollee's eligibility at the time appeared to be with the MCO the provider tried to bill. This exception will be added to the MCO Manual. **Please refer to revision #38 in Part 2 below.**
190	Appendix B Model Contract	2.18.8.8	Claims System Edits	234	Given the requirement that the Contractor's rate of reimbursement shall be no less than the published Medicaid FFS rate; should we deploy CMS mandated edits for Medicaid; National Correct Coding Initiative (NCCI) edits; or nationally recognized clinical editing standards at the Contractor's discretion or seek LDH approval when these changes are more restrictive than FFS? Will LDH support these mandates?	The Contractor shall employ CMS mandated edits for Medicaid, which currently include NCCI edits, *and* nationally recognized clinical editing standards in accordance with Model Contract Section 2.18.8.8.
191	Appendix B Model Contract	2.19.12.2.1	Information Systems Availability	258	Requirement 2.19.12.2 stipulates that Contractors make their data available to LDH personnel and other users either via online access or through regular data submission. Sub-requirement 2.19.12.2.1 stipulates that access shall be provided to Contractor systems. Please confirm this requirement should read 'data', not 'systems.'	LDH shall have access to all systems and all data contained within those systems.

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192	Appendix B Model Contract	2.19.12.2.1	Information Systems Availability	258	Requirement 2.19.12.2 stipulates that Contractors make their data available to LDH personnel. Please confirm that Contractors may meet this requirement through submission of files to LDH in lieu of a reporting environment.	Submission of files to LDH does not satisfy this requirement. The Contractor must provide access either through a SQL based production-like reporting environment to be updated no less than weekly and/or through direct data submissions to LDH, no less than weekly.
193	Appendix B Model Contract	3.1.15	Health Needs Assessment Instrument (HNA)	290	Please confirm when the MCOs will have access to the Health Needs Assessment (HNA) instrument in order to integrate the HNA into current documentation systems.	LDH shall provide the draft HNA to selected Contractors after contracts have been awarded. Selected Contractors will have the opportunity to comment on the draft HNA instrument before it is finalized by LDH prior to the initiation of MCO readiness reviews.
194	Appendix B Model Contract	3.1.15.1	Health Needs Assessment Instrument (HNA)	290	Please confirm the Proposer may add supplemental questions to the HNA? Will the Agency provide a copy of the Health Needs Assessment (HNA) ahead of RFP submission?	The required HNA may not be modified, but there will be optional screening domains that the MCOs may add, subject to LDH approval. **Please refer to revision #40 in Part 2 below.** Please see response to question #193.
195	Appendix B Model Contract	3.1.15.1	Health Needs Assessment Instrument (HNA)	290	The Model Contract states that LDH shall provide the Contractor with the HNA instrument. Will LDH consider including the MCOs in the development of the HNA tool?	See response to question #193.
196	Appendix B Model Contract	4.4	Financial Incentives for MCO Performance	298	The withhold of 2% has quality and VBP measures associated with it. How will the reasonably achievable portion of this withhold be developed?	The State's contracted actuary will review quality/health outcome measures and VBP payments, and, based on past MCO performance, make a determination if outcomes are reasonably attainable. Should the actuary determine that any single outcome measure is not reasonably attainable across all MCOs, it will make an adjustment to all impacted rate cells in

Question No.	Document Reference	Section Number	Section Heading	Page	Question	Answer
						order to comply with actuarial standards of practice.
197	Appendix B Model Contract	4.1.2	Capitated Payments	298	If a member is enrolled on Jan 5th with a retroactive effective date of Jan 1st, will the capitation for that member be paid in February, March, or as part of the retroactive PMPM payment cycle? Will LDH continue to publish an MCO PMPM Payment Schedule on www.lamedicaid.com?	Capitation payments are paid beginning with the first month of an enrollee's eligibility. In the example given, if an enrollee's eligibility begins in January 2019, the MCO will receive a capitation payment for the January service month in the month of February. Capitation payments for retrospective enrollment are also made monthly, going back to the first month of an enrollee's eligibility, subject to a limitation of 12 months of retrospective enrollment. Yes, the payment schedule will be published on www.lamedicaid.com.
198	Appendix B Model Contract	4.3.1	MCO Payment Schedule	298	Will LDH continue to publish an MCO PMPM Payment Schedule on www.lamedicaid.com? Should we expect the schedule to be similar to the ones currently posted?	Yes, the payment schedule will be published on www.lamedicaid.com. No significant changes to the payment schedule are anticipated at this time.
199	Appendix B Model Contract	4.4.1.2	Financial Incentives for MCO Performance	299	Does LDH plan to provide a more definitive allocation between the Quality Withhold and the VBP Withhold? Will it vary by contract year?	Yes, per Model Contract Section 4.4.1.2, LDH will notify MCOs of the relative portions of the quality and VBP withholds no later than August 1 for the subsequent calendar year. LDH does have flexibility in adjusting the allocations on an annual basis, however, at least half of the total withhold amount will be allocated to quality.

