



Solicitation Addendum

Solicitation Number: 30-2020-052-DHB

Solicitation Description: BH I/DD Tailored Plan Request for Applications (RFA)

Solicitation Opening Date and Time: February 2, 2021 at 2:00 PM ET

Addendum Number: 6

Addendum Date: December 18, 2020

Addendum Description/Purpose: Department Response to Questions

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NOTIFICATIONS AND INSTRUCTIONS:

- 1. Return one properly executed copy of this Addendum #6 with response. Failure to sign and return this Addendum #6 may result in the rejection of Offeror's proposal.**
 - 2. Following are questions received for this solicitation and the Department's response to the questions.**
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No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
1.	I.C.5.	Page 5 of 73, FN 3	<p>This Section of the Behavioral Health and Intellectual/ Developmental Disability (IDD) Tailored Plan (TP) Request for Applications # 30-2020-052-DHB (RFA) states that the Traumatic Brain Injury (TBI) waiver is available for individuals with a TBI “in limited geographies” and FN3 references the four Alliance Health counties as the only counties in which the TBI Waiver is currently offered. Information shared by the Department in other settings indicates that there is currently no intention to expand the TBI Waiver statewide and that the Departments plans to add one (1) additional LME/MCO catchment area starting in May 2021:</p> <ul style="list-style-type: none"> · What process will the Department use to determine the “limited geographies” (i.e. additional counties/ regions) where the TBI Waiver will be available, and thus which LME/MCOs will be eligible to operate the TBI Waiver when it is expanded to other counties/ regions? · What is the five-year timeline for expansion of the TBI Waiver to other counties/ regions so that the LME/ MCO can factor this timeline into its planning for TP RFA Response and Go-Live? · Does the LME/MCO need to apply for the pilot TBI Waiver to secure the opportunity to deliver TBI Waiver services when it is expanded? If so, when is the anticipated date of the application to operate the pilot/ expanded TBI Waiver? 	<p>The Department is in the process of determining the method to be used to identify the expansion counties. While no decision has been made, the Department is contemplating to the TBI waiver statewide by December 31, 2026.</p>
2.	I.C.5.	Page 5 of 73, FN 3	<p>For LME/MCOs that are not currently eligible to operate the TBI Waiver, can the Department provide additional clarity about how to respond to the sections of the RFA (e.g., TCM requirements in Section V.B.) that reference the TBI Waiver? For example, should the response be based on an assumption that the TBI Waiver will be available in their TP Region as of the TP Go-Live date?</p>	<p>The Applicant should respond as if the TBI waiver is available in the geographical region for which it may be awarded.</p>

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3.	I.D.1. II.G.10. Attachment Q.17.	Page 7 of 73 Page 21 of 73 Page 118 of 123	<p>Subsection 10.a. states: "Applicants must submit responses to the Supplemental Evaluation Questions in Section VIII. Attachment Q.17. Supplemental Evaluation Questions for Empty Region(s) to be considered for the award of an Empty Region."</p> <p>Subsection 10.c. states: "The Department will notify eligible Applicants if there is an opportunity to submit responses to the Supplemental Evaluation Questions."</p> <p>Q.17 states that "These Supplemental Evaluation Questions are to be completed only upon request by the Department. Applicants who wish to be considered for the award of an Empty Region must submit responses within the time specified by the Department at the time of notification."</p> <ul style="list-style-type: none"> • Please confirm that the LME/MCO is not permitted to submit responses to Attachment Q.17 as part of its RFA response and is only permitted to submit responses to Attachment Q.17 after the Department notifies the LME/MCO in writing that it is eligible to respond. • Please confirm that any such notice of eligibility to respond to Attachment Q.17 will occur after the Department determines not to award a specific Region to an Applicant, i.e., after the RFA response deadline of February 2, 2020. • Will the Department allow LME/MCOs that are not contiguous with an Empty Region to respond to the Supplemental Evaluation Questions? 	<ol style="list-style-type: none"> 1. Confirmed. 2. Confirmed. 3. Yes.
4.	RFA Section II.E.3.a.iv	15	<p>Within the RFA, section II.E.3.a.iv states that "The entire body of this RFA, excluding attachments" must be included in the response.</p> <p>Please confirm the entire body of the RFA as referred to in Section II.E.3.a.iv. includes Sections I-VI as described in the Table of Contents, regardless of the fact that the sections are in separate documents, including only the following 3 provided documents:</p> <ul style="list-style-type: none"> · NC DHHS Tailored Plan RFA · Section V. Scope of Services, A – B · Section V. Scope of Services, C and Section VI. C <p>If other documents are to be included as part of this requirement, please specify.</p>	<p>Confirmed.</p> <p>Due to size limitations when posting files to the IPS website, the RFA was posted in six (6) parts which includes Addenda 1 - 5. Subsequent Addenda, starting with Addendum #6, are required to be signed and returned per RFA Section II.E.3.a.v., and will include a signature section for each addendum.</p> <p>The required documents listed in Section II.E.3.a.i-iv. include the following documents according to the solicitation number and (abbreviated) description on the IPS website:</p> <p>30-2020-052-DHB RFA 30-2020-052-DHB-1 Addendum 1, Section V.A.-V.B. 30-2020-052-DHB-2 Addendum 2, Section V.C and Section VI</p>

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5.	RFA Section II.E.3.a.v	15	<p>Within the RFA, section II.E.3.a.v states that "Each addendum released in conjunction with the RFA, including signed acknowledgement of receipt pages, as applicable" must be included in the response.</p> <p>Section V. Scope of Services A-B and Section V. Scope of Services C and Section VI.C. were labeled as Addendum 1 and Addendum 2, respectively, on the IPS site. Are these documents to be considered "addenda" as referred to II.E.3.a.v.?</p> <p>If so, these documents do not include an acknowledgement of receipt page. Please confirm that these initial addenda released with the RFA do not need to be included as part of this requirement, and only subsequently released addenda should be included here.</p>	See response to Question #4 above.
6.	RFA Section II.E.3.a.v	15	<p>Within the RFA, section II.E.3.a.v states "Each addendum released in conjunction with the RFA, including signed acknowledgement of receipt pages, as applicable" must be included. Pursuant to our prior question, if addenda 1 through 5 do need to be included as part of this specific requirement, please confirm that a second copy of addenda 1 (Section V. Scope of Services, A – B) and 2 (Section V. Scope of Services, C and Section VI.C) do not need to be repeated, as they are already included per the requirement in section II.E.3.a.iv.</p>	See response to Question #4 above.
7.	RFA Section II.E.3.a.v	15	<p>Within the RFA, section II.E.3.a.v states "Each addendum released in conjunction with the RFA, including signed acknowledgement of receipt pages, as applicable" must be included. Pursuant to our prior question, if addenda 1 through 5 do need to be included as part of this specific requirement, please provide an acknowledgement of receipt form.</p>	<p>"As applicable" means a returned addendum must be signed if it includes a signature section.</p> <p>See response to Question #4 above.</p>
8.	RFA Section II.E.4.a.i	15	<p>Within the RFA, section II.E.4.a.i requests signed copies of appropriate documents. Please confirm that digital signatures are acceptable for all signed documents.</p>	The Department will accept a digital or electronic signature. The original copy should be marked as "original".
9.	RFA Sections II.E.4.a and II.E.4.b	15	<p>RFA sections II.E.4.a and II.E.4.b request 3 copies of the application response, 15 copies of Section VIII. Attachment Q. Application Response and Completed Attachments, and corresponding digital media. Due to COVID-19, would DHHS consider an electronic only submission?</p>	The Applicant's RFA submission must include the materials as specified within the RFA, including physical copies of materials where specified.
10.	RFA Section II.E.4.b.i	16	<p>Within the RFA, section II.E.4.b.i requests bidders to mark copies as RFA #30-2020-052-DHB. Please confirm that it is acceptable to name our digital files, and use labeling, that also includes our bidding name (e.g. [BIDDER] RFA #30-2020-052-DHB).</p>	Confirmed.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
11.	Section II.F.4.	17	With respect to the prohibition on Applicant's having any communications with any person (long list of examples) "if the communication refers to the content of Applicant's application or qualifications" - please clarify that this provision does not prohibit the Applicant from communicating with confirmed or prospective PHP partners, confirmed or prospective subcontractors, or consultants that are aiding the Applicant in preparing its RFA Response.	Confirmed.
12.	I-VI	19-21	Is it the intent of the Department to release the rating scale developed for evaluating the application? Or are applicants only to use the evaluation criteria listed?	The Department is not releasing rating scales. The Evaluation Criteria is provided in Section II. General Procurement Information and Notice to Applicants, G. Evaluation and Contract Award, 8. c.
13.	II.G.8. II.G.10.e.	Pages 19-20 of 73 Page 22 of 73	<p>The Evaluation Criteria section states that awards will be made based on "a rating scale developed by the Department to result in an award(s) most advantageous to the Department and State" and that the "evaluation criteria are listed in descending order of importance with no specific percentage or weight...". Section II.G.10.e. states that "the Committee will recommend Empty Region awards most advantageous to the Department or State, considering the ranking of Applicants who submitted responses to the Supplemental Evaluation Questions...".</p> <ul style="list-style-type: none"> • Will awards be made on a pass/fail basis per Region or will the Department issue a ranking of awards identifying the final score of each LME/MCO? • If there is a ranking of awards, will the rankings be made public? • Will the ratings of each evaluation criteria for each Applicant be made public? • Will ranking of Applicants only occur in the event that an Empty Region is awarded? 	The evaluation process and resulting award recommendations will be made based on the criteria identified in the RFA. Information for the final scoring results will be made public post Contract award.
14.	III. Definitions, Abbreviations, Contract Term, General Terms and Conditions, Other Provisions and Protections	Page 24	#18 Is the Behavioral Health Crisis Referral System a web-based application the State is developing or is each Tailored Plan expected to develop the application?	This is a state system that EDs, inpatient providers, FBCs, BHUCs and MCM providers are encouraged to participate. See https://www.ncdhhs.gov/bh-crsys

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15.	III. Definitions, Abbreviations, Contract Term, General Terms and Conditions, Other Provisions and Protections	Page 26	#41 - Question 41 states in part that claims may be filed for dental transactions - Is dental outside the scope of a Tailored Plan?	See RFA Section V. Scope of Services, B. Medicaid, 2. Benefits, Table 1: Services Carved out of Managed Care.
16.	III. Definitions, Abbreviations, Contract Term, General Terms and Conditions, Other Provisions and Protections	Page 27	#44 - Should behavioral claims be referenced as well?	The requirement includes both behavioral and physical health.
17.	III. Definitions, Abbreviations, Contract Term, General Terms and Conditions, Other Provisions and Protections	Page 28	#65 - Should behavioral claims be referenced as well?	The requirement includes both behavioral and physical health.

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18.	III. Definitions, Abbreviations, Contract Terms, General Terms and Conditions, Other Provisions and Protections	Page 28	#65 - Can we get clarity regarding the meaning of a denied claim where it states, a Tailored Plan or subcontractor refuses to reimburse a service provider for all or a portion of the services submitted on the medical or pharmacy claim. Currently when a portion of a claim line is denied - for example 4 units approved out of 6 billed - the claim status is approved for the cost of 4 units. In addition to approved, the claim will also have a reason code to note why the 2 additional units denied.	This is a change from the current LME/MCO contracts. The BH I/DD Tailored Plan are expected to send both paid and denied claims to the Department as encounters. This means both fully denied (i.e., no units approved/paid) and partially denied services.
19.	III.A.187	37 of 73	A "subcontractor" is defined as "an entity having an arrangement with the BH I/DD Tailored Plan, where the BH I/DD Tailored Plan uses the products and/or services of that entity to fulfill some of its obligations under the Contract. Use of a Subcontractor does not create a contractual relationship between the subcontractor and the Department, only the Contractor. Network providers are not considered Subcontractors for the Contract." In certain instances, the RFA expressly states which services may be subcontracted, but in other areas the RFA is silent. Unless specifically noted otherwise, can all obligations under the RFA be delegated to subcontractors?	Yes. However, the BH I/DD Tailored Plan is required to obtain written approval from the Department in accordance with RFA Section III. D. Terms and Conditions.46. <u>SUBCONTRACTORS.</u>
20.	III.D.39	58 & 59	RFA states PIHP shall adhere to record retention standards in 45 CFR 74.53. That section was removed from the federal register in 2014. Will Department clarify applicable record retention standards, which are located in 42 CFR 438?	See Addendum #7 for revisions to the RFA.
21.	III.D.46	60	Can the Department explain when it may "deem" it appropriate to force the PIHP to substitute a subcontractor? Will the Department revise the RFA to clarify that it may only do so for specified instances of good cause?	1. The Department may deem it appropriate if the subcontractor fails to meet performance requirements. 2. No.
22.	III.E.4	65	PIHP, as a local political subdivision of the State of North Carolina, is not subject to Article 2A of Chapter 75 of the North Carolina General Statutes. Can the Department clarify PIHP must only provide the notice required in GS 75-65 when required under GS 132-1.10?	Confirmed.

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23.	E. Confidentiality, Privacy and Security Protections	Page 68	6 c ii - When is the SOC2 Type 2 report required - at go live or after contract award? Does the initial report need to cover a full year or a lesser period? If a lesser period, what time frame?	<ol style="list-style-type: none"> 1. The SOC report/ SSAE 18 is required after award before the Department starts sharing the data which should cover the scope of the contract. 2. See the response to Question #24 below for additional information. 3. See the response to Question #24 below for additional information.
24.	III.E.6.c.	Page 68 of 73	As described by the AICPA, a SOC 2 Type II report reflects suitability of the design and operating effectiveness of an organization's controls throughout a specified "look back" period. Assuming a TP Go-Live date of July 1, 2022, please confirm it is acceptable for the LME/MCO to have an audit (6 month look back) period of October 1, 2022 through March 31, 2023, with the SOC 2 Type II report provided to DHHS within 30-days of report completion, no later than June 30, 2023, and complete subsequent annual SOC 2 Type II audits and reports on the same annual cadence/timetable, to be submitted to DHHS by June 30 each year?	Confirmed.

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25.	III.E.6.c.	Page 68 of 73	<p>The five SOC 2 Trust Service Criteria (TSC) are Security, Confidentiality, Availability, Privacy and Processing Integrity. The Security and Confidentiality TSCs appear to align well with TP operations, but the remaining three criteria do not. Complying with all 5 criteria adds significant administrative costs to the LME/MCO:</p> <ul style="list-style-type: none"> · The Privacy TSC does not seem to apply because the TP is a Business Associate of NC DHHS and seems to be more applicable to DHHS as the Covered Entity. Can DHHS confirm that the Privacy TSC is excluded from the TP's SOC 2 scope? · The Processing Integrity TSC appears to apply to the SaaS vendors who are performing transactional processing for the TP (e.g., claims processing and financial vendors). Can DHHS confirm that it will be acceptable for the TP to require these vendors to provide their own SOC 2 Type II report including this TSC, and then share this report with DHHS? · The Availability TSC appears to apply to the vendors who are providing colocation, data center, or hosting services for the TP (e.g., Microsoft Azure/O365, Managed Care Information Systems vendors). Can DHHS confirm that it will be acceptable for the TP to require these vendors to provide their own SOC 2 Type II report including this TSC, and then share this report with DHHS? · Similarly, can DHHS confirm that TPs that utilize vendors for transaction processing and datacenter/hosting services do not have to independently meet the Processing Integrity and Availability TSCs, and that the Processing Integrity and Availability TSCs are excluded from the TP's SOC 2 scope for LME/MCOs? 	Not confirmed.
26.	Section V.A.1.iv.	N/A	<p>At the 9/29/2020 LME/MCO CEO BH I/DD TP RFA Q&A Meeting, the Department indicated that an LME/MCO contract with a PBM affiliated with or owned by a Standard Plan would not be sufficient to meet the requirements of S.L. 2018-48. Based on the Department's explanation in the 9/29/2020 response, it is our understanding, however, that an LME/MCO contract with a PHP license holder for the PHP license holder to provide pharmacy management services for the BH I/DD Tailored Plan would satisfy the requirements of this section. Can the Department confirm this understanding is correct?</p>	Confirmed.
27.	V.A.1	2	<p>What is the proposed timing for expanding the TBI Waiver statewide, or to additional counties?</p>	While no decision has been made, the Department is contemplating expanding the TBI waiver statewide by December 31, 2026.

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28.	V. Scope of Services	Page 2	v. "any federal funding which is used by the BH I/DD Tailored Plan to reimburse the BH I/DD Tailored Plan for any of its duties under this Contract." - Should this say used by the Department to reimburse the BH I/DD Tailored Plan?	See Addendum #7 for revisions to the RFA
29.	V. Scope of Services	Page 3	i. xi. Will the State funded contract template be updated by the State to reflect this requirement or will the LME/MCO need to update the template?	The BH I/DD Tailored Plan is required to develop contract templates the comply with the requirements of the RFA. The Department will review and approve the templates.
30.	Section V.A.1.i(viii)	3	The provision requires Cardinal Innovations to "provide certification concurrently with the submission of all data, documentation, or information required under federal and state law and under this Contract to the Department. For Medicaid Managed Care, the BH I/DD Tailored Plan shall provide such certification in accordance with 42 C.F.R. § 438.606." The cited regulation limits the types of information requiring certification, by cross-reference to 42 C.F.R. 438.604. Does the CFR limitation apply to the certification requirement stated in the RFA or does the broader language in the RFA control?	Certification is required for all data submitted. For certain Medicaid Managed Care data, the certification must meet the requirements of 42 CFR 438.606.
31.	V. Scope of Services	Page 5	ii. d. 3. How are these costs determined?	The costs will be assessed based on the scope of the change to the BH I/DD Tailored Plan Operational Report and expected cost of the Department to reassess readiness.
32.	Section V.A.1.ii, iv (i)(b)	5	Please provide more specifics regarding the requirement that BH I/DD plans "meaningfully leverage PHP expertise" to support and strengthen the Tailored Plan capabilities. What are the Department's expectations with regard to specific functions or requirements for the Tailored Plan alignment with their partner PHPs? What will be reviewed and scored to determine that the tailored plan is meeting requirements for integration?	The Applicant should provide information on how it will leverage PHP expertise with the requirements of the RFA.

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33.	V. Scope of Services	Page 6	If the member Opts out of tailored care management program, the behavioral health tailored plan must provide the innovation or the waiver care coordination services related to the 1915(c) with does this mean that the innovation and TBI are separate case management program or are they WRAPPED INTO tailored program? are they configured different lines of business?	For members enrolled in the Innovations or TBI waiver who engage in BH I/DD Tailored Care Management, Innovations and TBI waiver care coordination will be part of their BH I/DD Tailored Care Management and delivered by the same care manager as other BH I/DD Tailored Care Management services, regardless of whether the care manager is based at the BH I/DD Tailored Plan, AMH+ practice, or CMA. For members enrolled in the Innovations or TBI waiver who opt out of Tailored Care Management, Innovations and TBI waiver care coordination will be delivered outside of Tailored Care Management by the BH I/DD Tailored Plan. These members will not receive other BH I/DD Tailored Care Management services.
34.	Section V.A.1.ii, iv (iii)(a)	6	This section prohibits Tailored Plans from dividing physical and BH risk or savings among the partners in a way that is inconsistent with integrated care. What operational functions should also be performed jointly by the partners to ensure that there is integration of physical and behavioral health?	The BH I/DD TP RFA outlines what is prohibited when subcontracting; however, it is up to the BH I/DD Tailored Plan to determine what operational function they want to perform jointly with a subcontractor.
35.	V.A.1.iv.(iii)	Pages 6-7 of 254	Please confirm that pharmacy services and LTSS services are excluded from the financial requirements for all third-party subcontracting contracts described in this Section.	The financial requirements apply to all third-party subcontracting contracts allowed under this RFA
36.	V.A.1.iv.(iii)	Pages 6-7 of 254	This section provides the following example, "a BH I/DD Tailored Plan may not enter a contract with a PHP that sub-capitates all physical health services and holds the PHP accountable for the risk associated with those services." We understand this to mean that we cannot contract all physical health services AND assign risk to a PHP for only physical health services. The RFA is silent about when we can enter into contracts with other Subcontractors and assign risk to them for only physical health services. Please confirm that the Tailored Plan may enter into a contract with a PHP (or any other Subcontractor) that sub-capitates all physical health services, provided that the PHP/Subcontractor is not accountable for the risk associated with only physical health services.	The requirement that risk not be segregated based on type of service or percent of premium allocated to service type applies to all sub-contractors, not just Standard Plan PHPs.
37.	V.A.1.vi.(i) Attachment D	Page 8 of 254 Pages 38-42 of 227	Should the LME/MCO be prepared for the readiness review to be conducted immediately after Contract Award in June? If not, when will the readiness reviews begin as some documentation is not due until several months post Contract Award, and the readiness review dates are not referenced in Attachment D, Contract Implementation Schedule?	The final readiness review timeline will be shared after Contract award and comply with notification process outlined in the RFA.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
38.	V.A.1(vii)(iv)(a)(4) Non-Discrimination for Medicaid and State-funded Services	Page 10 of 254	What is meant by liquidated damages in correlation with member and employee complaints? V.A.1(vii)(iv)(a)(4) The BH I/DD Tailored Plan shall develop and adhere to a written Non-discrimination Policy specifying the prohibition against discrimination. At a minimum the Non-Discrimination Policy shall include:... The BH I/DD Tailored Plan's internal complaint process for members, recipients, and employees including liquidated damages.	See Addendum #7 for revisions to the RFA.
39.	V.A.1.ix.(ii) Staffing and Facilities for Medicaid and State-funded Services	Page 11 of 254	This section States "In a format to be specified by the Department, the BH I/DD Tailored Plan shall identify proportion of responsibilities across Medicaid and State-funded Services fulfilled by key personnel to allow for appropriate cost allocation across Medicaid and State-funded Services." Please provide information regarding this format?	The format will be a narrative and include the cost allocation methodology.
40.	V.A.1.ix.(iii)(a)	11	Does the Department anticipate BH I/DD Tailored Plans needing to screen employees for exclusions under the Federal Acquisition Regulation and/or EO No. 12549, or only contractors? Or both employees and contractors?	The screening includes both employees and contractors/subcontractors. See RFA Section V.A.1.ix.(iii)(a).