Question No.	Document Reference	Section Number	Section Heading	Page	Question	Answer
200	Appendix B Model Contract	4.4.2.4	Financial Incentives for MCO Performance	299	In the event that MCOs focus their limited resources on improving different performance measures, it may not be reasonably attainable for any given MCO to meet all targets defined by the best performing MCO for each measure. Please confirm that the actuarially sound rate will reflect reasonably attainable financial incentive payments in aggregate and not just on a measure-by-measure basis.	See response to question #196. Additionally, although the targets for non-HEDIS measures are determined by the best performing MCO, an individual MCO's performance is evaluated against that target or the MCO's performance for that measure for the prior year. See Model Contract Section 4.4.2.7. The evaluation of what is reasonable and attainable will consider the expectation of the MCO to improve on its own performance for all incentive-based performance measures. Per Model Contract Section 4.4.2.6, the incentive measures are equally weighted, and the expectation for improvement for each measure is considered in the determination of what is reasonable and attainable.
201	Appendix B Model Contract	4.4.2.7	Financial Incentives for MCO Performance	300	What does the 2.0 points referenced mean? Are these percentage points?	The 2-point improvement refers to an absolute change for all incentivized quality measures with established numerical targets. For measures that are reported as percentages, such as Adolescent Well Care Visits, an example of a 2-point improvement as an absolute change, is the measure improving from 51% to 53%. For measures that are reported as rates, such as Ambulatory Care Emergency Department Visits/1000MM, an example of a 2-point improvement as an absolute change, is the measure improving from 78 to 76 (Note: this is also an example of an inverse measure).

Question No.	Document Reference	Section Number	Section Heading	Page	Question	Answer
202	Appendix B Model Contract	4.4.3.1.3.1	Financial Incentives for MCO Performance	301	The following provision states "If LDH determines that the Contractor has successfully completed this deliverable, LDH shall release all of the Contractor's remaining VBP withheld funds from CY2020." Was this statement intended to mean that regardless of the earn back from the Strategic Plan and summary report components, as long as the MCO report is submitted on time and shows the MCO attains minimum VBP thresholds then the MCO will earn back 100% of the VBP withhold?	The intent of this statement was not to permit 100% of the earn back of the VBP withhold if the Contractor has not satisfied the other requirements and deliverables in this section. LDH will update the language accordingly in this and subsequent sections. **Please refer to revision #41 in Part 2 below.**
203	Appendix B Model Contract	4.5.3	Medical Loss Ratio	302	Is the intention to distinguish the SBH/NEMT only members from the full member population? If the intention is to separate behavioral health services from physical health services, does LDH/Mercer plan to distinguish the physical health and behavioral health component of the capitation rate to perform an MLR calculation?	LDH reserves the right to request that MCOs provide a separate MLR reporting for specialized behavioral health services. At such time, LDH would provide guidelines for calculation of revenues and expenses to be included in the nominator and denominator of an SBH MLR, including a breakout of the SBH component of capitation rates.
204	Appendix B Model Contract	4.6.3	Payment Adjustments	302	Should the Proposer consider the date of notification to be the date the enrollee's status changes on the 834 eligibility file or would it be the date of notification that the PMPM/capitation payment is recouped from the MCO?	The date of notification is the date of an enrollee's status change on the 834 eligibility file.

Question No.	Document Reference	Section Number	Section Heading	Page	Question	Answer
205	Appendix B Model Contract	4.8.3.3	Determination of MCO Rates	304	Please describe how LDH would adjust rates due to “budgetary constraints” while continuing to meet the required definition of “actuarial soundness”?	LDH must operate the Louisiana Medicaid managed care program within its legislatively authorized annual appropriation. LDH must also develop capitation rates that meet CMS requirements for actuarial soundness -- that is, rates must provide for all "reasonable, appropriate, and attainable" costs required under the contract. Budget limitations may require modification of the MCO contract to ensure that required services align with approved rates and cost projections.
206	Appendix B Model Contract	4.18.1.3	Performance Bond	315	Will the performance bonds currently in place for incumbent MCOs satisfy this bond requirement?	No.
207	Appendix B Model Contract	6.68	Withholding in Last Month of Payment	323	Considering the 1 month delay in capitation payment and the performance bond requirement, would LDH consider waiving the 75% withhold if the MCO is in good standing?	No.