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41.	V.A.1.ix.(iv)(c)	Table 1 beginning on Page 12 of 254	<p>The Key Personnel requirements listed in Table 1 appear to be more prescriptive than for the Key Personnel listed in the Standard Plan Scope of Work (e.g., the TP includes required Duties and Responsibilities for the Role as well as specific reporting lines associated with certain Key Personnel positions, whereas the SP only listed each required position without corresponding duties and responsibilities):</p> <ul style="list-style-type: none"> · Can the Department explain the basis for the difference between its Key Personnel requirements for Standard Plans versus Tailored Plans, especially given the successful 1915 (b)/(c) implementation and 7+ years of North Carolina managed care experience demonstrated by the LME/MCOs? · Will the Department consider alternative Key Staffing models that minimize the need for significant and potentially costly/ inefficient/ wasteful internal re-organization or additional hiring so long as all Key Personnel functional requirements are met? · For example, if an LME/MCO does not have a Chief Operations Officer but instead has a Chief Population Health Officer who manages all population health functions including care management, utilization management, member services and provider network, can that person be designated as the COO even though certain functions listed under the COO (provider and vendor contracting, enrollment and claims management, staffing and training) are assigned to other Key Personnel? · Conversely, if the LME/MCO decides to designate an individual as the Chief Operating Officer but wishes for Provider Network functions to report to its Chief Population Health Officer rather than the COO, will the Department consider that structure to meet the functional requirements listed in Table 1? · If the Department will not consider alternative staffing models or exceptions to the Duties and Responsibilities listed in Table 1, what is the timeframe by which the LME/MCO must come into compliance with the TP Key Personnel structure? 	<p>The Department has determined the requirements for Key BH I/DD Tailored Plan Personnel aligns with the Department's expectations for administration of the plan. See RFA Section V. A. 1. ix. (iv) Key BH I/DD Tailored Plan Personnel for requirements and processes for Key Personnel.</p>

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42.	V.A.1.ix.(iv)(c)	Table 1 beginning on Page 12 of 254	<p>Unlike Standard Plans, LME/MCOs can currently only operate within the constitutional scope of N.C.G.S. Chapter 122C (i.e. LMEs “are responsible for the management and oversight of the public system of mental health, developmental disabilities, and substance abuse services at the community level. An LME shall plan, develop, implement, and monitor services <u>within a specified geographic area</u> to ensure expected outcomes for consumers within available resources”), do not operate health plans outside of North Carolina, and do not have staff operating from corporate work units located in other states:</p> <ul style="list-style-type: none"> · Accordingly, can the Department explain the basis for requiring certain Key Personnel (CEO, CFO, COO, CMO, CCO, Quality Director, UM Director, PN Director, Deputy CMO, IDD/ TBI Clinical Director, Population Health Director) to “reside in North Carolina”? · Given that remote or home-based work has proven to be successful for LME/MCOs, the Department and organizations across the nation during the ongoing COVID-19 pandemic, will the Department consider exceptions to the North Carolina residency requirement for the positions referenced above? · For example, may an LME/MCO whose region borders another State hire an individual who resides in the border State for a Key Personnel position? 	See response to Question #53 below.
43.	V. Scope of Services	Page 12-17	Key Personnel Requirements: Please confirm that positions currently staffed by personnel living in adjacent states are either exempt or grandfathered from this requirement.	See response to Question #53 below.
44.	V.A.1.i: Table 1. Key Personnel Requirements	Pages 12 - 17 of 254	Table 1 dictates reporting structures of multiple key personnel. Will DHHS consider alternative reporting structures to what is proposed in this section so long as all key personnel positions are filled? The reporting structure as included in this section would require a substantial reorganization. It is important to note that our planned Tailored Plan organizational structure is based on years of evolution and input from multiple industry experts. Our Tailored Plan organizational chart will be provided as part of our RFA response as required for review by DHHS. Within this org chart, there are dotted lines between some positions, for example, the QM Director has a dotted line to our CMO.	The Applicant must adhere to the requirements stated within RFA.

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45.	V.A.1.ix.(iv)(c)	Table 1, Item 3. Pages 12-13 of 254	For purposes of the Chief Medical Officer oversight of "utilization management, pharmacy, population health and care management, and quality management", please confirm that a dotted line is sufficient or that the LME/MCO may use a color-coded supervisory line structure (e.g., green for clinical oversight, red for administrative/ operational oversight). If neither of these approaches is permitted by the Department, what is the timeframe by which the LME/MCO must come into compliance with the Tailored Plan CMO requirements?	See Addendum #7 for revisions to the RFA.
46.	Section V. Scope of Services	13	For the Chief Information Security Officer position, is the NC residency a requirement?	Yes. See Addendum #7 for revisions to the RFA.
47.	V.A.1.ix.(iv)(c)	Table 1, Item 6. Pages 13-14 of 254	If the LME/MCO has an existing staff member who otherwise meets the requirements and is well-qualified for the Chief Information Security Officer/ Chief Risk Officer position but who does not hold the required certification, by what deadline must the staff member obtain this certification? By TP Go-Live or will the Department consider allowing a glide path, for example by the end of Year 1 of TP operations?	See RFA Section V. Scope of Services, A. United, 1. Administration and Management, ix. (iv) Key BH I/DD Tailored Plan Personnel for requirements and processes for Key Personnel.
48.	Section V. Scope of Services	14	For the Quality Director licensure requirement, is a LPA or LMFT acceptable as well?	See response to Question # 49 below.
49.	V.A.1.ix.(iv)(c)	Table 1, Item 7. Page 14 of 254	Please confirm that the list of clinical licensure options for the Quality Director ("e.g. LCSW, LCMHC, RN, MD, DO") is not exhaustive and that the LME/MCO may hire a Quality Director who holds a different North Carolina clinical license, including clinical licenses not typically associated with behavioral health.	The list is not exhaustive. There are other licensures that could be considered; however, their functions should be within the scope and appropriate for the role they are fulfilling.
50.	Section V. Scope of Services	14	For the Utilization Management licensure requirement, is a LPA acceptable as well?	See response to Question #49 above.
51.	V.A.1.iv.c Table 1	14-17	In other sections of the RFA, the list of licensed clinicians who can provide clinical services if they are "fully licensed," includes LPA. In the Key Personnel table, for the Quality Director, Utilization Management Director, and Director of Population Health, the LPA licensure category is not referenced. Was this an oversight or intentional?	See response to Question #49 above.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
52.	V.A.1.ix.(iv)(c)	Table 1, Item 10. Page 15 of 254	Given that current capitation does not include administrative costs associated with hiring a Deputy Chief Medical Officer, what is the timeframe by which the LME/MCO must hire the Deputy CMO? Will it be sufficient to hire this individual to start on the TP Go-Live date, or 90- or 180-days post TP Go-Live?	See RFA Section V. Scope of Services, A. Unified, 1. Administration and Management, ix. (iv) Key BH I/DD Tailored Plan Personnel for requirements and processes for Key Personnel, including the requirement for Key Personnel positions for be fill for the duration of this Contract.
53.	V.A.1.ix.(iv)(c)	Table 1, Item 10. Pages 16-17 of 254	The current 1915(b)/(c) Waiver Contract with the Division of Health Benefits includes the I/DD Clinical Director as a required position but does not require that the individual be a Doctorate-level clinical psychologist, pediatrician or psychiatrist as referenced at this Section. Will the Department consider an exception for the licensure/ education requirements for this role based on demonstrated experience?	See RFA Section V. Scope of Services, A. Unified,1. Administration and Management, ix. (iv) Key BH I/DD Tailored Plan Personnel for requirements and processes for Key Personnel.
54.	V.A.1.iv.c Table 1	17	We note that the Pharmacy Director must be licensed in NC, but is the only Key Personnel position that does not have to live in NC. Does this mean that the Pharmacy Director could be dedicated to our plan, but be an employee of our subcontracted PBM?	See Addendum #7 for revisions to the RFA.
55.	V.A.1.ix.(vii)	Page 18 of 254	This section states that the Department “may, at its sole discretion, <u>require the removal</u> of any Key Personnel providing services under this Contract.” We recognize this is standard terminology applicable to many State vendors, including the Standard Plans. However, unlike Standard Plan employees, LME/MCO staff are local government employees subject to the North Carolina State Human Resources Act pursuant to N.C.G.S. § 126-5(a)(2)a. Furthermore, the Key Personnel described within the Contract do not meet the definition of “exempt position[s]” described at N.C.G.S. § 126-5(b) because that designation is not applicable to local government employees. Given that LME/MCO employees, including Key Personnel, can only be terminated, dismissed or demoted for “just cause” as defined in N.C.G.S. Chapter 126, can you explain how the Department requiring the “removal” of a Key Personnel will meet this statutory just cause standard? Additionally, if a Key Personnel who is removed pursuant to this Section challenges his or her removal at the NC Office of Administrative Hearings, can the Department provide guidance about how the LME/MCO should defend such an action and what role the Department will play in any such administrative hearing?	See the response to Question #56 below.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
56.	V.A.1.ix.(vii)	18	Per the RFA "The Department may, at its sole discretion, require the removal of any Key Personnel providing services under this Contract." The CEO serves at the pleasure of the Board, per GS 122C-121(a) and the CEO makes all the other personnel decisions per 122C-121(c). Staff have appeal rights to any demotions or terminations under NCAC.	The right to request removal by the Department is regarding designation of key personnel for a role under the contract. It is at the discretion of the tailored plan whether the individual is demoted or terminated within the organization. Any request to remove the CEO as key personnel will be addressed to the Board.
57.	V.A.1.ix.(vii)	Page 18 of 254	This section states that the Department "may, at its sole discretion, <u>require the removal</u> of any Key Personnel providing services under this Contract." The Chief Executive Officer, referred to in N.C.G.S. Chapter 122C as the Area Director, is listed as one of the Key Personnel. Given that N.C.G.S. § 122C-121(a) states that the Area Director "serves at the pleasure of the Board" and thus the LME/MCO Board of Directors has the sole discretion to hire and fire the Area Director, can you explain how the Department can require the "removal" of the CEO under this statute and how this language does not abrogate the statutory authority of the LME/MCO Board of Directors?	See the response to Question #56 above.
58.	V.A.1.ix.(xi)	Page 18 of 254 Attachment A, beginning on Page 3 of 227	Please confirm that a single FTE employee may fill more than one "role" described in Attachment A. For example, can the Waiver Contract Manager (Item 32 on Page 12) also serve as the Liaison to DHB and DMH/DD/SAS (Item 27 on Page 11)? Similarly, can the SIU Director (Item 29 on Page 11) also serve as the Liaison to the MID (Item 28 on Page 11)? If not, can the Department confirm that the administrative capitation includes sufficient funding for these distinct FTEs?	Confirmed. In accordance with the requirements of the RFA, certain roles are designated to be filled with a single FTE. Where the requirement is not specific to the requirement of a single FTE for the role, the BH I/DD Tailored Plan may use a single FTE to fill more than one role.
59.	V.A.1.ix.(xi)	Page 18 of 254 Attachment A, beginning on Page 11 of 227	Attachment A, Item 28 describes this role as a "Liaison between the Department and the Attorney General's MID for the North Carolina Medicaid Managed Care Program and State Funded Services". We assume that this individual serves as a Liaison to the Department's Office of Compliance and Program Integrity and the MID, not between the Department and the MID, and that this was a typographical error. Please confirm whether this assumption is correct.	Confirmed.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
60.	Section V. Scope of Services	19	This statement indicates that staff with prior experience providing diversion, in reach or transition services who do not meet the minimum credentials for "Transition Coordinator" or "Diversion Specialist" shall be permitted to fill the Transition Coordinator or Diversion Specialist role. For clarification, on page 7 of Section VII. RFA Attachments, it indicates the position must be a Master's level fully licensed LCSW, LCMHC, LPA, LMFT or RN. If a staff member has prior experience in providing these services, however they are not fully licensed (but provisional level) will they be able to continue providing these services?	See Addendum #7 for revisions to the RFA.
61.	V .A.1.iv.(xii)(e)	20	What is the difference between role # 27, Liaison to DHB and DMH/DD/SAS and role #32, Waiver Contract Manager? Today, our Waiver Contract Manager also serves as the primary liaison to both Divisions.	The Role for 27. Liaison to DHB and the DMH/DD/SAS for the North Carolina Medicaid Managed Care Program and State-funded Services has been removed. See Addendum #7 for revisions to the RFA.
62.	V .A.1.ix.(xii).(e)) and V.A.2.a. Table 1	19-20 and 22	Will the Department clarify what is meant by the term "located in" for front-line positions referenced in these areas? Currently, LME-MCOs have been able to employ staff who reside within a certain proximity outside of NC as long as staff in applicable positions maintain NC licensure and have an associated NC office base.	In addition to noting Key Personnel that must reside in NC, the RFA outlines personnel and roles, at a minimum that shall be in and operate from within the State of NC. See Section V, A-B (xii) Physical Presence in North Carolina and Section VII. Attachment A, BH I/DD Tailored Plan Organization Roles and Positions for Medicaid and State-funded Services. The Department's priority is to leverage contracts as appropriate to develop job opportunities within North Carolina and ensure Contractors are in and know the communities in which they serve. Please see exception request noted in Section V.A.1. ix.(x). The Department reserves the right not to accept a Contractor's exception request.
63.	V.A.2.i.(i)	Page 21 of 254	Please confirm that service line resolution in "one touch" means in one phone call, including any warm transfers or conferencing in other staff to assist with answering more complex questions.	Confirmed. This term means resolving an issue in a single interaction, eliminating the need for calling back again about the issue.
64.	V.A.2.iii.(iv)	Page 27 of 254	In order to support North Carolina colleges and universities and help grow the next generation of behavioral health clinicians, this Applicant routinely hires interns who work anywhere from 30 days to over a year depending on the program. Please confirm that any interns who are unpaid and/or participating in a 90-day program or less may be excluded from the new hire training requirements referenced in this Section.	The BH I/DD Tailored Plan must comply with the training requirements set forth in the RFA. See RFA Section V. Scope of Services, A. Unified, 2. Program Operations, (iii) regarding training at all levels and across all disciplines to fulfill the responsibility of the position.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
65.	Section V.A.2.v	30-31	This section requires that BH I/DD Tailored Plans "shall submit policy documents for Medicaid and State-funded Services to the Department for review and approval as defined in the Contract." Presently, the Department reviews and approves all LME/MCO policies and procedures annually through its EQRO vendor and the annual EQR process. Does the Department anticipate that following the BH I/DD Tailored Plan that this requirement will be fulfilled through the annual EQR process, or does the Department intend for the BH I/DD Tailored Plans to submit their policies and procedures directly to the Department for review/approval? When does the Department anticipate requiring the BH I/DD Tailored Plans to make their initial submission of policy documents for Department review and approval?	The Department will review policy documents outside of the EQR process in advance of go-live. Deadlines for policy reviews are noted in Section VII. RFA Attachments, Attachment D. Anticipated Contract Implementation Schedule.
66.	Section V.A.2.v.(iv)	31	"After initial approval, the BH I/DD Tailored Plan shall submit any material modifications, additions, or deletions of all Medicaid and State-funded Services policies to the Department at least thirty (30) Calendar Days prior to implementation, unless another time frame has been specified in the Contract." Will the Department require all modifications/additions/deletions to be approved by the Department before the BH I/DD Tailored Plan is permitted to implement the changes? If the BH I/DD Tailored Plan has submitted modifications/additions/deletions to the Department at least 30 days in advance of implementation but has not received an approval or denial response from the Department prior to the proposed implementation date, is the BH I/DD Tailored Plan permitted to implement the change?	Specific policies that require Department approval prior to use are noted within the RFA.
67.	V, A-B	35	The current NC DHHS Provider Monitoring process is not mentioned by name in the RFA. Is the intent to sunset the current NC DHHS Provider Monitoring process? If yes, when and will Tailored Plans be responsible for developing their own monitoring process?	Yes, the Department Provider Monitoring process will be sunset. Each BH I/DD Tailored Plan will be responsible for developing their own process post contract award. The specific date has not been determined.
68.	V.A.3.ii Program Integrity (PI) for Medicaid and State-Funded Services	Page 35 of 254	Will the Tailored Plan be permitted to request the names, DOB and SS# of a providers' owners, agents and managing employees on the Tailored Plans' provider application request in order to complete the required sanctions status reviews?	The Department will provide the data to fulfill the requirements of the RFA as determined appropriate. This may or may not include the items stated in this question.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
69.	V.A.3.ii.(ii)(f) (4)	38, also 209	Did the Department intend to state that BH I/DD Tailored Plan Network Providers, which are not subcontractors of the PIHP, to have compliance programs that meet the requirements of 42 CFR 438.608 and policies and procedures that meet the requirements of the Deficit Reduction Act of 2005? Network Providers are not directly subject to the Managed Care rules set forth in 42 CFR 438. This mandate is also set forth on Page 209.	See Addendum #7 for revisions to the RFA.
70.	V, A-B	40-41	As it relates to the SIU members adequate training and experience and throughout the document, please explain if the use of the term "shall" is used in the context as meaning "mandatory."	See Section II. General Procurement Information & Instructions, C. Request for Proposal Functionality and Related Notices, 1. RFA Functionality use of the phrase "shall".
71.	V.A.3.iv (xi) (a)(4)i. Third Party Liability (TPL) for Medicaid	Page 46 of 254	Item (xi) states that the TP shall have a TPL policy, including analysis of the State motor vehicle accident report file data exchange required under 42 C.F.R. § 433.138(d)(4)(ii) to identify potential subrogation claims and identify beneficiaries with a legal liable third party. Will the TP be required to obtain State vehicle motor vehicle accident report data directly from DMV or will this be through the Department?	The Department does not provide the motor vehicle accident report data.
72.	V.A.3.iv (xi) (a)(4)ii. Third Party Liability (TPL) for Medicaid	Page 46 of 254	The section provides a range of ICD-9 codes to be utilized by the Tailored Plan to identify potential subrogation claims. Will the Department provide a list of ICD-10 codes?	Yes. These will be provided upon request.
73.	V.A.3.vi.(viii)	47	Will the Department make the 'defined Department policies' available and if so, when may we expect them?	The Department will make the policies for investigating and reporting Recipient Explanation of Medical Benefits available after Contract Award.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
74.	V.B.1.i.(iv) V.B.4.v(v) IX. Medicaid Tailored	Page 58 of 254 Page 225 of 254 Page 228 of Draft Rate Book	<p>Section B.1.i.(iv) states: "The Department is exploring seeking a change in State law to allow Beneficiaries who are medically needy, participate in the NC HIPP program, or are enrolled in the CAP/C or CAP/DA waivers if they meet one of the BH I/DD Tailored Plan eligibility criteria to enroll in a BH I/DD Tailored Plan for Medicaid-covered BH, I/DD, and TBI services. They would receive all other Medicaid-covered services through NC Medicaid Direct." Similarly, the Draft Rate Book states: "Beneficiaries enrolled in both Medicare and Medicaid (dual eligible) for whom Medicaid coverage is not limited to the coverage of Medicare premiums and cost sharing ... will only be eligible to receive BH, I/DD and TBI services through the BH I/DD Tailored Plan."</p> <p>Will the LME/MCO be required to offer Tailored Care Management (TCM) to the dual Eligibles who are eligible at TP Go-Live, or will those individuals be exempt from TCM since they will not receive physical health and pharmacy services via the Tailored Plans?</p> <p>If these dual Eligibles will not be exempt from TCM, what is the estimated number of individuals, by Region number, who will require TCM?</p> <p>Can the Department provide the estimated number of 1) NC HIPP; 2) Medically Needy; 3) CAP/C; and 4) CAP/DA individuals, by Region number, who may be eligible for Tailored Plans if the General Assembly passes the referenced change in State law during the 2021 legislative session?</p> <p>Will the LME/MCOs be required to offer TCM to the above-referenced individuals if they enroll in a Tailored Plan?</p>	<p>Section B.1.i.(iv) states: "The Department is exploring seeking a change in State law to allow Beneficiaries who are medically needy, participate in the NC HIPP program, or are enrolled in the CAP/C or CAP/DA waivers if they meet one of the BH I/DD Tailored Plan eligibility criteria to enroll in a BH I/DD Tailored Plan for Medicaid-covered BH, I/DD, and TBI services. They would receive all other Medicaid-covered services through NC Medicaid Direct." Similarly, the Draft Rate Book states: "Beneficiaries enrolled in both Medicare and Medicaid (dual eligible) for whom Medicaid coverage is not limited to the coverage of Medicare premiums and cost sharing ... will only be eligible to receive BH, I/DD and TBI services through the BH I/DD Tailored Plan."</p> <p>Will the LME/MCO be required to offer Tailored Care Management (TCM) to the dual Eligibles who are eligible at TP Go-Live, or will those individuals be exempt from TCM since they will not receive physical health and pharmacy services via the Tailored Plans?</p> <p>If these dual Eligibles will not be exempt from TCM, what is the estimated number of individuals, by Region number, who will require TCM?</p> <p>Can the Department provide the estimated number of 1) NC HIPP; 2) Medically Needy; 3) CAP/C; and 4) CAP/DA individuals, by Region number, who may be eligible for Tailored Plans if the General Assembly passes the referenced change in State law during the 2021 legislative session?</p> <p>Will the LME/MCOs be required to offer TCM to the above-referenced individuals if they enroll in a Tailored Plan?</p>