Question No.	Document Reference	Section Number	Section Heading	Page	Question	Answer
208	Appendix B Model Contract	2.4.2, 2.4.4.1, 2.9.19	Voluntary Opt-In Populations, Non-Emergency Medical Transportation	63, 65, 124	Section 2.4.2 and other sections label Non-Emergency Medical Transportation (NEMT) and Non-Emergency Ambulance Transportation (NEAT) as two different services. In Section 2.4.4.1 and other sections, the language specifically states "and non-emergency transportation, including non-emergency ambulance transportation...." However, there are also references to only NEMT throughout the Scope of Work. Can it be assumed that NEMT provisions do not apply to NEAT services unless specified? Considering they are two completely different services, lumping them into one general category would seem ambiguous and confusing.	While NEAT is a distinct service from NEMT in that the enrollee cannot be transported via a regular vehicle and providers must be registered through Health Standards instead of through transportation brokers, many of the same rules apply. Relevant provisions in the Model Contract have been revised accordingly. **Please refer to revision #23, 25, and 28 in Part 2 below.**
209	Appendix B Model Contract	2.7.6	Tiered Case Management Based on Need	91,92	In the Model Contract, page 18 of 347, LDH defines "Interdisciplinary Team". The contract also refers to "Multidisciplinary Care Team" in multiple sections. Please define Multidisciplinary Care Team.	**Please refer to revision #22 in Part 2 below.**
210	Appendix B Model Contract	General Inquiry			Throughout the Scope of Work there are references to the MCO Manual. Has this manual been published? If so, where can it be found?	A draft version of the MCO Manual has been provided in the procurement library.
211	Appendix C Proposal Compliance Matrix	2.9.6.1	Required Forms and Certifications	1	The column titled "Proposal Page(s)" is asking for page numbers. Please confirm that the Agency is aware that page numbers will exceed 250 including the questions and attachments that are exempt. Is there a preferred way the Agency would like MCOs to demonstrate they have stayed under the 250 page limit	Confirmed. Proposers should clearly number pages and identify exempt pages to demonstrate that it has complied with page limit requirements. LDH reserves the right not to evaluate any proposal content which exceeds the stated page limits.

Question No.	Document Reference	Section Number	Section Heading	Page	Question	Answer
					for non-exempt questions and attachments?	
212	Appendix C Proposal Compliance Matrix		Proposal Compliance Matrix		What information should we include under the column labeled “Proposal Section” in the Proposal Compliance Matrix? Should it be the same as what is listed under the column labeled “RFP Section” or is LDH looking for other information?	Proposers should provide the proposal's section number that matches the corresponding section of the RFP as well as the number of any attachments, if applicable.
213	Appendix E Medicaid Ownership and Disclosure Form	Section VI	Information on Each Individual or Agent Who is Part of Management	3	The hyperlink provided in Appendix E, Section VI does not appear to work: http://www.access.gpo.gov/nara/cfr/waisidx_01/42cfr455_01.html Please provide Proposers with a new link.	Proposers may use this alternate link: https://www.ecfr.gov/cgi-bin/text-idx?SID=94276cfb9fef4013fbfcd1570a7938ac&mc=true&tpl=/ecfrbrowse/Title42/42cfr455_main_02.tpl
214	Appendix E Medicaid Ownership and Disclosure Form	2.9.6	Required Forms and Certifications	17	Please provide a Word version or another format that allows for easier input of the requested information.	Appendix E has been provided as a fillable PDF form (see procurement library). Proposers may append to the form with a separate file (e.g., Microsoft Word or Excel), if needed.
215	Appendix F Material Subcontractor Response Template		Material Subcontractor Response Template	4	In checklist item 26 of Appendix F, MCOs are required to make full disclosure of the method and amount of compensation or other consideration subcontractors are to receive from the MCO. Due to sensitivity of this information, please confirm this information can be redacted from the original version of the response.	Disclosure of the method of compensation or other consideration must be included in the original version of the response but may be removed from the redacted copy. See response to question #20.
216	Attachment D Provider Network Standards	N/A	Access and Distance Standards	1	Primary Care Ratio –Is the ratio listed per FQHC/RHC or per practitioner affiliated with the FQHC/RHC?	Practitioner affiliated.