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
75.	V.B.1.(ii) (c) 4 and V.B.1.(ii) (c) 5 AND V.B.1.(ii) (g) Transitions of Care	Page 61 of 254	<p>Previously, transition of care required honoring a prior authorization for 90 days as noted in GS 58-67-88(d). Section V.B.1.ii.c.4 notes a member shall be allowed to complete an existing authorization. Section V.B.1.ii.c.5 then states the Tailored plan shall honor a transitional period of 180 days in lieu of the cited NCGS.</p> <p>1. Please clarify how long the Tailored Plan must honor a prior approval by another plan during MCL (the time period that Standard Plans are live, but we are operating as LME/MCO)?</p> <p>2. Please clarify how long the Tailored Plan must honor a prior approval by another plan after we are live as a Tailored Plan?</p> <p>3. Will BH I/DD Tailored Plans be required to honor prior approvals longer than 180 days?</p>	<ol style="list-style-type: none"> 1. The BH I/DD Tailored plan must honor the prior approval from another LME-MCO or a PHP for the duration established in the LME-MCO contract. 2. For prior authorizations at Crossover. See RFA Section V.B.1 ii (ii) (g). For Ongoing Transition of Care. See RFA Section V. Scope of Services, B. Medicaid, 1. Members, ii.c.4. 3. For prior authorizations at Crossover, see RFA Section V.B.1 ii (ii) (g). For Ongoing Transition of Care. See RFA Section V. Scope of Services, B. Medicaid, 1. Members, ii.c.4.
76.	Beginning at V.B.1.ii(i)(c)(5)	61 and throughout RFA document (25 uses within document)	<p>There are several references to G.S. 58, which refers to the Department of Insurance. Is our adherence to those standards contingent on a change to state law allowing us to be licensed as a PHP? If not, are we only required to adhere to those specific provisions of Chapter 58 referenced in the RFA? Will the Department be monitoring adherence to Chapter 58, or will DOI be responsible for that?</p>	<p>The BH I/DD Tailored Plan must comply with Chapter 58 general statute requirements as set forth in the RFA. Chapter 58 provisions that require legislative change to be applicable have been specifically identified within the RFA, i.e. G.S. 58-93-110. The other Chapter 58 references are applicable pursuant to the RFA and as authorized by G.S. 108D-60 and 108D-65(6)f.</p>
77.	Section V.B.1.ii(i)(d)(1)i	62	<p>This provision states regarding transition of care with change of providers, following a termination/non-renewal unrelated to quality of care or program integrity, if "the member is in an ongoing course of treatment or has an ongoing special condition, the BH I/DD Tailored Plan shall permit the Member to continue seeing their provider, regardless of the provider's network status, in accordance with N.C. Gen. Stat. § 58-67-88(d), (e), (f), and (g)." When this provision applies, during the course of the member's ongoing care, is the provider subject to contract requirements and monitoring, and will BH I/DD Tailored Plan maintain its supportive relationship with the provider (technical assistance, etc.)?</p>	<p>Yes. The BH I/DD Tailored Plan may condition coverage of continued treatment by a provider upon the permissible terms and conditions outlined in G.S. §58-67-88(h). Refer to G.S. § 108D-65(6)f. for information on the applicability of statutes from Chapter 58 of the NC General Statutes to Medicaid Managed Care.</p>

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
78.	Section V.B.1.ii(ii)(a)	63	This provision requires the BH I/DD Tailored Plan to comply with the requirements of Section V.B.1.ii.(i) to support members transitioning during the Cross-over period." Section III.A.59 defines "Crossover" as "the timeframe immediately before and after implementation of BH I/DD Tailored Plans in the applicable Region." Is there a definition for "cross over period"? Can the Department provide any greater detail on the intended timeframe beyond "the timeframe immediately before and after implementation"? If not, when does the Department anticipate identifying the cross-over period?	The Crossover definition in RFA Section III.A.59: Crossover-related requirements and timeframes are activity-specific but are all designed to ensure continuity of care for the crossover population during this time of transition. The Department will establish timelines related to Crossover planning and governance. And communicate these timelines to the BH I/DD Tailored Plans within ninety (90) days of Contract Award.
79.	Section V.B.1 iii (v) Member Engagement	Page 65 of 254	This section states "Unless otherwise stated, all written communications, call center scripts, websites, or other communications directed to members or potential members must adhere to the requirements in this Contract and receive prior approval from the Department before the material is communicated. The Department may require changes to previously approved communications, at its sole discretion." 1. Does this include all routine materials developed for members by the BH I/DD Tailored Plan or subcontractor? 2. If so, what are the timeframes for approval by the Department?	Unless otherwise specifically stated in the RFA, materials must be submitted no less than thirty (30) days in advance for the Department to review and approve.
80.	V.B.1.iii(vii)(c)(6)	66	The Ombudsman program must be referenced in numerous places (brochures, procedures, new member letters, website, handbook, etc.). When will contact information and formal directives on their involvement be released?	The Department will provide this information when it becomes available.
81.	V.B.1.iii(ix)(b)(7)i-xv	68	Will the Department remove the reference to the top 15 taglines to comply with the Executive Order ending that requirement?	No.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
82.	V.B.1.ix.(b)(3)) Written and Verbal Member Materials	Page 68 of 254	When printed materials (e.g. brochures) are requested in languages other than English or Spanish, must the equivalent product (requiring graphic layout and printing) be provided, or is it sufficient to provide the translated text in a Word document?	The Department believes the correct RFA Section reference for this question is Section V. Scope of Services, B. Medicaid, Members, iii. (ix)(b)(3) and has used this Section to respond. For materials in languages other than English or Spanish, you can provide a translator to talk through the document with the member. If you are planning to provide a written document in another language, it must be presented the same as the English and Spanish versions. For materials in a language other than English or Spanish, an alternative format may be provided by use of a translator or other means indicated within the RFA. If written materials are to be provided, the materials must be presented in the same format with the same information that mirrors the English and Spanish version.
83.	V.B.1.ix.(b)(7)) Written and Verbal Member Materials	Page 68 of 254	Please clarify regarding the requirement for taglines in the top 15 prevalent non-English languages. Does this apply to all materials regardless of physical size, i.e. brochures, post card- or business card-sized print pieces, etc. where there is very limited space compared to, for example, a member handbook?	The Department believes the correct RFA Section reference for this question is Section V. Scope of Services, B. Medicaid, 1. Members, iii. (ix)(b)(7) and has used this Section to respond. Per the Managed Care Final Rule and Section 1557 of the ACA, for only small-sized materials like postcards, include a statement that the information can be requested in additional languages on [insert tagline location on website] or by calling [your contact center]. Members must be able to find resolution at either location.
84.	Section V.B.1.xi.g and Section VII, Attachment Q Question 49	69 and 55	During low volume call times or emergency situations (staff illness, staff turnover situations, etc.) may language line be used as a backup/supplement for Spanish speaking staff on the Service Lines?	The language line is not a substitute for Spanish-speaking representatives. Service Line staffing models are expected to be designed to anticipate the situations listed.
85.	V.B.1 xiii Member Identification Cards	Pages 70-71 of 254	This sections states "The BH I/DD Tailored Plan is required to generate an identification card for each member enrolled in the BH/IDD Tailored Plan with the following information: The toll-free help line numbers for the Member and Recipient Service Line, Behavioral Health Crisis Line, Nurse Line, Provider Service Line, and Prescriber Service Line". Please confirm that the Provider Service Line and Prescriber Service Line need to be included on member ID cards.	The Department believes the correct RFA Section reference for this question is Section V. Scope of Services, B. Medicaid, 1. Members, iii(xiii) and has used this Section to respond. Confirmed.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
86.	V.B.1.iii(xi)(h)(2)	70	RFA states: Translation of materials into Spanish and up to three (3) additional languages, as required by the Department. RFA response asks for materials in Spanish and Chinese. Have the other two languages been determined yet?	The Department has not determined the additional languages beyond Spanish and Chinese. The Department will advise the BH I/DD Tailored Plan of the languages to be included as specified in Section V. Scope of Services, B. Medicaid, 1. Member, iii(xi)(h)(2).
87.	V.B.1.iii.(xiv)(a)	71	RFA refers to a "model handbook" and this is part of the expected response. I did not see a model handbook in the RFA materials. Where do we find or when can we expect to receive the model handbook?	The Department's template for the BH I/DD Tailored Plan Member Handbook will be provided after Contract award.
88.	V.B.1 xiv. (a) Member Handbook, Innovations Member and Family Handbook and TBI Handbook	Page 71 of 254	This section states "The BH IDD Tailored Plan shall use the Department's model BH/IDD Tailored Plan Member Handbook as guidance in the development of the BH/IDD Tailored Plan's Member Handbook". Please advise where we may access the current template.	The Department believes the correct RFA Section reference for this question is Section V. Scope of Services, B. Medicaid, 1. Members, iii(xiv)(a) and has used this Section to respond. The Department's template for the BH I/DD Tailored Plan Member Handbook will be provided after Contract award.
89.	Section V.B.1 xiv(h) Member Handbook, Innovations Member and Family Handbook and TBI Handbook	Page 73 of 254	This section states "The BH I/DD Tailored Plan shall notify each member, using Department-developed templates, of any Significant Change to the Member Handbook, Innovations Member and Family Handbook, and TBI Handbook at least thirty (30) Calendar Days before the intended effective date of change". Where may we access the referenced Department-developed template?	The Department believes the correct RFA Section reference for this question is Section V. Scope of Services, B. Medicaid, 1. Members, iii (xiv)(h) and has used this Section to respond. Department developed templates will be provided after Contract award.
90.	V.B.1 xiv. (19) Member Handbook, Innovations Member and Family Handbook and TBI Handbook	Page 73 of 254	This section states that Member Handbooks shall include at a minimum: "The toll-free help line numbers for the Member and Recipient Service Line, Behavioral Health Crisis Line, Nurse Line, Provider Support Line, and Prescriber Service Line" (Section V, page 73). Please confirm that Provider Support Line and Prescriber Service Line numbers should be included in all Member Handbooks. This seems like information that will make it confusing for Members and potentially cause them to contact incorrect lines within the Tailored Plan. (The companion requirement in the Standard Plan RFP did not require this information to be listed on Member-facing material).	Information must be provided as required in RFA Section V. Scope of Services, B. Medicaid, 1. Providers, iii(xiv)(e)(19).

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
91.	V.B.1.iii(xx)(a)-(c)	75	Are the healthy behavior criteria tied to both BH and PH? Will encounter data be required for these payments? And, will these apply to both Medicaid and State funded eligible members?	The Healthy Behavior criteria is tied to both behavioral and physical health and encounter data will be required for these payments. This applies to only to Medicaid Members.
92.	V.B.1.iv.xi.b.6	77	The BH I/DD Tailored Plan shall not cross-market with a Standard Plan. Confirming this means we can never mention our SP partner in any communications to providers, on our website, etc.	This is not allowed in any activities that would be considered marketing. The Department would need more information on the other communications that are being referenced.
93.	V.B.1.v.(iii) and V.C.1.d.iii	79 and 12	Will the Department consider allowing us to maintain one "Member Handbook" that clearly describes the differences in the benefits covered through Medicaid and State Funded (as opposed to one Member Handbook and one Recipient Handbook)? Partners considers all persons served "members" and believes the distinction can be seamless to the member in regards to payment for services. This approach provides simplification for our members who may transition between being covered through Medicaid or State Funded benefits.	Individuals are identified in two (2) groups: 1. "Members" are those individuals who receive Medicaid and 2. "Recipients" are those who receive State-funded services. The BH I/DD Tailored Plan may maintain one (1) handbook but should clearly separate and identify the Medicaid Member section and State-funded Recipient section as benefits are different depending on the payer. The Department acknowledges that individuals may transition between these two (2) groups. These different terms are intentional and need to be used appropriately in materials.
94.	V.B.2.i(iii).(c) Table 1	94	Per RFA: Services for Medicaid applicants provided prior to the first day of the month in which eligibility is determined in cases where retroactive eligibility is approved (with exception of deemed newborns) unless otherwise defined in the Contract) Question: Does this mean that the TPs will no longer pay for retroactive dates of service when retroactive Medicaid eligibility is approved?	Per SL 2016-121, and consistent with the Standard Plan requirements, the BH I/DD Tailored Plan is not responsible for services provided prior to the enrollment effective date into the BH I/DD Tailored Plan. Any period retroactive to the BH I/DD Tailored Plan enrollment date is covered through NC Medicaid Direct.
95.	V. Scope of Services	Page 99	Please confirm that overflow and/or secondary call-center staff are exempt from local/in-state location requirements.	Confirmed.
96.	V. Scope of Services	Page 99	5. B.1 a requires the tailored plan to develop a UM program for medical, DH, IDD, LT SS, and pharmacy services that is based on nationally recognized evidence-based clinical practice guidelines and decision support methodology to support UM and prior authorization for services not otherwise defined in the mandated clinical coverage policy. What medical services are they referring to or are they already covered under the standard plan?	The Department does not understand the question due to the reference to "standard plan." However, the BH I/DD Tailored Plan is responsible for providing medical services which includes both physical and behavioral health services as defined within the RFA.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
97.	V.B.2.i(v)(e)(5)	100	Can the Department clarify why PIHP is required to meet clinical practice guideline requirements required for Health Plan Accreditation with LTSS distinction in Contract Year 1, when PIHP is not required to have such accreditation until Contract year 3?	As a key component of ensuring that Standard Plans and BH I/DD Tailored Plans are held to consistent, current standards for quality, access, and timeliness of care, Standard Plans and BH I/DD Tailored Plans are required to attain Health Plan with LTSS distinction accreditation from the National Committee for Quality Assurance (NCQA) within the first three years of operations. Use of a single accrediting body ensures that Standard Plans and BH I/DD Tailored Plans are held to a uniform standard, aligned with the State's Quality Aims, Goals, and Objectives. The Department aims to avoid duplication and inconsistency in quality functions completed across the accrediting body, EQRO, and Department-related to plan operations, quality measurement and assessment, and compliance with Department standards. The Department will streamline these activities over time and, where appropriate, exercise the option to use information provided by the accreditation reports to avoid duplication of mandatory activities as permitted by 42 CFR 438.360.
98.	Section V.B.2.i.v.k	103	Will the Department's standardized prior authorization request form replace the LME/MCO's current Treatment Authorization Request (TAR) form? Of so, when will the Department's standardized form be available?	The Department's standardized form will be utilized and provided after Contract Award.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
99.	I.A.4.c. V.B.3.1.(i)	Page 3 of 73 Pages 125-126 of 254	<p>This question relates to the Department's stated goal at Section I.A.4.c. Vision for NC Medicaid Managed Care Program of "Overseeing a transition to provider-based care management at the site of care, in the home or in the community to promote in-person interaction with members;" and the statement in Section V.B.3 Care Management.1.(i) "The Department believes that care management is a crucial driver to help achieve key goals of BH I/DD Tailored Plans, including integrated, whole-person care and fostering coordination and collaboration among care team members across disciplines and settings" using one of the 3 approaches defined in 3.1.(ii).(a)(1)-(3) AMH+, CMA or TP care management. In approach one, "... To be eligible to become an AMH+, the practice must intend to become a PCP in the BH I/DD Tailored Plan network. Only AMH Tier 3 practices certified as an AMH+ practice may provide Tailored Care Management as defined in Section V.B.3.ii.(xviii) Certification of AMH+ Practices and CMAs." AMH+ Practice and CMA Certification Policy. Cross referencing the requirements on p. 143, AMH+ Practice and CMA Certification Policy: "To demonstrate experience and competency to serve the BH/IDD Tailored Plan eligible population, each AMH+ applicant must attest that has a patient panel with at least 100 active Medicaid patients who have an SMI, SED, or severe SUD diagnosis; an I/DD; or a TBI." We are concerned this requirement will negatively impact the Department's goals, particularly in rural regions. Would the Department allow the TP to be less restrictive on active Medicaid patient level, for example lower the requirement to 50 active Medicaid patients to enable primary care practices to build their active patient level over first 3 years?</p>	No.
100	V.B.3 Care Management	Pages 125-194 of 254	<p>This is a general question for the Care Management requirement in this Scope of Services: As part of the Standard Plan RFP, applicants were required to respond to how they would complete a health risk assessment on all of their members. There is no mention of this requirement in this Scope of Service. Will the Tailored Plans be required to complete a health risk assessment on any new members to the plan?</p>	<p>Both the PHP contract and the BH I/DD Tailored Plan RFA use the term "care needs screening" versus "health risk assessment."</p> <p>For members engaged in Tailored Care Management, the care management comprehensive assessment will serve as the federally required initial care needs screening under 42 CFR 438.208(b)(3). See RFA Section V.B.3.ii.(vii) for additional guidance and requirements.</p> <p>For members who have opted out of or are excluded from Tailored Care Management, BH I/DD Tailored Plans must conduct an initial care needs screening. See RFA section V.B.3.iii.(vii).(b) for additional guidance and requirements</p>

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
101	Section V.B.3.ii.ii.b.4	127	What is the expectation of the Department if the percentage of people who choose to receive Tailored Care Management from the BH I/DD Tailored Plan does not align with the identified annual percentages of people expected to receive Tailored Care Management from CMA's and AMH's?	The Department expects the BH I/DD Tailored Plan to work with providers in its regions to build a high-quality network of AMH+ practices and CMAs that will enable the BH I/DD Tailored Plan to meet the targets for provider-based BH I/DD Tailored Care Management required by the RFA.
102	Section V.B.3.iii.a.1	127	With the exclusion of ACT members from receiving Tailored Care Management, how would the State want us to manage TCL members in ACT? Approximately, 50% of all TCL members receive ACTT services.	In-reach and transition functions are outside of Tailored Care Management. For the TCLI population, including BH I/DD Tailored Plan members obtaining ACT, TCLI functions will largely be performed by BH I/DD Tailored Plan-based staff.
103	V.B.3.ii.(iii)(b)	127	The Department reserves the right to require TP to allow beneficiaries enrolled in Medicaid Direct in Tailored Care Mgmt (TCM) if they meet the criteria so regardless of if the TP or CMA is providing TCM, how would this service be paid if the individual isn't a TP enrolled member?	If the Department allows beneficiaries in NC Medicaid Direct to enroll in BH I/DD Tailored Care Management, the Department will release additional guidance on this topic at a later date.
104	V.B.3.ii(iii)(b)	Page 127 of 254	This Section states: "The Department reserves the right to require Tailored Plans to allow beneficiaries enrolled in NC Medicaid Direct to enroll in Tailored Care Management if they meet the Health Home eligibility criteria that will be specified in the forthcoming Health SPA." Can the Department provide an estimated number of potentially eligible NC Direct beneficiaries who may meet the Health Home eligibility criteria, by Region number?	The Department is not releasing these data at this time.
105	V.B.3.ii(iii)(a) (1,2,3,4)	Page 127 of 254	The RFA is clear that Diversion activities are required for members receiving TCM by the agency delivering TCM, but not clear regarding those who are excluded from TCM. Does the Department intend for the Tailored Plan to be responsible for providing Diversion activities to members excluded from Tailored Care Management but who meet Diversion eligibility?	The BH I/DD Tailored Plan is responsible for providing diversion activities; however, the BH I/DD Tailored Plan may delegate the activities to the provider providing care management activities or other services. The BH I/DD Tailored Plan remains responsible for the individual receiving Diversion services even if delegated.
106	Section V.B.3.iv.b.3.i	128	Can care coordination <i>only</i> be rendered by the TP, and not by CMA's or AMH's? This is in relation to the statement, "In cases where a member enrolled in the Innovations or TBI waiver opts out of Tailored Care Management, the BH I/DD TP must provide the Innovations or TBI waiver care coordination services as stipulated by the applicable 1915(c) waiver."	For members enrolled in the Innovations or TBI waiver who opt out of BH I/DD Tailored Care Management, the BH I/DD Tailored Plan must provide Innovations or TBI waiver care coordination.
107	Section V.B.3.vii.a	130	Will the Department require the BH I/DD Tailored Plans to use a Department-identified Care Management Comprehensive Assessment form or tool, are the BH I/DD Tailored Plans permitted to develop their own forms or tools to complete these assessments?	The Department is not mandating the use of a standardized form or tool for care management comprehensive assessments. BH I/DD Tailored Plans will be permitted to develop their own form or tool as long as the RFA requirements are met.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
108	V.B.3.ii(vii)(m)	Page 132 of 254	Can the Department provide more clarity or a specific example in reference to the requirement to “develop methodologies and tools for conducting the care management comprehensive assessment, as appropriate for differing member demographics and needs”? For example, is this referring to administrative/ timeframe differences or substantive/ content differences?	The Department does not have additional information to provide.
109	Section V.B.3.viii.a	133	Will the same ISP template that’s currently utilized for NC Innovations members be utilized for non-Innovations I/DD members?	The Department is not mandating the use of the existing ISP template. The BH I/DD Tailored Plan may use the exiting ISP template or a different template as long as all essential elements and requirements are included.
110	Section V.B.3.viii	133	Will the Care Management Comprehensive Assessment and the Care Plan take the place of the current Person Centered Plan?	No, the care management comprehensive assessment and the care plan will not take the place of the current person-centered plan. BH I/DD Tailored Plans are required to use person-centered plans as described in the clinical coverage policies.
111	V.B.3.ii(viii)(a)	Page 133 of 254	This Section states that the Tailored Plan “shall develop a Care Plan for members with BH needs and an ISP for members with I/DD and TBI needs.” However, this Applicant has been approved by the Department for the past several years to implement and use a Care Plan document designed by Applicant that includes the required elements of the Innovations Waiver Individual Support Plan (ISP) but is not on the ISP template. Please confirm that after TP Go-Live, Applicant will continue to be permitted to use an alternate Care Plan template for Innovations Waiver members, so long as it includes the required elements of the ISP.	The Department is not mandating the use of a standardized template for Care Plans or ISPs. The BH I/DD Tailored Plan is permitted to develop its own templates, as long as they meet the requirements in the RFA.
112	Section V.B.3.viii.e	134	When trying to contact a member for the assessment or planning process, “best effort” is defined as including at least three documented strategic follow-up attempts. Is this time frame of contact to be aligned with NCQA – three documented attempts in a 2 week period? There doesn't appear to be a reference to the time frame of the attempted contacts.	This timeframe for the BH I/DD Tailored Plan is not aligned with NCQA.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
113	V.B.3.ii(vii)(f)	Page 134 of 254	This Section states: "The BH I/DD Tailored Plan shall ensure that development of the Care Plan or ISP does not delay provision of needed services to a member in a timely manner, even if that member is waiting for a Care Plan/ISP to be developed." Does this language mean that the LME/MCO should authorize Innovations Waiver services on a time-limited or pass-through basis without verification of medical necessity (similar for example to a 3-day inpatient stay pass-through) while the Care Manager is completing the assessment and care plan?	See Addendum #7 for revisions to the RFA.
114	Section V.B.3.x.1	139	Will the state be defining the criteria for high, moderate and low acuity related to member contacts or will this be the discretion of the BH I/DD Tailored Plan?	The Department will define the criteria for high, moderate, and low BH I/DD Tailored Care Management acuity levels and establish a standardized methodology to assign each member to a acuity tier. See RFA Section V.B.3.ii.(x).(k).
115	V.B.ii.(x)(l)	Page 139 of 254	This Section states, in reference to TCM: "Public facing video communication applications, such as Facebook Live, Twitch, or TikTok, shall not be used." If the member prefers or requests the use of non-secure applications (including but not limited to Skype or Basic Zoom) and signs a waiver acknowledging the privacy risks associated with use of non-secure or public-facing video communication applications, will the use of such applications be permitted, as during the COVID-19 pandemic?	Such use of non-secure "private facing" applications is currently allowed without a signed waiver under the RFA, so long as the care manager follows the requirements of Section V.B.ii.(x)(l), including notifying the member that the third-party application potentially introduces privacy risks. Note that telehealth practices are governed by federal HIPAA regulations not controlled by the Department, and the privacy requirements in this area could change at the conclusion of the COVID-19 emergency.
116	V.B.3.ii(xii)(a)	Page 141 of 254	This Section states: "The BH I/DD Tailored Plan shall ensure that members are identified who are at risk of requiring care in an institutional setting or ACH are provided diversion interventions...". After TP Go-Live, will the Department continue using the North Carolina Pre-Admission Screening and Resident Review (PASRR) process to notify Tailored Plans of requests for admission to Adult Care Homes so that Tailored Plans can timely begin diversion activities?	The PASRR process is no longer used for group home, assisted living levels of care. The RSVP system is the process that is used and will continue to be used under BH I/DD Tailored Plans.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
117	RFA Section V, A – B, c	Page 144 of 254	<p>(c) Care Manager Qualifications (1) The BH I/DD Tailored Plan shall ensure that all care managers providing Tailored Care Management to members have the following minimum qualifications: i. Bachelor's degree in a field related to health, psychology, sociology, social work, nursing or another relevant human services area or licensure as a registered nurse (RN). a) If serving members with BH needs, the care manager must have two (2) years of experience working directly with individuals with BH conditions. b) If serving members with an I/DD or TBI, the care manager must have two (2) years of experience working directly with individuals with I/DD or TBI. c) If serving members with LTSS needs, the care manager shall meet the minimum requirements defined above and shall additionally have at a minimum two (2) years of prior LTSS and/or HCBS coordination, care delivery monitoring and care management experience. This experience may be concurrent with the two years of experience working directly with individuals with behavioral health conditions, an I/DD, or a TBI, as described above. d) If the member is dually diagnosed with a BH condition and I/DD or TBI, the assigned organization providing Tailored Care Management shall determine the appropriate care manager assignment.</p> <p>NOTE: No question for this section. Added for ease of reference/comparison purposes.</p>	The Department acknowledges a question is not presented for response.
118	Section V.B.3.ii.xv.b. 4.iii	149	This section lists several incidents of "sharing" of the acuity level results w/ AMHs and CMAs. What if AMHs or CMAs disagree with the result? Is there formal recourse?	The Department will release additional guidance on circumstances in which a member's acuity tier may change once this is developed.
119	V.B.3.ii(xv)(b)(6)	Page 150 of 254	Will the Department assist LME/MCOs with accessing available Medicare data referenced in this Section and if so, when will that occur? What is the Department's expectation for this requirement if the LME/MCO is unable to get access to Medicare data as contemplated in this Section?	The RFA describes that the BH I/DD should use data as much as is applicable and available, so it not required for the BH I/DD Tailored Plans to have access to Medicare data.
120	V. Scope of Services	Page 150	6. What does integrate and use available Medicare data mean? Would this be Medicare data that is coming in from the GEF or 834 or will there be another data feed for Medicare data that we will be required to ingest into our system?	BH I/DD Tailored Plans will be provided Medicare data through the GEF and 834. Additional details on file layouts and ingestion requirements will be provided after Contract Award.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
121	V. Scope of Services	Page 151	For the ADT feed requirement would connecting with the Health Information Exchange meet the requirement if all our hospitals are connected to it?	Yes.
122	V.B.3.ii.(xix)(o)	155	The Department must be notified within 7 days for any AMH+, CMA, CIN or other partners for Tailored CM and the department reserves the right to specify the timing and format. Is this for the entire contract period or initial year only?	The requirement applies to the entire contract period. As specified in the RFA. See RFA Section V. Scope of Services, B. Medicaid, 3. Care Management, ii.(xix)(o).
123	V. Scope of Services	Page 158	Similarly the RFA permits the use of an overflow or secondary call center to meet the capacity requirements or to augment services provided. Do the overflow or secondary centers also have to be located in NC	The BH I/DD Tailored Plan shall be permitted to use overflow or secondary call centers to meet capacity requirements or to augment services provided as defined in Section V. Scope of Services, A. Unified, 2., Program Operations, i. (vi). Secondary/Overflow call centers do not have to be in North Carolina.
124	V.B.3.ii.vii.(i)(a)	Page 170 of 254	The RFA indicates that members can receive both TCM and In Reach/ Transition services and further indicates that In Reach and Transition services must be delivered by the Tailored Plan (not the provider agency). This appears to mean that members may be receiving TCM from an AMH+ and In Reach and Transition services from the LME/MCO at the same time. Can you confirm this interpretation is correct? If so, should the Tailored Plan include in its RFA Response a plan for collaboration with the AMH+ in such instances to ensure no duplication of care management services?	The RFA indicates that members can receive both TCM and In Reach/ Transition services and further indicates that In Reach and Transition services must be delivered by the Tailored Plan (not the provider agency). This appears to mean that members may be receiving TCM from an AMH+ and In Reach and Transition services from the LME/MCO at the same time. Can you confirm this interpretation is correct? If so, should the Tailored Plan include in its RFA Response a plan for collaboration with the AMH+ in such instances to ensure no duplication of care management services?
125	V, A-B	178, 194,195, 199, etc	The term "sufficient" is used throughout the document to describe the network capacity required, please explain and/or quantify the meaning of a "sufficient network"?	With regard to references to "sufficient" as they relate to the BH I/DD Tailored Plan's provider network, the BH I/DD Tailored Plan is expected to have a network of providers that is sufficient in number and type of providers to assure that all covered services will be accessible on a timely manner as measured by compliance with the network adequacy time/distance standards and appointment wait time standards and any other applicable provider network related requirements that relate to the number or types of providers with whom BH I/DD Tailored Plans must contract.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
126	V.B.3.x(iii)(a)	187	Can the Department clarify what is meant by "medical-legal partnerships"?	Medical-legal partnerships combine health and legal services at a single site of care. A multidisciplinary team works together to address medical and social/legal problems (for example, an unwarranted eviction) that have an impact on overall health. When a problem requiring legal action is identified, clinical staff can refer patients directly for legal services. Legal staff are available to consult with clinical and non-clinical staff about system and policy barriers to care.
127	V.B.4.i	194-195	Is the Standard Plan non-contracting provider policy applicable to BH/IDD TPs?	The Department does not understand the question or reference to "the Standard Plan non-contracting provider policy." The requirements for payment to out-of-network providers are located in RFA Section V. Scope of Services, B. Medicaid, 4. Providers, iv. (xix).
128	V, A-B	196	Will the current NC CHHS HCBS tracking system and monitoring process (provider self-assessment, etc.) sunset?	No. HCBS monitoring will continue to demonstrate compliance with HCBS final rule.
129	Sec V.B.4.v	198	Clarify steps that BH I/DD Tailored Plan needs to take in the event a Veterans Home refuses to contract with BH/IDD Tailored Plan as an essential provider, or if Veterans Home refuses to accept rates as described. Would we need to follow the exception request steps as outlined in the section that follows (Section V.B.4.vi.b)?	If a BH I/DD Tailored Plan is unable to contract with any essential provider as required in the RFA, then yes, the BH I/DD Tailored Plan should submit a request for the Department's approval of an alternative arrangement for the essential provider.
130	V, A-B	198	The term "sufficient" is used to describe the requirement of having interpreter capability, please expand on the meaning of sufficient interpreter capacity.	Sufficient interpretation is one that faithfully and accurately conveys the meaning of the source language orally, reflecting the style, register, and cultural context of the source message, without omissions, additions or embellishments on the part of the interpreter.
131	V.B.4.i.(iv)(e)	Page 198 of 245	Will the Tailored Plan be responsible for requiring, via contract, that applicable provider facilities coordinate with the Contract Section of the NC DHHS Division of Health Service Regulation for any necessary construction or remodeling work to meet the requirements of this Section, or will the appropriate coordination with DHSR be at the provider's discretion?	Pursuant to 42 CFR 438.206(c), the BH I/DD Tailored Plan is responsible for ensuring that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
132	V.B.4.i.(iv)(g) (1)	Page 198 of 245	For purposes of satisfying the network adequacy requirements of this Section related to providers "across a regional border", will the Tailored Plan be authorized to use Out of Network Agreements, or must the Tailored Plan have a network contract with the provider?	Network adequacy compliance is based upon the network of providers with whom the BH I/DD Tailored Plan has written contracts/agreements, i.e. based on "participating providers". A BH I/DD Tailored Plan is permitted to use single-case agreements ("Out of Network Agreements") in instances where a member seeks care from an out-of-network provider as the BH I/DD Tailored Plan deems appropriate. However, providers with whom the BH I/DD Tailored Plan executes single-case agreements are not participating providers and therefore are not included in the analysis for compliance with network adequacy standards.
133	V.B.4.i.(viii) V.C.4.a.xi.a)	Page 199 of 254 Page 47 of 82	Will the Department provide a template (similar to the current Network Adequacy and Accessibility Analysis template) to guide the format of the Network Access Plan? If so, when will this template be provided?	Yes, after Contract Award the Department will provide a template to guide the format of the Network Access Plan as well as templates for separate components of the Plan such as demonstration of the geographical location of providers in the Network in relation to where members reside. See Addendum #7 for revisions to the RFA.
134	V.B.4.ii(ii) Provider Network Management	Page 204 of 254	During the "Provider Credentialing Transition Period" we understand the data will be coming from NCTracks, which is not NCQA accredited. 1. What consideration has the Department given for the Tailored Plan/MCO that in order to meet NCQA standards, must either perform credential functions directly or have a delegated agreement with an entity that is NCQA accredited? 2. Once the PDM/CVO is in place, will the Department allow the Tailored Plan to enter into a delegated credentialing agreement with the PDM/CVO so that we will be aligned with NCQA accreditation standards?	BH I/DD Tailored Plans must achieve NCQA Health Plan Accreditation with LTSS Distinction by the end of contract Year 3. The Department is working with NCQA to develop a solution.
135	V.B.4.i.(iii)(d) V.B.4.i.(xiii)(e)	Pages 205 and 210 of 254	Both the contracting and credentialing sections in Section V.B.4. reference the "Department's applicable objective quality standards" that the Tailored Plan must apply for network contracting determinations. Can the Department confirm these are standards that the Department will issue in the future and the Tailored Plan is not expected to develop its own independent quality standards? Also, can the Department explain how these objective quality standards relate to, or are distinct from, the LME/MCO's required "written policies and procedures for selection and retention of network providers" referenced at 42 CFR § 438.214?	The Department will apply appropriate standards for participation during the NC Medicaid provider enrollment and credentialing process, negating the need for plans to conduct additional quality determinations and credential committee reviews. 42 CFR § 438.214 requires that the Department ensure that each PIHP implements written policies and procedures for the selection and retention of network providers. The requirement for submission of such policies is outlined in RFA Section V. Scope of Services, B.4.ii(x) and Section VII. Attachments, Attachment M. Policies, 7.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
136	Section V.B.4.i.v	207	Does the RFA require Cardinal to contract with all DSOF hospitals in the state (or just our catchment area), and will the state provide the contract language/template and rates guidance?	Yes. See RFA Section V. Scope of Services, B. Medicaid, 4. Providers ii. (iii)(v). The Department-developed contract template will be provided after Contract Award
137	V.B.4.ii(iii)(q) and V.C.4.b.iii(j)	207 and 51	Section V.B.4.iii.q States The BH I/DD Tailored Plan may utilize evergreen contracts, i.e. a contract that automatically renews, with Medicaid Managed Care providers on the condition that the contract also includes provisions regarding how the contract may be terminated or non-renewed. Section V.C.4.b.iii.r states The BH I/DD Tailored Plan may utilize evergreen contracts (i.e. a contract that automatically renews), with State- funded providers on the condition that the contract also includes the reasons the contract may be terminated or non-renewed However VII Attachment G1 and G2 states Contract Term shall not exceed term of BH I/DD Tailored Plan with the State. How are these reconciled if the contract with the State has an end date?	The contract may renew automatically but cannot extend beyond the term of the contract between the State and the BH I/DD Tailored Plan.
138	Section V. B. 4. iii (y).	208	<p>For any provider subject to a rate floor as outlined in Section V.B.4.iv. Provider Payments, a BH I/DD Tailored Plan may include a provision in the provider's contract that the BH I/DD Tailored Plan will pay the lesser of billed charges or the rate floor only if the provider and the BH I/DD Tailored Plan have mutually agreed to an alternative reimbursement amount or methodology which includes a "lesser than" provision. A BH I/DD Tailored Plan shall not consider a provider who is subject to a rate floor to have refused to contract based upon the provider's refusal to agree to a "lesser than" provision.</p> <p>Question: In the Standard Plan RFP, Standard Plans were not permitted to include Lesser Of language in their agreements with providers. Has this changed per this section? If no, this could cause confusion with some providers if standard plan and TP rules differ.</p>	There is no change to the BH I/DD Tailored Plan RFA language. The Department is reviewing the Standard Plan language to confirm consistency across all plans.
139	V.B.4.ii(viii)	209	Will the PIHP be able to obtain credentialing information from a Standard Plan in the event one assigns all or part of its network to the PIHP?	All enrollment and credentialing activities are handled by the Department's fiscal agent and health plans are not required to conduct additional credentialing activities or send contracting decisions through a Provider Network Participation Committee (PNPC). In the future PDMCVO model, it is expected that the vendor will form a credentials committee to perform the functions of a PNPC which will satisfy the quality determination requirements and render collective and consistent decisions to ease the burden on the health plans.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
140	V.B.4 (viii) Credentialing and Recredentialing Process	Page 209 of 254	This is a general question for this entire section: Please clarify whether this section is referring to credentialing/recredentialing, or is it more accurately referring to contracting and enrollment as the description provided in this section prohibits true credentialing activities.	The Department believes the correct RFA Section reference for this question is Section V. Scope of Services, B. Medicaid, 4. Providers, ii. (viii) and has used this Section to respond. This is referring to the credentialing and recredentialing activities performed by the plan above those completed by NC Medicaid. However, plans may now accept the credentialing and verifications performed by the Department without the need to conduct additional review. As the Department transitions to a PDMCVO model, credentialing activities are expected to include the formation of a credentials committee, further negating the need for the plans to conduct additional determinations during the contracting process.
141	V.B.4 (viii) Credentialing and Recredentialing Process	Page 209 of 254	This is a general question for this section: Please provide the Department's definitions of 1. Good Faith Contracting and 2. The Departments Objective Quality Standards	The BH I/DD Tailored Plan shall develop a Good Faith Provider Contracting Policy that considers all factors and circumstances surrounding a provider's willingness to contract before determining that the provider has refused the plan's "good faith" contracting effort. The Department's objective quality standards are met as the provider completes the enrollment process and is credentialed and approved for participation with NC Medicaid. 2. See RFA Section III. A. Definitions, 137. Objective Quality Standard.
142	V.B.4 (viii)(h) Credentialing and Recredentialing Process	Page 210 of 254	<ol style="list-style-type: none"> 1. Aside from the hold harmless clause, what recourse will the Tailored Plan have to obtain correct information if the information provided by the CVO or other Vendor is incorrect? 2. Will the Department publish a list of acceptable information the Tailored Plan/MCO is permitted to request from providers to remediate the receipt of incorrect information received by the CVO? 	The Department believes the correct RFA Section reference for this question is Section V. Scope of Services, B. Medicaid, 4. Providers, ii. (viii)(h) and has used this Section to respond. There are mechanisms in place for continuous monitoring of provider accreditation information as well as a requirement that providers report any material and/or substantial change in information contained in the enrollment application.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
143	V.B.4 (viii)(e) (1) and (2) Credentialing and Recredentialing Process	Page 210 of 254	<p>This section states "After the Provider Credentialing Transition Period, the BH/IDD TP shall apply the Departments applicable Objective Standards for participation every 3 years." This plan would require all of the providers to go through this process simultaneously on the date the transitional period ends. For example, If transitional period ends on June 30, 2020 and the Tailored Plan/MCO has 600 provider contracts, the language in this section appears to require all 600 to be completed on July 1. This could present issues as opposed to staggering the dates for providers</p> <ol style="list-style-type: none"> 1. Is the Department giving consideration to staggering this process? 2. During the Provider Credentialing Transition Period will Tailored Plans/MCOs be permitted to use our own Quality Determinations, if approved by the Department, or are we required to only use the approval from the Department's source? 	<p>All enrollment and credentialing activities are handled by the Department's fiscal agent and health plans are not required to send contracting decisions through a Provider Network Participation Committee (PNPC). In the future PDMCVO model, it is expected that the vendor will form a credentials committee to perform the functions of a PNPC which will satisfy the quality determination requirements and render collective and consistent decisions to ease the burden on the health plans.</p>
144	V.B.4 (viii) Credentialing and Recredentialing Process	Page 211 of 254	<ol style="list-style-type: none"> 1. What is the mechanism for providers to notify MCO, NCTracks or the PDM/CVO when they move office locations? 2. What are the expectations that NCTracks or the PDM/CVO have regarding timeframes for notifications? 3. Will this information be provided to MCO? <p>This is important to ensure we can meet the timelines outlined within this section.</p>	<p>The Department believes the correct RFA Section reference for this question is Section V. Scope of Services, B. Medicaid, 4. Providers, ii. (viii) and has used this Section to respond. Providers use the Manage Change Request (MCR) process in NCTracks to report changes to the information in their provider record. Every enrolling provider signs a participation agreement that includes notifying the Department of changes to their record (including office address changes) within thirty (30) days. Under the PDM/CVO, there will be similar requirements and available for providers to report and/or make changes. Full information is shared with health plans through a nightly file.</p>
145	V.B.4 (viii) Credentialing and Recredentialing Process	Page 211 of 254	<p>What information will the TP receive on providers from PDM/CVO? For instance if there is a hit on the NPDB or Criminal background checks, will the Tailored Plan obtain the specifics, or will we need to run this ourselves? If the Tailored Plan is required to need to run these checks directly in order to make a quality determination and/or contract decision, we may need to request releases i.e. NPDB, CAQH Sanctions database. Will the Department permit the Tailored Plans do this?</p>	<p>The Department believes the correct RFA Section reference for this question is Section V. Scope of Services, B. Medicaid, 4. Providers, ii. (viii) and has used this Section to respond. Initial approvals are shared with plans as they occur. Providers are recredentialled every five (5) years. This will change to three (3) years with implementation of the PDMCVO model. The process to transition from five to three years for recredentialing remains in discussion and will vary depending on the length of time the provider has before the next recredentialing due date.</p>