Question No.	Document Reference	Section Number	Section Heading	Page	Question	Answer
217	Attachment D Provider Network Standards	N/A	Access and Distance Standards	1	Are the new recurring LDH reporting templates currently published? If so, can LDH please provide?	No. Proposers may reference the current reporting templates located at http://ldh.la.gov/index.cfm/page/1700, as specified in the MCO Manual.
218	Attachment D Provider Network Standards	N/A	Access and Distance Standards	1, 2	Page 1, Primary Care Ratio lists 1:1000 for physicians Page 2, Primary Care Ratio lists 1:2500 for physicians and 1:1000 for Physician Extenders Please confirm that the correct Primary Care Ratio for both pediatric and adult primary care physicians is 1:2500.	Page 1 refers to Network Ratio and Page 2 refers to Linkage Ratio. The Network Ratio is 1:1000 for adult and pediatric PCPs.
219	MCO Manual	2.5.15	Perinatal Services	35	Please confirm that the Proposer is required to submit with the proposal a plan to address prematurity prevention and improved perinatal outcomes. If confirmed, is there a preferred location for it within the Technical Proposal?	LDH shall not respond to questions related to the MCO Manual, as it was provided in the procurement library in draft form for reference only. However, please note that the MCO Manual will be applicable to MCOs contracted as a result of this procurement.
220	MCO Manual	2.16.4	Outcome Assessment for Behavioral Health Services	101	The MCO Manual lists “reserved”. Please confirm when LDH will provide this information.	See response to question #219.
221	MCO Manual	2.9.2	Provider Network Monitoring	57, 58	In the SBHS manual, FFT, Home Builders, and MST are currently excluded from certain requirements within the rehab services; however, previously, we were auditing MST and ACT. Are we to exclude MST from our PQM audit tool?	See response to question #219.
222	MCO Manual	2.16.3	Adverse Incident and Quality of Care Concern Management and Reporting	99-100	The MCO Manual lists restraints, seclusions, and protective hold, however in the current version revised on 10/18 those definitions have been removed. Please clarify.	See response to question #219.

Question No.	Document Reference	Section Number	Section Heading	Page	Question	Answer
223	N/A	N/A	N/A	N/A	In many cases historical Health Plan Advisories (HPAs) have been incorporated into the new Model Contract. Please confirm that the historical HPAs will be retired.	Historical Health Plan Advisories (HPAs) that will be relevant in the new contract period have been or will be incorporated into the Model Contract or the MCO Manual. Those not relevant will be retired.
224	Provider Network Capacity Response Template	2.10.7	Provider Network	24	The Instructions tab in the Provider Network Capacity Response template is blank. Are there specific instructions that the bidder must follow for completion of the template for submission? If so, can LDH please provide the specific instructions?	The Instructions tab in this file is not blank.
225	Provider Network Capacity Response Template	N/A	PCP Tab	N/A	The formula for the Region 1 Totals appears to be incorrect. It includes cells in Region 2.	This formula has been corrected. **Please see the updated Provider Network Capacity Response Template file in the Procurement Library.**
226	Provider Network Listing Response Template	2.10.7	Provider Network	24	The Instructions tab in the Provider Network Listing Response Template is blank. Are there specific instructions that the bidder must follow for completion of the template for submission? If so, can LDH please provide the specific instructions?	The Instructions tab in this file is not blank.
227	Provider Network Listing Response Template	2.10.7	Provider Network	24	For the Hospitals tab in the Provider Network Response Template, is there specific criteria that defines what types of facilities should be classified as Hospitals and included on the list? For example, should Long-term Acute Care Facilities be included on the Hospitals tab?	See http://ldh.la.gov/index.cfm/directory/detail/722. LTAC may be identified in the Specialized Services column.

Question No.	Document Reference	Section Number	Section Heading	Page	Question	Answer
228	Provider Network Listing Response Template	2.10.7	Provider Network	24	The Non-BH Providers & Specialties tab does not have a section for facilities and applicable facility types. Can LDH please clarify how Non-BH facilities should be classified? For example, should Long-term Acute Care Facilities be listed on the Hospitals Tab?	See http://ldh.la.gov/index.cfm/directory/detail/722. LTAC may be identified in the Specialized Services column.
229	Provider Network Listing Response Template	2.10.7	Provider Network	24	We have identified the following provider types that are currently tracked and reported to LDH that are not included on the list of Non-BH Providers and Specialties to be reported. Should the Proposer include these provider types in its network listing submission? If so, should these provider types be included on the Specialties tab, or another location? SURGERY - COLON AND RECTAL SURGERY - CARDIOVASCULAR RADIOLOGY - DIAGNOSTIC RADIOLOGY - THERAPEUTIC PODIATRY PHYSICAL THERAPY PEDIATRICS - ALLERGY HOME HEALTH INFUSION THERAPY AMBULANCE SERVICES DME NEMT PHARMACY	Proposers should only include the provider types listed in the template for evaluation purposes.

Question No.	Document Reference	Section Number	Section Heading	Page	Question	Answer
230	Provider Network Listing Response Template	2.10.7	Provider Network	24	We have identified the following provider types on the Non-BH Providers and Specialties tab that do not have corresponding S-codes. Can LDH provide guidance on how these are defined and how these should be designated and reported in the Proposer's response? Cardiac Electrophysiology Clinic or Other Group Practice Individual Certified Prosthetist - Ortho Orthodontist Diagnostic Laboratory Independent Laboratory Med Supply/Certified Orthotist Med Supply/Certified Prosthetist	Identifying information, in the form of taxonomy codes, for these providers has been provided in the table in Section 2.9.1 of the MCO Manual (see procurement library).
231	Provider Network Listing Response Template	2.10.7	Provider Network	24	We have identified the following provider types on the BH Services and Providers tab that do not have corresponding S-codes. Can the state provide guidance on how these are defined and how these should be designated and reported in the Proposer's response? Physician Assistants (No code specific to BH) Rural Health Clinic (Provider Based) Rural Health Clinic (Independent)	Proposers should only include the provider types listed in the template for evaluation purposes.
232	Provider Network Listing Response Template	2.10.7	Provider Network	24	The BH Services and Providers tab includes a section for the responder to submit its network of Coordinated System of Care (CSoC) Providers. CSoC is not currently included as a covered service under our current MCO Contract. Please clarify if LDH intended to include the CSoC providers. If yes, please clarify what type of information should be submitted.	Proposers should not include CSoC providers in its response. The table included on the "BH Services and Providers" tab is inclusive of all established provider types and provider specialty codes for delivery of specialized behavioral health services.

Question No.	Document Reference	Section Number	Section Heading	Page	Question	Answer
233	Provider Network Listing Response Template	N/A	Non BH-Providers & Specialties, BH Services and Providers tabs	N/A	Both the Non BH-Providers & Specialties tab and the BH Services & Providers tab include LCSWs. Please confirm LCSWs should only be included in the BH Services & Providers tab.	Confirmed. LCSWs should only be listed under the "Outpatient BH Providers" tab for purposes of this evaluation.

PART 2: REVISIONS

Revision No.	Document Reference	Page	Revised Provisions	Q&A Cross Ref.
1	RFP	9	**2.2.2.2** Name and address of corporate principal office~~r~~ registered with the Louisiana Secretary of State, email address, website URL, and telephone number;	7
2	RFP	10	**2.2.2.12** A brief statement of the Proposer ~~ever~~ having had within the last ten (10) years a Medicaid managed care contract (1) ~~a contract~~ terminated or not renewed for non-performance or poor performance and/or (2) ~~a contract~~ terminated on a voluntary basis prior to the contract end date. The Proposer must provide the name and contact information of the lead program manager of the contracting entity;	13
3	RFP	10	**2.2.4** ~~The Proposer must~~ LDH strongly urges proposers to adhere to page limits wherever specified. Proposals ~~shall~~ should not exceed two hundred and fifty (250) pages in total, inclusive of attachments and appendices, unless explicitly exempted. **LDH reserves the right not to evaluate any proposal content which exceeds the stated page limits.**	12, 19
4	RFP	11	**2.3.2** The evaluation team will utilize both the hard copies and the electronic copy to evaluate the proposal. It is the Proposer's responsibility to ensure that all copies are complete and contain all required components for the evaluation. ~~The Proposer must certify that all copies are correct and complete.~~	21
5	RFP	14	**2.9 Business Proposal Requirements [5 page limit]** The Proposer shall meet all standards and must comply with all business proposal submission requirements in this section. The Proposer's business proposal ~~shall~~ should not exceed five (5) pages.	12, 19
6	RFP	15	**2.9.1.5** Comply with all Louisiana Department of Insurance applicable standards. Information can be found at LDI's website: www.ldi.louisiana.gov. The MCO must meet solvency standards as specified in 42 C.F.R. §438.116 and Title 22 of the Louisiana Revised Statutes. Documentation of compliance with these requirements may be included in separate attachments and will not count toward the business proposal and total page limits;	25
7	RFP	15	**2.9.1.6** Have a minimum of five (5) years of experience as an MCO for a Medicaid managed care program prior to the deadline for receipt of proposals*; **2.9.1.7** Have, within the last thirty-six (36) months, been engaged in a contract or awarded a new contract as a Medicaid MCO in a state with a Medicaid population equal to or greater than that of Louisiana*; and **2.9.1.8** Have its principal place of business be located inside the continental United States.~~; and~~ ~~**2.9.1.9** Have not had a contract terminated, withdrawn in lieu of termination, or not renewed for non-performance or poor performance within the past ten (10) years.~~ * Experience requirements in Sections 2.9.1.6 and 2.9.1.7 may be satisfied if the Proposer is a new	26, 27