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
146	V.B.4 (viii) Credentialing and Re-credentialing Process	Page 211 of 254	Will the Department provide a list of the credentialing and verified information that NCTracks or the PDM/CVO will be collecting to ensure that we are not asking for the same information in order to generate the providers' Contract?	The Department believes the correct RFA Section reference for this question is Section V. Scope of Services, B. Medicaid, 4. Providers, ii. (viii) and has used this Section to respond. The information required for participation in NC Medicaid is currently available in the Provider Permission Matrix and the application job aids available on the NCTracks Provider webpage. As the Department transitions to a PDM/CVO, similar assistance will be available to identify enrollment requirements. https://www.nctracks.nc.gov/content/public/dam/jcr:ccce8958-7f2b-429b-9d6e-92feb51e90a4/Public Facing Provider Permission Matrix 11-23-2020.xlsx
147	Section V.B.4.2.(x)	211-212	Will non-contracted rendering practitioners need to be reviewed by the Provider Network Participation Committee if they aren't seeking a network contract but simply want to render services on behalf of a network provider?	All providers rendering or billing services for Medicaid and/or NC Health Choice beneficiaries must be enrolled with NC Medicaid. All enrollment and credentialing activities are handled by the Department's fiscal agent and health plans are not required to send contracting decisions through a Provider Network Participation Committee (PNPC). In the future PDMCVO model, it is expected that the vendor will form a credentials committee to perform the functions of a PNPC. In short, contracted or not, the primary enrollment process will occur and include a committee review as deemed necessary for the enrollment application submitted.
148	Section V.B.4.2.(x)	211-212	NCQA currently allows an individual Medical Director or qualified Physician themselves to approve "clean" practitioner files and a Credentialing Committee to review practitioner files that may have one or more background incidents. Is the proposed Provider Network Participation Committee intended to replace this NCQA approval process for contracted and/or non-contracted practitioners for both clean files and files with incidents?	PDM/CVO requirements have not been determined. The Department is working toward the PDM/CVO establishing a credentialing committee that will complete the quality determination process described here under the Provider Network Participation Committee and negate the need for the vendor (PHP, LME/MCO) to form this committee.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
149	Section V. A - B	213	<p><u>Regarding:</u> Provider termination and member notification requirements</p> <p>Question: Regarding notification to members impacted by a provider termination, the RFA states that, "...The BH I/DD Tailored Plan shall notify each member who, at a minimum, received his or her primary care from, <i>or was seen in the previous twelve (12) months by a terminated provider...</i>". Currently, DHB requires that LME/MCOs give such notice to those enrollees who received services from the terminated Provider within the sixty (60) calendar day period immediately preceding the date of the notice of termination. Is the department going to make a notification distinction for behavioral health services, which can be episodic or ongoing, and physical health services, which can be annually?</p>	There is no distinction.
150	V.B.4.ii. Provider Directory	Page 214 of 254	<p>There are several discrepancies that pertain to the requirements of the Provider Directory. This section states that the TP update the electronic version of the Directory within 10 business days. However on pg 211 (b)(6) it states that changes to a provider's service location, demographic data or other information related to access to services be uploaded within 30 days. In addition, on pg 215 it states " In no case shall a provider be loaded into the provider directory which cannot receive payment on the BH I/DD Tailored Plan's current payment cycle" Also on page 214 (6) it indicates that all provider directories must comply with 42 C.F.R. § 438.10(h)(1) which states:</p> <p>Information included in a paper provider directory must be updated at least monthly and electronic provider directories must be updated no later than 30 calendar days after the MCO, PIHP, PAHP or PCCM entity receives updated provider information.</p> <p>In summary it appears that in other sections that the MCO has up to 30 days to make changes that would affect the provider directory. This timeframe is reasonable vs. 10 days, and the timeframes for updates should be consistent. Can the provider directory update timeframe be changed from 10 days to 30 days to align with the other requirements?</p>	See Addendum #7 for revisions to the RFA.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
151	V.B.4.iii.(ii)(d)	215	Please clarify what is meant by "enrollment notice" in this section- (d) The BH I/DD Tailored Plan shall send a Provider Welcome Packet and enrollment notice to providers within five (5) days of executing a contract with the provider for participation within its Medicaid Managed Care network. The Provider Welcome Packet must include orientation information and instructions on how to access the BH I/DD Tailored Plan's Provider Manual.	The enrollment notice is a notice to providers following the execution of the provider's contract, confirming their provider network participation status.
152	V.B.4.i.ii.x.g. 6.xxiv	215	Provider directory requirements (for members) ask for contract end date to be included. Our current system prevents providers from showing up in the online directory if their contract end date has passed. Is this sufficient or do we have to include a contract end date as well?	See RFA Section V. Scope of Services, B. Medicaid, 4. Providers, ii.(x)(g)(6) for requirements.
153	V.B.4.iii(iv)	216-217	The Provider Manual must include content that is not due to the Department until 120 days after Contract Award. Will Department clarify that a DRAFT Provider Manual is due 30 days after Contract Award?	The Provider Manual is due thirty (30) days after Contract Award. See RFA Section V. Scope of Services, B. Medicaid, 4. Providers, iii. (iv)(d). Section V. Scope of Services, B. Medicaid, 4. Providers, iii. (iv) outlines the requirements for reviewing, updating and maintaining the Provider Manual to incorporate changes and updates as needed.
154	V.B.4.iv(vi)	Page 219 of 254	<p>Given that PHP will not have available aggregate hospital cost data required to calculate the rate factor for each hospital facility, please confirm that DHB will provide the Medicaid rate floors for the following hospital services within 90 days following Contract Award:</p> <ul style="list-style-type: none"> a) Calculation of outpatient RCC rate based on cost hospital cost reports, required for payment to both Contracted and Out of Network Hospitals. Facility specific RCC rates are currently b) Any changes in percentage of costs adjustment factor required for outpatient RCC calculations (currently RCC x 70% of changes) c) Inpatient psychiatric daily rate floor for each NC community hospital facility needed for Out of Network hospital payment agreements that are not negotiated by the LME/MCO with non-Contracted hospitals. d) DRG Hospital Rate e) Rehabilitation per diem rate. f) Inpatient DRC Specific RCC outlier rate. <p>If DHB is unable to provide the above-listed information, what other alternative information will be provided or made available to the LME/MCOs for development of provider reimbursement rates?</p>	All rates will be made available. Any changes to cost adjustment factors will also be provided as they occur

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
155	Section V. Scope of Services, A - B 4. Providers iv. Provider Payments, and (xii) Additional Directed Payments for Certain Providers	219-220	(e) The BH I/DD Tailored Plan shall make additional, utilization-based, directed payments to in-network hospitals owned by UNC Health Care or Vidant Medical Center as described in Section V.B.4.iv.(xii) Additional Directed Payments for Certain Providers (as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B)), and (xii) Additional Directed Payments for Certain Providers (as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B)) (a) The BH I/DD Tailored Plan shall make additional directed payments as determined by the Department to certain in-network providers. This includes, but may not be limited to, LHDs, public ambulance providers, certain faculty physicians affiliated with the teaching hospitals for each University of North Carolina medical school, and hospitals owned by UNC Health Care or Vidant Medical Center. Q: Will the state give LME/TP guidance on what this reimbursement will look like?	Yes. The Department is drafting an Additional Utilization Based Payments (AUBP) Policy which will support and identify the process flow for these payments. To summarize, the Plans will submit quarterly paid claims data reports to support the AUBP calculations. The Department will verify these reports and make payment of the AUBPs to the Plans, who must, in turn, remit these same payments to the providers.
156	V.B.4.iv(vii)	Page 219 of 254	Please confirm that DHB will provide Federally Qualified Health Center and Rural Health Center's respective core rate or T-1015 code within 90 days following Contract Award.	Confirmed.
157	V.B.4.(xx) Out of Network Emergency Services and Post-Stabilization Services Payments	Page 223 of 254	Will the Department require that Out-of-State emergency and crisis providers be enrolled in NCTracks to receive payment from the Tailored Plan?	The Department believes the correct RFA Section reference for this question is Section V. Scope of Services, B. Medicaid, 4. Providers, iv. (xx) and has used this Section to respond. All providers rendering or billing services for Medicaid and/or NC Health Choice beneficiaries must be enrolled with NC Medicaid.
158	V.B.4.iv(xix)(b)	222	Is there, or will there be, a sample or template for the Good Faith Provider Contracting Policy that is to be submitted to the Department for review 90 days after Contract Award?	No. The Department does not have a sample or template to provide.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
159	V.B.4.iv.(xx)(b)	Page 223 of 254	This Section requires that the Tailored Plan reimburse out-of-network hospitals at no more than the applicable Medicaid Fee for Service Rate. Please confirm that the applicable Medicaid FFS rate refers to the North Carolina Out of State inpatient rates, and not the Medicaid rate from the hospital's home state.	<p>The North Carolina Medicaid FFS rate is the appropriate reference point for Out-of-State inpatient rates.</p> <p>BH I/DD Tailored Plan shall reimburse out-of-network hospitals at no more than the applicable Medicaid Fee for Service Rate. The applicable Medicaid FFS rate refers to the North Carolina in-state inpatient rate for in-state /out-of-network providers and the North Carolina Out of State inpatient rates for out-of-network hospitals out of state.</p>
160	V.B.4.iv.(xxi)	Page 224 of 254	Locum Tenens services are billed under the absent physician's NPI number. Please confirm that the Locum Tenens physician does not need to be confirmed as enrolled in NC Medicaid and credentialed prior to billing for services, as the substitute physician's NPI is not present on the claims to confirm enrollment.	According to 42 CFR 455.410.b, all ordering or referring physicians or other professionals providing services under the State plan or under a waiver of the plan must be enrolled as participating providers. Locum Tenens services are defined by a modifier attached to the service code.
161	V.B.4.v.(i)	Page 225 of 254	Please confirm that the Tailored Plan may contract its member and/or provider grievance and/or appeals system to a Subcontractor for some, but not all, services to be provided. For example, the grievance and/or appeals system for pharmacy services may be contracted to a Subcontractor, but the remaining physical health, behavioral health, IDD and TBI services may be handled by the Tailored Plan staff. Similarly, can the Tailored Plan subcontract peer review and member appeals of adverse benefit determinations (ABDs) related to certain specialty physical health services to the Standard Plan PHP that it contracts with pursuant to N.C.G.S. § 108D-60(5)?	<ol style="list-style-type: none"> 1. Confirmed. 2. Yes.
162	V.B.4.v.(v)(c)	Page 225 of 254	In reference to the requirement that the Tailored Plan "shall have a method of allowing providers to submit Grievances through the ... provider web portal", is it acceptable to include a link within the portal that automatically redirects providers to the LME/MCO Incident Management Software or appeals process?	Yes.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
163	V.B.4.v.(i)	Page 225 of 254	Can the Department clarify the requirement that the provider Appeals and Grievance "system" be "distinct from that offered to members"? For example, may the LME/MCO utilize a unified electronic portal/ Incident Management Software for gathering and tracking all complaints and grievances, with specific policies, procedures, forms, communications/ instructions and staffing patterns dedicated to providers?	The BH I/DD Tailored Plan must have a process in place that allows providers to file grievances and appeals for provider related issues. A unified portal or system may be utilized for both provider and member appeals.
164	Section V. Scope of Services B. V. VII. Resloution of Appeals (a)	226	During appeals of provider competency, we determine the qualifications of the committee members. However, for those disputes such as those from Program Integrity described in Attachment I. Provider Appeals for Medicaid, NC Health Choice, and State-funded Services Providers below, what should be the qualifications of the committee members? (a) The BH I/DD Tailored Plan shall establish a committee to review and make decisions on provider Appeals. The committee must consist of at least three (3) qualified individuals who were not involved in the original decision, action, or inaction giving rise to the right to Appeal.	Members of the committee should have knowledge of the issue at hand. For example, if the issue relates to billing practices, then the committee members should be familiar with provider billing practices.
165	Section V. Scope of Services B. V. viii. Appeals of Suspension or Withhold of Provider Payment(a, b, c, d,)	226	What is meant by the statement "shall not address...fraud or abuse"? "b" in Attachment I(a)The BH I/DD Tailored Plan shall limit the issue on Appeal in cases of suspension or withhold or provider payment to whether the BH I/DD Tailored Plan had good-cause to commence the withhold or suspension of provider payment. BH I/DD Tailored Plan shall not address whether the provider has or has not committed fraud or abuse.	The issue for suspension is whether or not there is "good cause" which is defined as whether the provider failed to meets contract obligations with the Tailored Plan RFA. When a provider appeals a suspension or withhold of provider payment the appeal is to address whether the withhold or suspension of provider payment by the BH I/DD Tailored Plan was enacted according to policy. It does not include a suspicion of fraud which must be referred to the Department.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
166	Section V. Scope of Services B. V. viii. Appeals of Suspension or Withhold of Provider Payment(a, b, c, d,)	226	What is the criteria for good cause as referenced below? Appeals for Medicaid, NC Health Choice, and State- funded Services Providers below indicates providers may appeal Program Integrity's findings of fraud, waste, or abuse (b) The BH I/DD Tailored Plan shall notify the Department within ten (10) Business Days of a suspension or withhold of provider payment. (c) The BH I/DD Tailored Plan shall offer the provider an in person or telephone hearing when provider is Appealing whether BH I/DD Tailored Plan has good cause to withhold or suspend payment to the provider. What is the criteria for "good cause" (d) The BH I/DD Tailored Plan shall schedule the hearing and issue a written decision regarding whether BH I/DD Tailored Plan had good cause to suspend or withhold payment within fifteen (15) Business Days of receiving the provider's Appeal. Upon a finding that BH I/DD Tailored Plan did not have good-cause to suspend or withhold payment, BH I/DD Tailored Plan shall reinstate any payments that were withheld or suspended within five (5) Business Days.	See the response to Question # 165 above and Question #170 below.
167	Section V. Scope of Services B. V. viii. Appeals of Suspension or Withhold of Provider Payment(e)	226	Will the Department calculate the interest or identify a formula for calculation of this interest? (e) The BH I/DD Tailored Plan shall pay interest and liquidated damages for overturned denials, underpayment, or findings it did not have good-cause to suspend or withhold payment from the original date of payment, suspension, withhold or denial.	No, it is the responsibility of the BH I/DD Tailored Plan to calculate the interest and penalty under this section. See Addendum #7 for revisions to the RFA.
168	Section V. Scope of Services B. V. ix. Notice to Department(a)	226	(a) The BH I/DD Tailored Plan shall provide notice to the Department of any provider Appeal regarding the suspension or withhold of payment, finding or recovery of an overpayment by BH I/DD Tailored Plan, or any action related to a finding of fraud, waste, or abuse. Such notice must be provided within five (5) Business Days of the Appeal.	The Department does not understand the question and therefore is unable to provide a response.
169	V. Scope of Services	Page 226	vii (a) During appeals of provider competency, we determine the qualifications of the committee members. However, for those disputes such as those from Program Integrity described in <u>Attachment I. Provider Appeals for Medicaid, NC Health Choice, and State-funded Services Providers</u> , what should be the qualifications of the committee members?	Members of the committee should have knowledge of the issue at hand. For example, if the issue relates to billing practices, then the committee members should be familiar with provider billing practices.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
170	V. Scope of Services	Page 226	viii (c) What is the criteria for "good cause"?	Good cause is defined as the failure of the provider to meet its contract obligations with the BH I/DD Tailored Plan. It does not include a suspicion of fraud which must be referred to the Department.
171	V. Scope of Services	Page 226	viii (e) Will the Department calculate the interest or identify a formula for calculation of this interest?	See Addendum #7 for revisions to the RFA.
172	Section Scope of Services ix Quality Measures (a)	228	Will penalties assigned to each measure? (a) The BH I/DD Tailored Plan will be held accountable for performance on all measures listed in Section VII. Attachment E. BH I/DD Tailored Plan Quality Metrics that are meant to provide the Department with a complete picture of the BH I/DD Tailored Plan's processes and performance. The BH I/DD Tailored Plan's accountability may include: public reporting of measure performance by the Department, requirements to engage with Department staff around measure performance, and, beginning in Contract Year 2, financial accountability for a select set of measures to be specified by the Department.	No. The Department will assign performance incentive payments to high priority measures. The Department will share what those measures are in the beginning of each contract cycle.
173	Section V. Scope of Services B. V. xv. Quality Improvement-Provider Supports(a, b)	231	a.The BH I/DD Tailored Plan shall provide support to providers tailored to advance State interventions and ensure providers ability to achieve the goals outlined in the Quality Strategy. b.The supports offered will assist providers in clinical transformation and care improvement efforts at a regional and practice level. What percentage of providers will this include?	All providers should have opportunities for practice support depending on applicability of their role to a particular performance improvement project. Types of practice support will vary based on the level of intervention and coaching needed at the provider level.
174	V.B.5.ii.	231-233	Are I/DD members included in the premium calculation for VBP? Any other exclusions to calculate this value correct?	There are no exclusions defined for calculating total premium.
175	V.B.5.ii.	231-233	Do we need to calculate the % premium for past projects that our Standard Plan partner implemented?	Include information for any partners proposed to support value-based purchasing.
176	V.B.6. i.(iv)(a) Prompt Payment Standards	Page 234 of 254	The section states that "The BH I/DD Tailored Plan shall promptly pay Clean Claims, regardless of provider contracting status". Please provide clarification in what instances would a provider need to be paid absent a contract? Currently, we must have a contract for all services except ED visits.	Covered services will be provided by participating providers. However, it is possible that a non-participating provider may provide covered services, outside of emergency or post-stabilization services, when the BH I/DD Tailored Plan has approved the out-of-network services. This could occur, when the BH I/DD Tailored Plans network does not have a participating provider available to provide the service on a timely basis.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
177	Section V.B.6.i.iii.d.3	234	For Medicaid claims, the BH I/DD Tailored Plan "shall capture and retain the IP address/location and the user login/user name for all claims submitted via the on-line portal." How long will the BH I/DD Tailored Plan be expected to retain this data?	The BH I/DD Tailored Plan shall retain this data for the same period as the claims data.
178	Addendum 1	page 234	Should there be a section for BH claims listed under Prompt Pay Standards?	Behavioral Health claims fall under the requirements for Medical Claims for purposes of Prompt Pay Standards.
179	Addendum 1	page 235	Does this mean the provider has 180 days from the date of service to submit a claim and when it is not reasonably possible for them to submit within that timeframe they should be allowed an additional 365 days to submit it?	Yes.
180	V.B.6.ii. (ii)	Page 236 of 254	<p>1. Please clarify how denied claims trend analysis will be used as denied claims are not part of encounter data right now?</p> <p>2. Please provide information regarding how to include interest and penalties paid on an encounter file?</p>	The Department will provide further guidance on denied claims, interest payments, and penalty payments after Contract Award in the Department Encounter Companion Guide and Encounter Data Submission Guide.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
181	Section V - Scope of Services Sub-Section B 7.iii.(iv).(b)	242	<p>Financial Requirements</p> <p>This section states that, "risk-adjusted cost growth ... must be at least 2 percentage points (2%) below national Medicaid spending growth":</p> <ul style="list-style-type: none"> • Is the expectation that the plan's growth must be the national spending growth multiplied by 0.98 or national spending growth minus 0.02? • Over what time periods will the plan's cost growth be evaluated? Will year 1 be compared to a pre-tailored plan baseline? Or will evaluation start in year 2 compared to year 1? • Which risk adjuster should be used for determining risk-adjusted cost growth? Will risk-adjustment be performed by the Department or by the plan? • When calculating the plan's cost growth, what costs are included? Costs for benefits paid by the plan? Costs for cap rates due to the plan by the Department? The numerator from the MLR calculations? Something else? If a plan makes contributions towards certain high-impact initiatives to improve health outcomes as allowed under the MLR requirements, are those expenditures considered part of cost growth? • How does the Department anticipate responding if a plan does not meet the cost growth requirements? • How will reduced utilization due to the pandemic be incorporated into measurement of risk scores? 	<p>The evaluation of cost growth will begin with a comparison of experience in Contract Year 2 to experience in Contract Year 1. The Department will monitor annual cost growth of Tailored Plan expenditures by Region and population cohort to most closely align with the populations reported in the CMS Office of the Actuary's Report on the Financial Outlook for Medicaid. The Tailored Plans will be required to provide reports to the Department to demonstrate annual cost growth. The report will include a narrative that summarizes cost drivers, an evaluation of programs in place to address those cost drivers and plans for addressing future cost growth.</p>
182	V.A.7.iii.(iv)	244	<p>Will the Department share where we can locate a cost growth table for "non-expansion States." and if so, when may we expect it?</p>	<p>See the response to Question #181 above.</p>