Revision No.	Document Reference	Page	Revised Provisions	Q&A Cross Ref.
			MCO or a state-specific entity that takes direction from its parent organization, and the parent organization operates a Medicaid MCO that meets the requirements of those sections.	
8	RFP	15	**2.9.2.2** A signed Proposer's certification attesting that the Proposer does not have, nor does any of the Proposer's material subcontractors have, any financial, legal, contractual or other business interest in LDH's Enrollment Broker ~~or External Quality Review Organization~~ Contractor, or in such vendor's~~'~~ subcontractors, if any;	28
9	RFP	17	**2.9.5.1.1** Copies of audited financial statements for each of the last three (3) years, including at least a balance sheet, profit and loss statement, or other appropriate documentation, and the auditor's report. The Proposer shall also submit such information with respect to the Proposer's parent organization and any material subcontractors. The Proposer may submit this information in electronic format in lieu of hard copy; and	8
10	RFP	17	**2.9.6.3** Federal laws require full disclosure of ownership, management, and control of Medicaid MCOs. The Medicaid Ownership and Disclosure Form (Appendix E) must be submitted to LDH with the proposal. The Proposer may submit this information in electronic format in lieu of hard copy.	8
11	RFP	19	**2.10.2.2.2.4** For each such team or unit, the number of full-time equivalents (FTEs) on the team or unit, a brief description of their major qualifications and competencies, and a brief description of the team or unit lead. The Proposer may assume a total enrollment of 375,000 for this question, and should also describe its plan to scale staffing levels based on increased or decreased enrollment.	43
12	RFP	19	**2.10.2.4.1** The Proposer shall provide contact information (name, title, phone number and email) for the lead ~~state~~ program manager in each state or municipality, including Louisiana, if applicable, with which its organization has had a Medicaid managed care contract for comparable services within the past three (3) years. **2.10.2.4.2** For each reference, the Proposer should provide a brief description of the types and numbers of individuals served, the Proposer's key responsibilities under the ~~state~~ contract(s), and any compliance actions taken by the state or municipality, including but not limited to contract termination, corrective action plan, or monetary penalties.	48
13	RFP	20	**2.10.3.1** INTENTIONALLY LEFT BLANK	60
14	RFP	22	**2.10.4.5** … Note: This is an optional question. Responses will not be evaluated by the evaluation team nor counted toward the proposal score. If the Proposer chooses to respond, it ~~must~~ should limit responses to five (5) pages, though responses to this question will not be counted against the Population Health response page limit or total proposal page limit. The Proposer may submit this information in electronic format in lieu of hard copy.	8, 12, 19

Revision No.	Document Reference	Page	Revised Provisions	Q&A Cross Ref.
15	RFP	24	**2.10.6.3** Case 3: The Proposer has an enrollee who is a 65 year old Medicare-eligible male with a history of schizoaffective disorder, bi-polar sub-type. He has a history of medication non-compliance, suicide attempts, and multiple psychiatric hospitalizations with the last occurring several months ago. The enrollee has high blood pressure and suffers from chronic pain and weakness due to unspecified neuropathy. Though his chronic pain and subsequent weakness is limiting his ability to ambulate independently, the majority of his functional deficits are due to anxiety in performing tasks and/or not having proficiency in completing tasks independently. The enrollee is currently residing in a nursing home, though a recent evaluation of functioning by the state authority indicates he no longer meets eligibility for this level of care. Additionally, assessments by clinicians affiliated with the Pre-Admission Screening and Resident Review (PASRR) Level II office indicate the nursing home is not the least restrictive setting. He is estranged from his family and was evicted from his apartment during his nursing facility stay but expressed his preference to return to his previous apartment or another apartment. He has a history of frequent emergency department visits prior to his nursing facility stay for both physical health and behavioral health causes. Describe how the Proposer will manage care to transition him into the community and achieve the best health and behavioral health outcomes for the member.	77
16	RFP	26	**2.10.9** Provider Support [~~10~~14 page limit]	88
17	RFP	28	**2.10.11** Quality [20 page limit; clinical practice sample guidelines and NCQA rating attachment ~~is~~are exempt from section-specific and total page limits] **2.10.11.1** The Proposer should describe its organizational commitment to quality improvement and its overall approach and specific strategies that will be used to advance Louisiana Medicaid's Quality Strategy and ~~incentive-based~~ quality measures #27, 35, 37, and 50 from ~~identified in~~ Attachment G to the Model Contract. ... **2.10.11.6** The Proposer should submit, as an attachment using the Quality Response Template provided in the procurement library, its NCQA Health Insurance Plan Ratings (2018-2019) for all of the Proposer's and its parent organization's (including affiliates) Medicaid managed care contracts with full NCQA accreditation. If the Proposer has interim accreditation for Louisiana, it should include the Louisiana Medicaid experience. The Proposer may submit this information in electronic format in lieu of hard copy.	8, 90, 91, 94
18	RFP	30	**2.10.13** Claims Management and Systems and Technical Requirements [10 page limit; data flows and charts are excluded from section-specific and total page limits]	102
19	RFP	31	**2.10.13.5** The Proposer should describe the capability and capacity of the Proposer's Information Technology (IT) system to interface with LDH's system and that of its network providers and material subcontractors.	105

Revision No.	Document Reference	Page	Revised Provisions	Q&A Cross Ref.
20	RFP	33	**2.10.15.5** For additional information, see Appendix ~~F~~ G, *Veteran and Hudson Initiatives*.	111
21	Appendix B Model Contract	11	**Chronic Care Management** - Care management of multiple chronic conditions.	129
22	Appendix B Model Contract	18	**Interdisciplinary or Multidisciplinary Care Team** – A group that reviews information, data, and input from a person to make recommendations relevant to the needs of the person. The team consists of the person, his legal Representative if applicable, professionals of varied disciplines who have knowledge relevant to the person's needs, and may include his family enrollees along with others the person has designated.	209
23	Appendix B Model Contract	23	**Non-Emergency Medical Transportation (NEMT)/Non-Emergency Ambulance Transportation (NEAT)**– A ride, or reimbursement for a ride, provided so that an enrollee with no other transportation resources can receive services from an entity providing MCO covered services. NEMT/NEAT does not include transportation provided on an emergency basis, such as trips to the ED in life threatening situations.	208
24	Appendix B Model Contract	25	**Preventive Care** – Preventive health care services include immunizations, screenings for common chronic and infectious diseases and cancers, clinical and behavioral interventions to manage chronic disease and reduce associated risks, and counseling to support healthy living and self-management of chronic disease. ~~Refers to the treatment to avert disease/illness and/or its consequences. The term is used to designate prevention and early detection programs rather than restorative or treatment programs. There are three levels of preventive care: primary, such as immunizations, aimed at preventing disease; secondary, aimed at early detection of disease; and tertiary, such as physical therapy, aimed at restoring function after the disease has occurred.~~	131
25	Appendix B Model Contract	64	**2.4.2.3** Voluntary opt-in populations may return to FFS Medicaid for all State Plan services other than Specialized Behavioral Health and NEMT/NEAT effective the earliest possible month that the administrative action can be taken. **2.4.2.4** Voluntary opt-in populations who have previously returned to FFS Medicaid for all State Plan services other than Specialized Behavioral Health and NEMT/NEAT may exercise this option to return to Medicaid Managed Care for other State Plan services only during the annual open enrollment period. ... **2.4.4** Mandatory MCO Populations – Specialized Behavioral Health and Non-Emergency Medical Transportation (NEMT)/Non-Emergency Ambulance Transportation Services (NEAT)	208
26	Appendix B Model Contract	76	**2.5.2.1.9.4** Drug Efficacy Study Implementation (DESI) drugs; and **2.5.2.1.9.5** Select nonprescription drugs, not including OTC antihistamines, antihistamine/decongestant combinations, or polyethylene glycol.~~; and~~ ~~2.5.2.1.9.6 Narcotics other than those indicated for substance use disorder when treating narcotic addiction.~~	139