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
183	V.B.7.iii.(vii) AND V.C.7.i.i.ii.	Page 245 of 254 AND Page 71 of 82	<p>V.B.7.iii.(vii): This section states "The BH I/DD Tailored Plan must, by Day 1 of BH I/DD Tailored Plan launch, fully fund BH I/DD Tailored Plan capital reserves at twelve and a half percent (12.5%) of total expected annual BH I/DD Tailored Plan Medicaid capitation".</p> <p>V.C.7.i.i.ii.: This section states "The BH I/DD Tailored Plan must, by Day 1 of BH I/DD Tailored Plan launch, fully fund its BH I/DD Tailored Plan risk reserves at twelve and a half percent (12.5%) of total expected annual BH I/DD Tailored Plan Medicaid capitation".</p> <p>1. Please provide clarification why this is noted differently in these sections.</p> <p>2. Please provide clarification regarding what funding source(s) the Department will allow for inclusion to make up the 12.5%? In previous conversations between the Department and the LME/MCOs, it has been stated that other sources beyond the risk reserve will be counted toward the 12.5% as noted in the BH I/DD Tailored Plan Financial Requirements: Updates Since Pre-RFA Release Policy Paper (Sept. 29, 2020).</p>	See Addendum #7 for revisions to the RFA
184	V.B.7.iii(vii)(e)	Page 246 of 254	Does the "Stabilization for State Statute" requirement fall within the definition of "capital" or unencumbered Fund Balance?	No additional information is available at this time.
185	V.B.8	248	RFA refers to solely an 834 eligibility file in some places and then references "other standard eligibility and enrollment file" in others. Can we get clarification on the eligibility file we will receive?	The Department will provide a standard 834 eligibility file.
186	V.B.8.vii.(ii) VI.b.x	254 and 67	<p>Will the Department please provide clarification as to where claims and encounter data is to be submitted? There is conflicting information in the following two sections:</p> <p>Section V, A-B Page 254 vi Technology Documents, vii TP Data Mgmt and HIS, (ii): "...shall submit encounters and claims to North Carolina's Health Information Exchange, known as NC HealthConnex, as defined in NC Gen Stat ~90-414.4"</p> <p>Section V, C-VI, Page 67, 6. Claims Management, b. TP Submission of Claims, x. Submission Timeframes (a) "...shall submit to NC Tracks an electronic claim for every service reimbursed by the BH i/DD Tailored Plan"</p>	Per NC Gen Stat ~90-414.4, the BH I/DD Tailored Plan shall submit data to the NC HIEA. Additionally, the BH I/DD Tailored Plans must submit claims and encounter data to the Department as defined in the Medicaid and State-funded section of the Contract. The Department will work with the BH I/DD Tailored Plans and NC HIEA to streamline the submission process as appropriate.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
187	V. Scope of Services C	Page 2	ii. B. 2. Should this include more information? Currently state "Insurance Status/Other Financial Resources:"	See Addendum #7 for revisions to the RFA.
188	Section V.C.1.a.vi	2	Does the BH I/DD Tailored Plan need to solicit feedback from their CFAC on proposed State-funded Services eligibility criteria prior to submission of Application for the Department's review and approval, and if so, will the Application require documentation of this solicitation?	Engagement with CFAC on proposed State-funded services eligibility criteria is not required to occur before Applicant's submission. See Addendum #7 for revisions to RFA Section VIII, Attachment Q., 3. Applicant's Response to Evaluations.
189	Section V.C.1.a.xii	3	Prior to the launch of the statewide waiting list, will BH I/DD Tailored Plan be required to submit reporting on its waiting lists to the State, or will this be at the discretion of BH I/DD Tailored Plan to maintain and report?	RFA Section V. Scope of Services, C. State-funded Services, 1. Recipients, a.xii requires each BH I/DD Tailored Plan to report its waiting list for State-funded services to the Department upon launch of the statewide waiting list. In addition, the Department may, in its discretion, change the frequency of reports or require the BH I/DD Tailored Plans to submit additional reports (either ad hoc or recurring) at any time, pursuant to RFA Section V. Scope of Services, A. Unified, 2. Program Operations, iv.iii.
190	V.C.1.b.ix.b	7	Section V appears to be a copy from the Medicaid Services for State-funded Services, please clarify why we would need to notify DHHS since addresses are not included in CDW records.	See Addendum #7 for revisions to the RFA.
191	V.C.1 xii. Recipient Handbook	Page 9 of 82	Section b states "The BH I/DD Tailored Plan shall use the Department's forthcoming guidance to develop the Recipient Handbook." 1. When will this guidance be issued? 2. Is DHHS developing a template for the Recipient Handbook that we should anticipate receiving?	The Department believes the correct RFA Section reference for this question is Section V. Scope of Services, C. State-funded Services, 1. Recipients, b. xii. and has used this Section to respond. (1) A date of issuance has not been determined. However, once finalized, an announcement along with the guidance for the handbook will be disseminated to LME/MCOs and made available for download public access on the Department's website. (2) Yes.
192	V. Scope of Services C	Page 11	ix. What type of unique marketing code is to be assigned to all marketing materials distributed to recipients? Is this a statewide code?	This unique marketing code would be internal to the BH I/DD Tailored Plan. It would not be a statewide code.
193	V.C.2.a.vii.a. 2	19	"The BH/IDD TP shall not delegate its UM program to a Subcontractor." Does this mean that medical necessity decision denials for state funded recipients must be made internally?	Yes.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
194	Section V.C.2.a.vii.c	20	Will the Department's standardized prior authorization request form replace the LME/MCO's current Treatment Authorization Request (TAR) form? Of so, when will the Department's standardized form be available?	See the response to Question #98 above.
195	RFA Sections V.C-VI, iii	Page 22 of 82	<p>iii. Qualifications for the State-Funded BH Care Management Coordinator a) The BH I/DD Tailored Plan shall ensure that State-funded BH Care Management Coordinator(s) have the following minimum qualifications: 1. Be a Master's-level fully Licensed Clinical Social Worker (LCSW), Licensed (Licensed Clinical Mental Health Counselor (LCMC), or Licensed Psychological Associate (LPA); and 2. Three (3) years of supervisory experience of staff working directly with individuals with a BH condition who have complex needs.</p> <p>Question: Is the wording in RFA Sections V.C-VI, iii Page 22 of 82 regarding the Qualifications for the State-Funded BH Care Management Coordinator, specific to Part 2. Requiring three (3) years of supervisory experience of staff working directly with individuals with a BH condition who have complex needs, accurate?</p>	Yes.
196	Section V.C.3.c.	Pages 3 and 23 of 82	<p>Section V.C.3.c. Care Management Delivered Through the BH I/DD Tailored Plans for I/DD and TBI Populations references Section V.C.1.a.xiii. However, there does not appear to be a V.C.1.a.xiii</p> <p>Should this be section xii instead?</p>	See Addendum #7 for revisions to the RFA.
197	Section V.C.3.c.iv.a	23	RE: the requirement that the BH I/DD Tailored Plans store the results of all reviews of eligibility for care management in a system of record and transmit monthly in an electronic format TBD by the Department, when will this format be provided? What are all the requirements of the system of record for these eligibility reviews?	The Department will establish requirements and reporting formats prior to BH I/DD Tailored Plan go-live.
198	V.C.4.a.vi	45	Are all CASP funds subject to reallocation to providers or is this section referring to NEW CASP funds only?	CASP funds are subject to reallocation.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
199	V.C.4.b.ix.f	57	RFA states: The BH I/DD Tailored Plan shall ensure that the consumer-facing Network Directory: ... Includes accurate and updated provider information, including fidelity evaluation scores, consistent with Contract requirements; The section dedicated to the member-facing provider directory for Medicaid excludes some items (i.e., three- digit location code) but the directory in the State-funded section does not have similar exclusions. Curious if that was an oversight or if some items from state-funded (fidelity evaluation scores?) could be excluded as well.	The Department will set a prescribed format for reporting all provider directory information to the Department.
200	Section V.C.4.e.	Page 61 of 82	This section of the Scope of Service refers to Provider Grievances and Appeals; however, Evaluation Question 32b refers to State Funded Provider Complaints and Appeals. Furthermore, Provider Complaint is not provided in the definition list, but Provider Grievance is. What is the difference between a Provider Complaint and a Provider Grievance?	The term Provider Complaint, as used in RFA Section VIII, Attachment Q., 3. Applicant's Response to Evaluation Questions, Question 32.b. should be construed to have the same defined meaning as Provider Grievance.
201	V. Scope of Services C	Page 61	v. Will State ADATCs be required to bill claims?	Yes.
202	Section V.C.6.a.iii	67	For non-Medicaid claims, the BH I/DD Tailored Plan "shall capture and retain the IP address/location and the user login/user name for all claims submitted via the on-line portal." How long will the BH I/DD Tailored Plan be expected to retain this data?	The BH I/DD Tailored Plan shall retain this data for the same period as the claims data.
203	V. Scope of Services C	Page 68	c. i. Is the administrative funding in addition to current Single Stream Funding or just an allowable use of current Single Stream Funding?	The administrative funding is an "allowable use" of SSFs, in that it comes out of the BH I/DD Tailored Plan's SSF allocation to suppose expenses related to SSF services. There is not a separate allocation specifically for BH I/DD Tailored Plan administrative funding.
204	V.C. 7. Financial Requirements	Page 68 of 82	Regarding 7.b.f) 2. In the past, an allocation letter has been needed as proof of the transfer and allows for the draw down of funds. How will the LME/MCO be able to proceed if the Department does not provide a response?	The Department will continue to provide the response in the revised allocation letters that will document the realignment request
205	V.C. 7. Financial Requirements	Page 68 of 82	Regarding 7.c.i The current contract allows for the LME/MCO to retain up to 12% of its unrestricted state fund balance for administrative functions. What is the reason for the change to 10% given the LME/MCO uninsured population and the administrative responsibilities under the Tailored Plan RFA are both increasing?	See RFA Section V. Scope of Services, C. State-funded Services, 7. Financial Requirements, c.i. for the requirements.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
206	Section V.C.7.d.ii	69	<p>Please provide further details on the Changes in Funding sections for State Funded Services, in particular, if funding is less than the required MOE:</p> <p>a) In the case of expansion of funding, use up to ten percent (10%) of expansion service funding for administrative expenses.</p> <p>b) In the case of reduced or de-allocated funding, use up to ten percent (10%) of the expended amount for the year for administrative expenses.</p>	<p>Funding source or other legal requirements, such as the 2015 Service Level Requirements, in addition to other determinations by the Department, can impact whether and how much administrative funding BH/IDD Tailored Plans may be able to collect up to the 10% contractual limits discussed in RFA Section V.C.7.d.ii. Ultimately, the allocation letters from DMHDDSAS will control how much, if any, administrative expenses the BH/IDD Tailored Plan may collect from expansion service funding, subject to the previously mentioned constraining authorities.</p>
207	Section VII. Attachment A. Table 1: BH/IDD Tailored Plan Organization Roles and Positions	Pages 3-12 of 227	<p>Please provide clarification regarding the LCAS license not being included among the clinical licenses for care managers and other non-supervisory positions. It was our understanding that an employee licensed as an LCAS was no longer eligible to serving in a supervisory capacity but was still eligible to perform non-supervisory functions.</p>	<p>An individual with the LCAS license is eligible to serve as a Care Manager non-supervisory role as long as they meet the requirements for the Care Manager role. Supervisory roles must meet the requirements defined in the RFA. See RFA Section VII. Attachment A. BH I/DD Tailored Plan Organization Roles and Positions for Medicaid and State-funded Services for the Minimum Certifications and/or Credentials.</p>
208	Section VII. RFA Attachments (a, b, c, d, e, f, g)		<p>Providers currently appeal decisions by Provider Monitoring, Claims, and the Credentialing process. Is this included in "g" under "violation of terms" or will these actions no longer be appealable by providers?</p>	<ol style="list-style-type: none"> 1. The BH I/DD Tailored Plan must allow providers to appeal those actions taken by the BH I/DD Tailored Plan identified in RFA Section VII., Attachment I. Provider Appeals for Medicaid, NC Health Choice, and State-funded Provider, Subsection 1.g). 2. Violation of terms between the BH I/DD Tailored Plan and provider is a reference to contract terms between the provider and the BH I/DD Tailored Plan.
209	VII RFA Attachments	Page 3-12	<p>Tailored Plan Organization Roles and Positions: Please confirm that positions currently staffed by personnel living in adjacent states are either exempt or grandfathered from this requirement.</p>	<p>In addition to noting Key Personnel that must reside in NC, the RFA is clear on additional personnel and roles, at a minimum that shall be located in and operate from within the State of NC. The Department's priority is to leverage contracts as appropriate to develop job opportunities within North Carolina and ensure Contractors are located in and know the communities in which they serve. See Section V, A-B (xii) Physical Presence in North Carolina and Section VII. Attachment A, BH I/DD Tailored Plan Organization Roles and Positions for Medicaid and State-funded Services.</p>
210	Section VII. RFA Attachments	3	<p>For the Supervising Care Manager position, please confirm that RN designations meet the minimum education requirement.</p>	<p>Yes. See RFA Section V. Scope of Services, B. Medicaid, 3. Care Management, ii (xiv)(c) and Section VII. Attachments, Attachment A. BH I/DD Tailored Plan Organization Roles and Positions for Medicaid and State-funded Services.</p>