Revision No.	Document Reference	Page	Revised Provisions	Q&A Cross Ref.
27	Appendix B Model Contract	91	**2.7.6** Tiered Case Management Based on Need The Contractor shall implement a tiered case management program that provides for differing levels of case management based on an individual enrollee's needs. The Contractor shall engage enrollees, or their parent or legal guardian, as appropriate, in a level of case management commensurate with their risk score as identified through predictive modeling combined with the care needs identified in the enrollee's plan of care and HNA, as described below. If requested by the enrollee, or the enrollee's parent or legal guardian, the frequency and/or method of engagement may be reduced or substituted. The Contractor must obtain a signed waiver from the enrollee approving the change. Where the enrollee's PCP or behavioral health provider offers case management, the Contractor shall support the provider as the lead case manager on the multi-disciplinary care team.	144
28	Appendix B Model Contract	124	**2.9.19** Non-Emergency Medical Transportation and Non-Emergency Ambulance Transportation **2.9.19.1** The Contractor shall have sufficient NEMT/NEAT providers, including wheelchair lift equipped vans, to transport enrollees to medically necessary services when notified forty-eight (48) hours in advance, and the NEMT/NEAT providers must be able to arrive and provide services within sufficient time to ensure the enrollee arrives at their appointment at least fifteen (15) minutes but no more than one (1) hour early.	208
29	Appendix B Model Contract	135	**2.9.33.7.2** Update the ingredient costs of medications at least weekly and within ~~twenty four (24) hours~~3 business days of new rates being posted;	158
30	Appendix B Model Contract	140	~~**2.10.5.3.3** The Contractor shall provide online accessible methodology for providers to review and update staff rosters of credentialed and contracted providers of mental health rehabilitation services.~~ [Following provisions renumbered.]	162
31	Appendix B Model Contract	140	~~**2.10.5.10** In addition to the specific website requirements outlined above, the Contractor's website shall be functionally equivalent to the website maintained by the LDH FI.~~	171
32	Appendix B Model Contract	145	**2.11.1.3** For inpatient hospital services, the Contractor shall have a system with the capacity to group claims and reimburse under a Diagnosis Related Groups (DRG) methodology as defined by LDH within one hundred eighty (180) days, or longer if deemed appropriate by LDH, of notification by LDH that such reimbursement method is required. Upon implementation, the Contractor's rate of reimbursement shall be no less than the DRG rate established by LDH, unless mutually agreed to by both the Contractor and the provider in the provider agreement.	164
33	Appendix B Model Contract	183	**2.13.14.5** Written materials shall also be made available in alternative formats upon request of the enrollee or potential enrollee at no cost. Auxiliary aids and services shall also be made available upon request of the potential enrollee or enrollee at no cost. Written materials shall include taglines in the prevalent non-English languages in the state~~, as well as~~ and large print~~, and~~	169

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			~~Braille~~ explaining the availability of written translation or oral interpretation to understand the information provided and the toll-free and TTY/TDD telephone number of the MCO's enrollee/customer service unit. Large print means printed in a font size no smaller than eighteen (18) point.	
34	Appendix B Model Contract	189	**2.14.6.4** The Contractor shall not conduct enrollee education or distribute enrollee education materials in provider offices, with the exception of health education materials (branded or non-branded) with the provider's consent.	170
35	Appendix B Model Contract	193	~~**2.14.9.7** The website shall be, at a minimum, functionally equivalent to the website maintained by the LDH FI.~~ [Following provisions renumbered.]	171
36	Appendix B Model Contract	221	**2.17.3.2** The payment model falls within Categories 2C, 3 ~~and~~or 4 of the LAN Alternative Payment Model Framework; and	182
37	Appendix B Model Contract	224	**2.17.9.1.1** Patient-centered medical home models that are part of a broader payment model that includes Category 2C or 3 APMs and which support the integration of behavioral health, SDOH, and/or populations with special health care needs;	185
38	Appendix B Model Contract	232	**2.18.7.5** LDH will identify and address any exceptions to these provisions in the **MCO Manual**.	189
39	Appendix B Model Contract	234	**2.18.8.9**~~**2.11.1.1**~~ The Contractor shall update CMS mandated edits and NCCI edits quarterly as directed by CMS and adhere to LDH timelines for the updates.	165
40	Appendix B Model Contract	290	**3.1.15.1** LDH shall provide the Contractor with the HNA instrument, which shall include the minimum necessary set of questions to identify an enrollee as potentially requiring case management support. The HNA will aim to identify physical, behavioral and SDOH risk factors. The required HNA may not be modified, but there will be optional screening domains that the MCOs may add, subject to LDH approval.	194
41	Appendix B Model Contract	301	**4.4.3.1.3.1** If LDH determines that the Contractor has successfully completed this deliverable, LDH shall release the VBP withheld funds estimated to be equal to seven (7) months of the VBP Withhold in CY2020.~~all of the Contractor's remaining VBP withheld funds from CY2020.~~ ... **4.4.3.2.3.1** If LDH determines that the Contractor has successfully completed this deliverable, LDH shall release the VBP withheld funds estimated to be equal to seven (7) months of the VBP Withhold ~~all of the Contractor's remaining VBP withheld funds~~ from the applicable Contract Year.	202

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42	Appendix F Material Subcontractor Response Template	4	[#19] INTENTIONALLY LEFT BLANK ~~Require the subcontractor to submit to the MCO a disclosure of ownership in accordance with RFP Section 2.9.6. The completed disclosure of ownership should be attached for executed contracts.~~	124