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
211	Section VII. RFA Attachments	4	For the State-funded BH Care Management Coordinator, please confirm that RN designations meet the minimum education requirement.	See Addendum #7 for revisions to the RFA.
212	Section VII. RFA Attachments	6	For the FT Transition Coordinator, please confirm that RN designations meet the minimum education requirement.	Confirmed.
213	Section VII. RFA Attachments	7	For the Diversion Specialist position, please confirm that RN designations meet the minimum education requirement.	Confirmed.
214	Section VII. RFA Attachments	7	For the DSOHF Admission through discharge Manager, please confirm that LMFT designations will meet the position requirements.	No. LMFT designations do not meet the minimum requirements for DSOHF Admission through Discharge Managers.
215	Section VII. RFA Attachments	10	For the FT Utilization Management Staff, please confirm that call center overflow does not require staff residency in North Carolina.	Confirmed.
216	Section VII. RFA Attachments	10	For the FT Utilization Management Staff licensure requirement, is a LMFT and LPA acceptable as well?	See the response to Question #49 above.
217	Section VII. RFA Attachments	11	For the Special Investigations Unit Lead and Staff, is the NC residency a requirement? (It is not listed on attachment A, however the statement on page 19 of Section V. Scope of Services: (xii-e) it states "the following personnel and roles, shall be located and operate with the state of NC)	See the response to Question #62 above.
218	Section VII, Attachment B. Table 1	17	HIV Case Management – If a BH I/DD TP elects to avail itself of either/both options listed above re: HIV Care Management, does DHB consider this to be a covered service?	No, HIV case management is not a covered service.
219	Section VII Attachment E.1	43	How, when and with what frequency will dental encounters be shared with the LME/MCOs? In order to meet the quality metrics for "Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH)", we will need to receive reporting.	BH I/DD Tailored Plans will receive all dental claims information on a monthly basis. The BH I/DD shall provide this information to AMH+/CMAs.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
220	Section VII, Attachment E.1. Table 1	43	The denominator for the Childhood Immunization Status measure states that the eligible population is children who turn two years of age during the measurement year. Does the Department intend that the Childhood Immunization Status measure applies to children outside the population focus?	NC Medicaid will follow HEDIS specifications for measures. Refer to the HEDIS specification for that measures because it is very specific to Bright Future guidelines for the immunization panel for children under the age of 2.
221	Section VII, Attachment G.1.1.f.ii.1	80	Is there a definition for "credentialing transition period"? If it is TBD by the Department, is there an estimate as to when the period will be identified?	There is no set time period for the credentialing transition period. This period will be until the PDM/CVO MES Module is implemented. The Department will provide sufficient notice as to when the credentialing transition period will end.
222	Section VII, Attachment G.1.1.g	80	Section states that providers must be obligated by contract to maintain Professional Liability Insurance (PLI). The provider insurance obligations required in the LME/MCOs' current DHB contract (Attachment B, Section 7.7.7) also require providers to carry Comprehensive General Liability, Automobile Liability (if provider transports members/recipients) and Workers' Compensation/Employer's Liability (if required by State law) insurance, as well as certain written attestations regarding these insurances. Does this section narrow current provider insurance requirements for all providers, including BH providers, or does it apply only to non-BH providers? (See also Section 2.g. below; same question for State-funded providers.)	This applies to any provider eligible for participation under the BH I/DD Tailored Plan.
223	Section VII, Attachment G.1.q	81	Provision states that "The contract must address the provider's obligations to comply with the BH I/DD Tailored Plan's UM programs, quality management programs, and provider sanctions programs with the proviso that none of these shall override the professional or ethical responsibility of the provider or interfere with the provider's ability to provide information or assistance to their patients." What barriers does the word "interfere" indicate?	Compliance with the UM program should not "prevent" the provider from providing information or assistance to their patients.
224	Section VII, Attachment G.2.g	87	Same question as for Section VII.1.g (Medicaid), but for State-funded providers: is the provision narrowing provider insurance requirements for all providers or only non-BH providers?	The provision requires that the contract between the provider and the BH I/DD Tailored Plan obligate the provider to maintain professional liability insurance coverage. This requirement applies to all providers with whom the BH I/DD Tailored Plan has a contract.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
225	VIII Attachment I	Page 97	Providers currently appeal decisions by Provider Monitoring, Claims, and the Credentialing process. Are these included in "g" below or are these not appealable by the provider?	<p>1. The BH I/DD Tailored Plan must allow providers to appeal those actions taken by the BH I/DD Tailored Plan identified in RFA Section VII., Attachment I. Provider Appeals for Medicaid, NC Health Choice, and State-funded Provider, Subsection 1.g).</p> <p>2. Violation of terms between the BH I/DD Tailored Plan and provider is a reference to contract terms between the provider and the BH I/DD Tailored Plan.</p>
226	VII.I	97	The Provider Appeals Table is inconsistent with Section V of the RFA in that it suggests PIHP takes action on findings of fraud. The table fails to reflect that the PIHP does not take action on fraud allegations, but refers fraud allegations to DHHS. As such, there should be no provider right of appeal to the PIHP for findings of fraud. Additionally, PIHP only suspends payments to a provider on the basis of a credible allegation of fraud when instructed by DHHS, under the authority allowed DHHS by federal law. It is not, and cannot be, an action taken by the PIHP. Will the Department update the table to be consistent with the RFA and accurately reflect how PIHP must handle fraud allegations or findings?	See Addendum #7 for revisions to the RFA.
227	VII.J	98-118	Can we get additional specifications for the reports listed in Attachment J? Specifically, we are looking for numerator and denominator information as far as data sources and data descriptors to evaluate efforts required to prepare reports.	Reporting templates/specifications are not available for distribution at this time. Information on quality measure numerators and denominators will be available in a Medicaid Managed Care Technical Specifications document that will be released in early 2021.
228	Section VII, Attachment J, Table 3 (12)	112	Capitation Reconciliation Report – BH I/DD Tailored Plans will indicate expected values and values observed on ASC x12 834 monthly file for members - Is this referring to the reconciliation of the 820 to the 834?	No. The Department has created a new reconciliation report that all vendors will be required to use in addition to the reconciliation of the 820 to the 834.
229	Section VII, Attachment J, Table 4 (A).1	115	Weekly Tailored Plan Eligibility Report – Would this be similar to the Weekly 834 eligibility or is there some other template the BH I/DD Tailored Plan will need to provide?	While it is similar, the Weekly Tailored Plan Eligibility Report will only include members that are eligible for a Tailored Plan service.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
230	Section VII, Attachment M.7	156	Attachment M.7. addresses the Uniform Credentialing and Re-credentialing Policy for Medicaid, NC Health Choice, and State-funded Providers. What is the implementation date for the policy? Section VII, <i>Att. D, Table 1, Item 8 at p. 38</i> , states that the LME/MCO must have a written policy supporting this attachment within 30 days after contract award, but it is unclear when the Uniform policy will actually take effect. Does this relate to the undefined term "credentialing transition period" in Section VII, Attachment G.1.1.f.ii.1?	The BH I/DD Tailored Plan policies take effect on the date approved by the Department unless otherwise specified in the RFA.
231	Section VII, Attachment M.7	156	Will the Department be conducting informational meetings leading up to the Credentialing Transition Period and PDM/CVO contract effective date? If so is there a contemplated schedule and mode of meetings?	The Addendum #7 for revisions to the RFA.
232	Section VII, Attachment M.7.e.i	156-159	The Centralized Credentialing and Re-credentialing Process contemplates a single application for all provider types, i.e., individual, organizational and hospitals. Is a copy available, along with a list of required documentation, in order to determine if the BH I/DD Tailored Plans need to specify required additional information in its Credentialing Policy described in Section VII, Attachment M.7.e.i?	All enrollment and credentialing activities are handled by the Department's fiscal agent and health plans are not required to conduct additional credentialing activities or send contracting decisions through a Provider Network Participation Committee (PNPC). In the future PDMCVO model, it is expected that the vendor will form a credentials committee to perform the functions of a PNPC which will satisfy the quality determination requirements and render collective and consistent decisions to ease the burden on the health plans. The information required for participation in NC Medicaid is currently available in the Provider Permission Matrix and the application job aids available on the NCTracks Provider webpage. As the Department transitions to a PDM/CVO, similar assistance will be available to identify enrollment requirements.
233	Section VII, Attachment M. Policies # 7.d.3	Pages 156-157 of 227	The Uniform Credentialing and Re-credentialing Policy for Medicaid, NC Health Choice, and State-funded Providers states the Department will "meet the most current data and processing standards for a credentialing process for an accredited health plan with accreditation from the selected, nationally recognized accrediting organization, and shall also meet the standards found in 42 C.F.R. Part 455 Subparts B and E." Can the Department confirm that the Tailored Plan will not be responsible for any verifications, reverification or continuous verifications listed in 42 C.F.R. Part 455 Subparts B and E effective for providers enrolled in the Tailored Plan? Can the Department confirm that the Medicaid Enrolled provider data file to be shared with the Tailored Plan, referenced in Section V.4 ii(ii) pg. 204, will include all necessary NC Tracks information and status of credentialing verifications outlined in in 42 C.F.R. Part 455 Subparts B and E.?	All enrollment and credentialing activities are handled by the Department's fiscal agent and health plans are not required to conduct additional credentialing activities or send contracting decisions through a Provider Network Participation Committee (PNPC). In the future PDMCVO model, it is expected that the vendor will form a credentials committee to perform the functions of a PNPC which will satisfy the quality determination requirements and render collective and consistent decisions to ease the burden on the health plans. Any information needed to fulfill the Departments expectations of the plans will be provided or allowed to be requested.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
234	Section VII, Attachment M. Policies # 7.d.3	Pages 156-157 of 227	The Uniform Credentialing and Re-credentialing Policy for Medicaid, NC Health Choice, and State-funded Providers indicates the Department's process is NCQA compliant. Can the Department confirm that the Tailored Plan will not be required to obtain NCQA accreditation for the Credentialing Module?	Not confirmed.
235	Section VII, Attachment M.7.e.i.11	157	Provision requires Cardinal to "identify standards and establish a documented process for making network contracting decisions on State-funded Services providers." At times the State identifies the provider(s) it wants to receive State funds in its allocations. In those instances, will BH I/DD Tailored Plan be expected to apply these standards within a contracting decision or move forward based on the State's designation alone?	In the event of a potential conflict between a provider identified in a Department allocation of State funds and a BH I/DD Tailored Plan's credentialing and contracting standards, the BH I/DD Tailored Plan would be expected to notify the Department of the potential conflict, and the Department would work cooperatively with the BH I/DD Tailored Plan to resolve the question based upon the specific circumstances involved.
236	Section VII, Attachment M.7.e.i.15	157	For recredentialing, is the BH I/DD Tailored Plan to consider only the State's recredentialing materials (as with initial credentialing)? Will the BH I/DD Tailored Plan be able to take in historical performance information into account?	Currently, all enrollment and credentialing activities are handled by the Department's fiscal agent and health plans are not required to conduct additional credentialing activities for contracting decisions. The BH I/DD Tailored Plan must make a good faith effort to contract with any willing provider and shall not exclude eligible providers except when the provider fails to meet the Department's objective quality standards or when a provider refuses to accept network rates.
237	Section VII, Attachment M.7.e.i.15	157	Since current NC Medicaid practice is for providers to re-credential/reverify every 5 years, what are the plans for BH I/DD Tailored Plan providers and practitioners due for their NCQA 3 year re-credentialing during the Transition period?	The transition plan for 5-year recredentialing to 3-year has not been determined. The BH I/DD Tailored Plan shall achieve NCQA Health Plan Accreditation with LTSS Distinction for Health Plans by the end of Contract Year 3 at which time the credentialing period should be transitioning back to three years. The Department will work with already NCQA certified plans to satisfy this requirement.
238	Section VII, Attachment M-#7	157	Q. Does the Department have any plans it can share about how the interface with the BH I/DD TPs for sharing provider credentialing records will work both by the Department and its PDM/CVO contractor and what records will be available and how they will be provided?	The Department will provide additional details on the interface and process after Contract Award.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
239	Section VII, Attachment M-#7	157	Q. Is credentialing and Recredentialing of practitioners that are non-contracted but who render services for a contracted network provider included within the scope of provisions of the Centralized Credentialing and Re-Credentialing Process (CCRP)?	If referring to subcontractors, the provisions for such contracts are detailed in the RFA. According to 42 CFR 455.410.b, all ordering or referring physicians or other professionals providing services under the State plan or under a waiver of the plan must be enrolled as participating providers and currently all enrollment and credentialing activities are performed by NC Medicaid's fiscal agent.
240	VII.M.7	156-158	Please provide clarification of the TP's role for credentialing of providers and practitioners with the Department assuming the role of credentialing and enrollment prior to a CVO being in place. TP will have to meet NCQA requirements for credentialing.	All enrollment and credentialing activities are handled by the Department's fiscal agent and health plans are not required to conduct additional credentialing activities or send contracting decisions through a Provider Network Participation Committee (PNPC). In the future PDMCVO model, it is expected that the vendor will form a credentials committee to perform the functions of a PNPC which will satisfy the quality determination requirements and render collective and consistent decisions to ease the burden on the health plans.
241	VII.M.7	156-158	Please provide clarification and details pertaining to the Objective Quality Standards. What specific quality standards will the Department review by Provider Type? How do the Objective Quality Standards differ between physical versus BH/SU/IDD provider types?	The information required for participation in NC Medicaid is currently available in the Provider Permission Matrix by provider taxonomy (type) and the application job aids available on the NCTracks Provider webpage.
242	VII.M.7	156-158	Does the Department intend to provide both initial and re-credentialing approvals to all plans at the 3 year interval date? How is the re-credentialing date determined for providers who are already enrolled in NC Tracks?	Initial approvals are shared with plans as they occur. Providers are recredentialled every five (5) years. This will change to three (3) years with implementation of the PDMCVO model. The process to transition from five (5) to three (3) years for recredentialing remains in discussion and will vary depending on the length of time the provider has before the next recredentialing due date.
243	VII.P.Table 1	207-227	The liquidated damages for Medicaid are nearly identical in type and dollar amounts as those set forth in the Standard Plan RFP. When factoring in all liquidated damages and SLAs, there are more than in the Standard Plan RFP. Does the Department anticipate eliminating any of these or revising the dollar amounts to reflect the differences in plan size? In the alternative, will the Department consider waiving all liquidated damages and SLAs during the first contract year?	No revisions to the requirements or dollar amounts will be made.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
244	VIII		Would an Executive Summary be counted toward the additional 10 allowable pages or is there an anticipated question response the State is expecting the LME/MCO to use for this overview?	Applicants should follow the Response Page Guidelines stated within the RFA.
245	VIII		Will the State require a wet signature or is a stamp signature sufficient with COVID precautions?	The Department will accept a digital or electronic signature. The original copy should be marked as "original".
246	General Question		Is the department's expectation that the organization respond to RFA questions within the text boxes/format as provided in RFA 30-2020-052-DHB Section VIII. Attachment Q. Application Response and Completed Attachments? Do supplemental responses also have to be in these pre-formatted boxes?	Yes.
247	Section VIII. Attachment Q. Application Response and Completed Attachments 1. Instructions	Page 1 of 123	This sections states "The Applicant's Proposal and Response must be typed, page numbered, single-spaced, and in at least a 12-point font on Letter-sized (8 1/2" x 11") paper with 1" margins." 1. Please confirm if a specific font type must be used. 2. Please confirm if the 1" margin requirement also applies to response text placed within the response table directly as table margins may need to be adjusted to allow for this spacing in the response tables.	A specific font type is not required. Applicant should choose a font that is easily read. It is not necessary to have a 1-inch margin for text within RFA Section VIII. Attachment Q., 3. Applicant's Response to Evaluation Questions.
248	Section VIII. Attachment Q. 1. Instructions	1	Within Attachment Q Application Response, section VIII.1 states that "Page numbers must be in the format 'Page X of Y'". Please confirm that supporting documentation added to the end of this response can be individually paginated, and do not need to continue numbering from the required Attachment Q content.	Confirmed; however, references to any supporting documentation within responses to questions in Attachment Q must clearly identify the location of the supporting documents and supporting documentation must be paginated in manner such that the documentation can be easily found.
249	Section VIII. Attachment Q. 3. Applicant's Response to Evaluation Questions	3	Within Attachment Q Application Response, section VIII.3 references "Section VIII. Attachment O. Application Response" in the first and third paragraphs. Please confirm that this is a typo, where the O should be a Q, and should instead read "Section VIII. Attachment Q. Application Response".	See Addendum #7 for revisions to the RFA.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
250	Section VIII. Attachment Q. Application Response and Completed Attachments , 3. Table 1: Response Page Guidelines	Pages 3-7 of 123	For the page limits provided in this table for each section, please indicate how the Department will consider the page space taken up by the RFA question and any other supporting text provided by the Department in the response table against the page limit; i.e. will that text count towards the applicant's page limits? For example, if a question is 3/4 page long and there is a 6 page limit, can the response be 6 3/4 pages long?	The Department's text will not count toward page guidelines.
251	Section VIII. Attachment Q. 3. Applicant's Response to Evaluation Questions, Section VIII.3. Table 1: Response Page Guidelines & Question #7	4 and 14	The Table and the question both reference Section V.A.1.i, and the question includes the section title <i>Staffing and Facilities for Medicaid and State-funded Services</i> , but this section title is located at V.A.1.ix. Please confirm the correct section reference is V.A.1.ix.	See Addendum #7 for revisions to the RFA.
252	Section VIII. Attachment Q. Application Response and Completed Attachments , 3. Table 2: Entities Performing Core Operations	Pages 9-11 of 123	For potential subcontractors that we do not have under contract at the time the RFA response is submitted, how should we provide that information to DHHS after the RFA response is submitted?	See RFA Section III. D. General Terms and Conditions, 46. SUBCONTRACTORS.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
253	Attachment Q Evaluation Question #4	Page 12 of 123	<p>Can the Department provide clear definitions or guidance for the terms “Non-Compliance”, “Fines”, “Penalties” and “Sanctions” referenced in Section VIII.3. Table 3?</p> <ul style="list-style-type: none"> · For example, is the term “Sanctions” limited to sanctions described at 42 CFR § 438.702? · Should the Applicant include corrective action plans issued by the Department’s External Quality Review Organization (EQRO), accrediting bodies and/or resulting from the DMH/DD/SAS Annual System review (formerly referred to as the Block Grant Audit)? · Do the terms “Fines” or “Penalties” include paybacks required by the DMH/DD/SAS annual financial audit? · Does the five-year look back period refer to the timeframe in which the penalty or fine was assessed, or the timeframe under audit (for example, should an LME/MCO list a payback assessed within the last five years that relates to a FY13/14 DMH/DD/SAS financial audit)? 	<p>The Applicant should complete Section VIII. Attachment Q. Application Response and Completed Attachments, 3. Table 3: Non-Compliance, Fines, Penalties and Sanctions with all information requested and provide details to support the Applicant's response, which may include the items stated within this Question. The five-year lookback period requirement is stated within instructions to complete Section VIII. 3. Table 3: Non-Compliance, Fines, Penalties and Sanctions</p>
254	Attachment Q Evaluation Question #4	Page 12 of 123	<p>Additionally, when listing sanction information from any entities providing core operations for the LME/MCOs, what level of detail is required for LME/MCOs to include in the RFA response for these subcontractor relationships?</p>	<p>The Applicant should complete Section VIII. Attachment Q. Application Response and Completed Attachments, 3. Table 3: Non-Compliance, Fines, Penalties and Sanctions with all information requested and provide details to support the Applicant's response.</p>
255	VIII.3.7.f.1	15	<p>In response to the draft organization chart, does the Department want the entire organizational chart or key personnel only? Should names be included along with roles and funding?</p>	<p>The draft organizational chart should include the roles which support Medicaid, State-funded Services or both, UM and Care Management leadership organizational charts should be included. It should identify proportion of responsibilities across Medicaid and State funded Services fulfilled by key personnel. The BH I/DD Tailored Plan shall include the names of the proposed individual to perform each role as part of the Applicant's Application.</p>
256	VIII.3.9	16	<p>Question 9 references both Medicaid and State-funded scope of services, but has questions for Medicaid only. Do we need to answer the questions for both Medicaid and State-funded services?</p>	<p>See Addendum #7 for revisions to the RFA.</p>

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
257	Section VIII. Offeror's Proposal and Response	Pages 17-18 of 123	Evaluation Question 11 regarding meeting the Department's Utilization Management expectations, please clarify if the response to item 11.g should be two separate responses. Can the Department clarify if the approach to ensure parity should be included in the same response regarding ensuring the UM program supports an integrated, holistic review of members needs? Question 11 has these as one element but this appears to be two separate topics.	Parity and integration are two separate topics within RFA Section VIII. Attachment Q., 3. Applicant's Response to Evaluation Questions Evaluation Question 11. Both topics should be included in the Applicant's response this question.
258	Attachment Q Evaluation Question #16.e. V.A. V.B.7.iii(vii)	Page 22 of 123 Page 9 of 254	This question requires the Applicant to "explain any State (including states other than NC) actions and entity responses related to solvency or inadequate financial management or oversight during the past ten (10) years, including all relevant details on the context and proceedings for all entities proposed to assume risk through the capitated contract as listed in Question #2." The Department has chosen to define solvency as meeting capital reserve requirements that are unique to the LME/MCO and defined current ratio and defensive interval ratio as additional measures. None of these are industry standards and it is unlikely that the subcontractors are measured in such terms. Please clarify what the Department defines as "actions and entity responses related to solvency or inadequate financial management or oversight."	No additional information is available at this time.
259	VIII.	Page 22 and Page 23 of 123	In Section VIII. Offeror's Proposal and Response Page 22 and Page 23 of 123, Question 16 asks for a response to managing and monitoring financial sustainability, as outlined in Section V.B.7.iii. Financial Management. Section C requires a listing of the sources and amounts of capital available at given timeframes. Our best understanding of this section is to provide fund balance amounts for each of the timeframes given. Can you confirm this understanding is correct?	For purposes of the capital requirements, capital reserves are defined as unobligated assets net of liabilities.
260	VIII.19	26	Will the Department provide a list of providers certified as an AMH Tier III and if so, when may we expect it?	The RFA describes that the BH I/DD Tailored Plan should use data as much as is applicable and available. It is not required for TPs to have access to Medicare data.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
261	Section VIII. Attachment Q. 3. Applicant's Response to Evaluation Questions, Question #33	40	The question identifies Section V.A.4.i <i>Engagement with Federally Recognized Tribes</i> . In the scope of work this section is titled <i>Engagement with Tribes for Medicaid Only</i> . Please confirm the section title should be updated in the question to match the scope of work.	See Addendum #7 for revisions to the RFA.
262	VIII.3.33	40	Would the State be looking for our team to address State-based tribes as well as Federally recognized tribes?	See Addendum #7 for revisions to the RFA.
263	Attachment Q Evaluation Question #38.b.	Page 44-45 of 123	Can the Department clarify whether Question 38.b. is focused on stakeholder and member engagement regarding the change from County to Tailored Plan coordination of NEMT, and how members transitioning from Medicaid Direct can access the service?	RFA Section VIII. Attachment 3. Applicant's Response to Evaluation Questions, Question 38.b. is not focused on stakeholder and member engagement. Question 38 b. is focused on the transition of care that includes NEMT services when care is transitioned upon BH I/DD Tailored Plan enrollment from NC Medicaid Direct. See RFA Section V. Scope of Services, B. Medicaid, 1. Members, ii. Transitions of Care.
264	Section VIII. Attachment Q. 3. Applicant's Response to Evaluation Questions, Question #s 40, 41	47-48	Under Supporting Documentation, the question asks for "Current policies, procedures, and data systems..." Please confirm whether documentation of data systems means a system description.	Yes.
265	VIII.43.a.	49	Will the Department consider amending the question to allow the Advanced Directive policy to be submitted as a supplemental Attachment and not count towards page limit (given that this question is limited to a one page response)?	The Advance Directives policy will not count against the page limits for this requirement. See Addendum #7 for revisions to the RFA.
266	Attachment Q Evaluation Question #43	Page 49 of 123	This question asks that the Applicant "include" our advance directives policy, but we are only allotted 1 page to answer. Our Advance Directives policy and procedure is longer than 1 page.	The Advance Directives policy will not count against the page limits for this requirement. See Addendum #7 for revisions to the RFA.
267	VIII.3.60	65-66	Need clarification on whether the State is looking for metrics or approach for internal monitoring	The Department does not understand the question and therefore is unable to provide a response.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
268	Section VIII. Offeror's Proposal and Response	Page 65-66 of 123	Evaluation Question 60: The current format shows the response box to be in the upper right-hand corner. Please clarify where we should write our response to this question -in the one box in the upper right hand corner vs. the individual boxes on the right side of the table? This will likely impact the page limit currently allowed for this response. Is there a formatting issue with this question that may be resolved once the fillable version is requested by the applicant and received from the Department?	The Applicant's response for the thirty-two (32) individual measures should be provided for each row in the Response column of the row.
269	Attachment Q Evaluation Question #61	Page 66-67 of 123	Meeting the quality metrics outlined in the RFA require access to immunization data. Will the LME/MCOs have access to North Carolina Immunization Registry prior to TP go-live? Having access to the NCIR significantly impacts strategy and thus, response to RFA. If the LME/MCOs are not given access to the NCIR prior to TP Go-Live, will the quality metrics be adjusted accordingly?	BH I/DD Tailored Plans will have access to immunization data in claims. The Department is working with DPH and the General Assembly to allow access to the Immunization Registry for quality management activities. That is currently not an allowable use per state law.
270	Attachment Q Evaluation Question #61	Page 66-67 of 123	Given that the LME/MCOs will not be operating statewide, can the Department confirm that a description of five regional/ catchment-wide community initiatives are acceptable for responding to this question, rather than a "state level" initiative?	That phrase means that the BH I/DD Tailored Plans will support the state-led, required project in all areas that it operates.
271	Section VIII. Attachment Q. 3. Applicant's Response to Evaluation Questions, Question #61	67	Under Supporting Documentation, the question asks for a "description of five (5) initiatives that the Applicant plans to deploy to collaborate or align with public health programs at the community level". Please confirm that these descriptions are excluded from the page guidelines for this section.	See Addendum #7 for revisions to the RFA.
272	Section VIII. Attachment Q. 3. Applicant's Response to Evaluation Questions, Question #61	67	The question references Section V.C.3.g. Prevention and Population Health management Programs. There is no section V.C.3.g. Please confirm which expectation and requirement the state is referring to in this section.	Prevention and Population Health Management Programs is located in Addendum 3 - RFA 30-2020-052 DHB, Section V. Scope of Services, C. State-funded Services, 3. Care Management and Prevention, g. beginning on page 42 of 82.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
273	Section VIII. Offeror's Proposal and Response	Page 69 of 123	Evaluation Question 64 mentions "quality improvement efforts" (64.a.i); "specific QI and ... performance improvement projects" (64.a.iv); and "multi-year quality improvement plans". Please give more definitions around those terms to help differentiate the requests. Are these terms being used interchangeably, or do they have different meanings? Only PIP is defined in the glossary of the RFA.	See Addendum 1 RFA 30-2020-052 DHB Section V Scope of Services, A-B, Footnote 19 on page 182 of 254.
274	VIII.66.a	71	Please define what is meant by total premium.	Total premium in this context may be interpreted to mean total capitation revenue.
275	Section VIII. Offeror's Proposal and Response	Page 71 of 123	Evaluation Question 65 asks for at least ten (10) examples of performance measures and further indicates that the question is for Medicaid and State-Funded services. Please clarify whether this means that we should provide at least 10 examples for Medicaid services and at least 10 examples for State-Funded services; i.e. for a total of 20 plus measures? Or at least 10 measures total that apply to both Medicaid and State-Funded services?	See Addendum #7 for revisions to the RFA.
276	Attachment Q Evaluation Question #66	Page 71-72 of 123	This question requests "the percent of total premium flowing to providers through the VBP arrangement." Please clarify the numerator and denominator of the percentage.	The numerator is the total payments to providers for which the payments are part of a value-based purchasing arrangement. The denominator is total premium or capitation revenue for the applicable business.
277	Section XIII Quality & Population Health: VBP, Question 66	71-72	When does the Department anticipate releasing its menu of provider value-based payment options?	The Department will issue additional guidance and details on VBP requirements for the BH I/DD Tailored Plans after Contract Award.
278	Section XIII Quality & Population Health: VBP, Question 66	71-72	Can Tailored Health Plans offer their own VBP options or will they be restricted to those on the menu?	The Department will issue additional guidance and details on VBP requirements for BH I/DD Tailored Plans after Contract Award.
279	Section XIII Quality & Population Health: VBP, Question 66	71-72	Will the department release regional and/or statewide historical performance for the quality metrics in Section VII. RFA Attachments so that Tailored Health Plans may use them to establish targets for their VBP programs?	Yes, the Department will release historical rates for the metrics in Section VII prior to BH I/DD Tailored Plan Implementation.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
280	Section XIII Quality & Population Health: VBP, Question 66	71-72	Will the Department permit a hybrid approach to measuring performance on quality metrics? If so, which ones?	Hybrid reporting will be allowed where it aligns to measure specifications. BH I/DD Tailored Plans will be expected to adhere to standardized specifications for each measure. More information will be provided in a Medicaid Managed Care Technical Specifications document that will be released in early 2021.
281	Section XIII Quality & Population Health: VBP, Question 66	71-72	Will the Department allow aggregation of small providers into pods for the purpose of VBP programs even though they are not clinically integrated?	The Department will provide additional guidance and details for VBP programs after Contract Award as needed.
282	Section XIII Quality & Population Health: VBP, Question 66	71-72	Do Foundational Payments for Infrastructure and Operations (HCP-LAN category 2A) other than care management fees count toward compliance with requirement for a specified portion of the network to be contracted under VBP?	The Department will issue additional guidance and details on VBP requirements for BH I/DD Tailored Plans after Contract Award.
283	Section XIII Quality & Population Health: VBP, Question 66	71-72	Will the Department play a role in beneficiary choice of a primary care provider or is that the sole responsibility of the health plan?	Beneficiaries will be able to choose a PCP at open enrollment. BH I/DD Tailored Plans are required then to auto-assign members to PCP based on a state-required algorithm if beneficiaries do not choose a PCP.
284	Section XIII Quality & Population Health: VBP, Question 66	71-72	Can a health plan change PCP assignment based on plurality of primary care using historical claims data or does that require member consent?	BH I/DD Tailored Plans are required to auto-assign members to a PCP based on a state-required algorithm if members do not choose a PCP.
285	Section XIII Quality & Population Health: VBP, Question 66	71-72	Will CIH get an accurate feed of dental claims from DHHS?	Yes.
286	Section VIII.3 (question 67)	73	Evaluation Question 67 references Section V.A.1.ii Entity Requirements for Medicaid and State-funded Services. However, sub questions 67(a) and 67(b) are focused on the governance structure of the BH I/DD Tailored Plan, which are covered by Section V.A.1.ii.(i) and (ii). Given the page limit for question 67 and the other detailed Evaluation Questions throughout Section VIII of the RFA, is it the Department's intent that the Applicant's response to Question 67 also include a description of its approach to meeting the Department's expectations with respect to Section V.A.1.ii.(iii) ("BD I/DD Tailored Plan Operating Plan").	The Applicant should respond to all components of the question as requested.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
287	Section VIII. Attachment Q. 3. Applicant's Response to Evaluation Questions, Question #79	82	The question states "The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in <i>Section V.C.6. Claims Management</i> . The Applicant shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The completed table (<i>emphasis added</i>) shall include the experience of the Applicant and any entity proposed to process and pay claims." Please clarify the reference to the "completed table". Is there a specific table template that should be used for this response?	See Addendum #7 for revisions to the RFA.
288	VIII.3.80 and VIII.3.81	84-85	We would like confirmation that Question #80 Technical Specifications is referring to the future state and how our systems will be able to meet new requirements versus Question #81 Technical Specifications is referring to how we currently operate and maintain our current systems.	RFA Section VIII. Attachment Q., 3. Applicant's Response to Evaluation Questions, Question #80 refers to the current systems and how these will meet the requirements defined in the RFA. Question #81 refers to the BH I/DD Tailored Plan's ability to adhere to the requirements defined in the RFA. The Department is assessing the flexibility of the systems to support new processes where required by the Department.
289	VIII.3.81	85	Is the Enterprise Architecture Standard Template on the NCDIT website the most updated version of this template? It was last updated 1/23/20.	RFA Section III.E. Confidentiality, Privacy and Security Protections provides information and links for the most current requirements, standards, templates and other items where appropriate. These may be updated from time to time with changes available on the designated websites.
290	Section VIII. Attachment Q. 3. Applicant's Response to Evaluation Questions, Use Case Scenario B	88	The use case references "historically underutilized businesses" can the Department provide a list of businesses that have been certified as historically underutilized?	See https://ncadmin.nc.gov/businesses/hub for additional information.
291	Section VIII. Attachment Q. 5. BH I/DD Tailored Plan Key Personnel	92	The first sentence references Section V.A.1.i Staffing and Facilities, but this section title is located at V.A.1.ix. Please confirm the correct section reference is V.A.1.ix.	See Addendum #7 for revisions to the RFA.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
292	Section VIII.8	101	The Disclosure of Litigation and Criminal Conviction, subpart 3, requires the Applicant to disclose any civil litigation, regulatory finding or penalty, arbitration, proceeding, or judgments against it . . . during the three years preceding its offer that involve . . . (3) a claim or written allegation that the Contractor or any subcontractor violated any federal, state, or local statute, regulation or ordinance." Nearly all provider administrative appeals involve an allegation that the LME/MCO has violated G.S. Chapter 108C, and most consumer administrative appeals involve an allegation that the LME/MCO violated federal or state law, regulation, and/or policy. Does DHB expect that an Applicant will list all provider and consumer administrative appeals brought in OAH over a three (3) year period in its RFA response?	Yes.
293	VIII(11)	104 of 124	The RFA requires subcontractor identification, and requests that PIHP identify and provide relevant information for all subcontractors that will be used in meeting the contract requirements. Does PIHP need to execute complete agreements with all subcontractors before the application deadline? If not, is there a minimum contractual arrangement or commitment that must exist before listing a subcontractor in the RFA?	The subcontractors provided in RFA Section VIII. Attachment Q. Application Response and Completed Attachments, 11. Subcontractor Identification should be those that the BH I/DD TP is committed to enter into contracts as part of this RFA.
294	Section VIII. Offeror's Proposal and Response	Page 116 of 123	Is applicant required to disclose lobbying activities of subcontracted entities?	Yes.
295	Section VIII. Offeror's Proposal and Response	Page 118 of 123	Will the Department confirm that the supplemental questions are not to be included in the proposal submission and should only be completed upon the request of the State?	Yes, the Department will notify Applicants if the supplemental questions need to be completed.
296	Draft Rate Book	General Question	Will DHHS provide an updated rate book with the contract award? Will there be an opportunity to ask questions following receipt of a revised data book?	Final capitation rates and associated rate book will be released in early 2022 prior to implementation. The Department may have a rate meeting with the BH I/DD Tailored Plans to review the final rate book. BH I/DD Tailored Plans will have the opportunity to submit written questions on the rates prior to finalization.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
297	Draft Rate Book	General Question	Can DHHS provide the following fields in existing data provided (or logic to capture the information represented in these fields): Special Needs Code; Deductible Liability Type; and State FFS COS?	<p>Special Needs Code is one of the fields the Department utilizes in identifying the Foster Care and related populations. The Foster Care populations that are not in a 1915(c) waiver or a managed care excluded group can currently be identified in the Global Eligibility File (GEF) and 834 by one of the following current Managed Care Status codes: MCS011, MCS012, MCS013 or one of the following future Managed Care Status Codes (applicable to Tribal and IHS-eligible populations): MCS030, MCS031, MCS032, MCS038, MCS039, MCS040.</p> <p>Deductible Liability Type is utilized to identify the population in the PACE program. The PACE population can be identified in the GEF and 834 utilizing MCS019.</p> <p>The State FFS COS is a field that is derived within NC Tracks, the Medicaid claims system. DHB will provide information about category of service mapping as part of the implementation process to support financial reporting.</p>
298	Draft Rate Book	General Question	How will DHHS determine if a member is actively engaged in Tailored Care Management?	<p>Actively engaged in Tailored Care Management is defined as a member receiving at least one (1) of the following six (6) core Health Home Services in the past month:</p> <ul style="list-style-type: none"> i. Comprehensive care management; ii. Care coordination; iii. Health promotion; iv. Comprehensive transitional care/follow-up; v. Individual and family supports; or vi. Referral to community and social support services. <p>See RFA section V.B.3.ii. (ii)(b)(3).</p>
299	Draft Rate Book	Page 14	Table 2 documents the program aid code/eligibility codes for each population group. There are program aid code/eligibility codes identified as Tailored Plan eligible members in the GEF file received from DHHS that are not included in this table (e.g. MAABN). Please provide clarification.	Certain populations, such as the Innovations population, were not identified using program aid/eligibility codes. Also, dual Eligibles meeting BH I/DD Tailored Plan criteria may have different program aid/eligibility codes. The example noted in the question is a dual eligible code.
300	Draft Rate Book	Page 14	Can DHHS provide a complete listing of the possible program aid code/eligibility codes for each detailed population group and COA?	The Department will work with the awardees to provide information needed to support implementation.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
301	Draft Rate Book	Page 30	To support our evaluation of the base experience and capitation rates, we need to understand the historical enrollment underlying the capitation rates as well as projected enrollment. Why are the historical and projected enrollment consistent?	Due to outstanding considerations surrounding BH I/DD Tailored Plan criteria and lookback dates, Mercer used the SFY 2018 historical MMs for the projected contract MMs in the RFA rates. MMs will be updated to reflect the latest BH I/DD Tailored Plan criteria information in final rate development.
302	Draft Rate Book	Page 30	Does the enrollment used reflect SFY 2018 enrollment or does it reflect the projected and simulated enrollment for SFY 2023?	It reflects SFY 2018 enrollment.
303	Draft Rate Book	Page 30	Did Mercer use the same logic for identifying the underlying TP enrollment as was provided to Alliance in the GEF?	The logic used by Mercer for the draft rates aligns with the State's BH I/DD Tailored Plan eligibility criteria as communicated August 2, 2019 and is summarized in Section IX. Medicaid Tailored Plan Draft Rate Book Appendix E. The logic was applied to beneficiaries enrolled in the program during SFY2018 (the beneficiaries identified in the GEF are more current). Any subsequent changes to the BH I/DD Tailored Plan criteria would not be reflected in the RFA rates. The final capitation rates will be updated to reflect any changes to the BH I/DD Tailored Plan criteria.
304	Draft Rate Book	Page 41	What is causing the four non-benefit expense columns on Table 32 to not add across and equal the total non-benefit expense percentage? Summing up this information for Region 5 equals 12.75% relative to the total reflected in Table 32 of 12.5%.	The first 3 columns are calculated as a percentage of the pre-tax (but post-admin/UWG/care management) capitation rate. The premium tax column is a percentage of the final (post-tax) capitation rate. Also, the percentages are not applied in a traditional multiplicative sense (e.g. rate*(1+x%)) but rather rate/(1-x%). This results in the total percentage not being a sum of the individual percentages.
305	Draft Rate Book	Page 41	Can DHHS provide all adjustments to the capitation rates by region and category of aid (e.g. TPL, NEMT, FWA, Hemophilia recoupment, directed payments, etc.)?	No additional information will be provided at this time beyond the detail included in the Draft Rate Book. The Department will consider providing additional details in the final rate documentation.
306	Draft Rate Book	Page 129	How will the directed payments be made? Will Alliance be involved in operationalizing the directed payments? If so, will Alliance receive a percentage of the directed payments to support operationalizing the directed payments?	The Tailored Care Management payments will not be considered directed payments. For Medicaid members AMH+ practices and CMAs will bill the BH I/DD Tailored Plan each month a member is actively engaged in Tailored Care Management. Additional guidance on billing is forthcoming. The BH I/DD Tailored Plan capitation rate will account for costs associated with oversight of the Tailored Care Management model; BH I/DD Tailored Plans will not receive a percentage of the Tailored Care Management payments to AMH+ practices and CMAs. See Addendum #7 for revisions to the RFA.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
307	Draft Rate Book	Page 132	Can DHHS provide a rationale for why they believe 75% of ultimate managed care savings can be achieved in year 1?	The 75% assumption for ultimate managed care savings in Year 1 was developed based on clinical and actuarial experience related to Medicaid managed care programs in other states. This assumption considers continuity of care requirements and implementation period for BH I/DD Tailored Plan care management strategies.
308	Draft Rate Book	Page 134	What are the assumptions related to 13.6% DME savings in Region 5?	As noted in the Draft Rate Book, Mercer evaluated the managed care opportunities by performing a series of data analyses and comparing the utilization statistics for services to metrics in other states.
309	Draft Rate Book	Page 140	Is the care coordination cost of Alliance assumed to be consistent for individuals receiving Tailored Care Management versus the 52% of individuals who only are receiving care coordination? If not, will the capitation rates be adjusted if the actual percentage of individuals receiving Tailored Care Management is different than projected?	BH I/DD Tailored Plan care coordination efforts are anticipated to require differential staffing for individuals receiving Tailored Care Management compared to individuals not receiving Tailored Care Management. More care coordinators are assumed to be needed (on a per person basis) for individuals not in Tailored Care Management, leading to higher assumed care coordination costs in the rates for those individuals. The assumed split of individuals receiving Tailored Care Management will be revisited as part of final rate development on a prospective basis but will not be adjusted retroactively based on actual percentage observed during the rating period.
310	Draft Rate Book	Page 140	It is stated that the Tailored Care Management model is aligned with a "federal Health Home program" – does this refer to Medicaid Health Home State Plan Option, authorized under the Affordable Care Act (Section 2703/1945 of the Social Security Act)?	Yes, the BH I/DD Tailored Care Management model was designed to align with the optional Medicaid State Plan benefit authorized by Section 2703 of the Affordable Care Act (Section 1945 of the Social Security Act).
311	Draft Rate Book	Page 140	How does the health home model allocate care management duties between the health home provider and the Tailored Plan? For example, what assumptions were used for oversight and support functions that the Tailored Plan will provide to health home providers?	<p>The RFA outlines the delineation of BH I/DD Tailored Care Management responsibilities between the BH I/DD Tailored Plan and AMH+ practices and CMAs.</p> <p>The RFA outlines the delineation of BH I/DD Tailored Care Management responsibilities between the BH I/DD Tailored Plan and AMH+ practices and CMAs. Expected costs incurred by the BH I/DD Tailored Plan for oversight of the Tailored Care Management model were considered as part of the draft capitation rate development. The Department will consider providing additional details as part of final rate setting.</p>

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
312	Draft Rate Book	Page 142	Can DHHS provide the area factor development and resulting factors (i.e. using BLS and Colliers International data) included within the non-benefit expense development?	The Department will consider providing additional information as part of final rate development.
313	Draft Rate Book	Page 142	Can DHHS provide the FTE variation by region included within the non-benefit expense development?	The Department will consider providing additional information as part of final rate development.
314	Draft Rate Book	Page 143	How were Standard Plan partner required under the contract costs considered in the model?	The administrative load was developed based on the administrative function requirements outlined in the RFA without explicit consideration for which entity performs which function(s).
315	Draft Rate Book	Page 144	How will DHHS be funding the required incentive payments to AMH+ and CMA providers?	BH I/DD Tailored Plans will be funded for BH I/DD Tailored Care Management payments outside of monthly capitation.
316	Draft Rate Book	Page 144	Why is the NC Health Choice population not eligible to receive separate care management PMPMs?	The Department is proposing that the federal authority for the Tailored Care Management program be derived through a Medicaid Health Home State Plan Amendment so that the State can obtain enhanced federal match. As a Medicaid State Plan service, Health Home payments can be made separately from the BH I/DD Tailored Plan capitation rate. The Health Home authority is not available to NC Health Choice (which is a separate CHIP program) through the CHIP State Plan, and as a result must be treated as part of the non-benefit component of the BH I/DD Tailored Plan capitation rate.
317	Draft Rate Book	Page 144	What portion of the capitation rate is expected to cover the care management costs of the NC Health Choice (i.e. CHIP) population?	The care management considerations for NC Health Choice is split based on an assumed proportion of Health Choice individuals who will engage in Tailored Care Management. For those who choose Tailored Care Management, an assumed PMPM in line with those illustrated in Section IX. Medicaid Tailored Plan Draft Rate Book, Table 33: Illustrative PMPMs for Tailored Care Management was included. For all others, care coordination costs in line with other populations who opt out of Tailored Care Management were considered.
318	Draft Rate Book	Page 145	What staffing ratio was assumed for FTEs not engaged in Tailored Care Management?	The staffing ratios were assumed to vary based on acuity of the population. The approach used for this assumption aligns with the approach utilized to develop the care coordination aspect of the Standard Plan capitation rates.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
319	Draft Rate Book	Page 145	What different staffing ratios and costs were assumed for beneficiaries utilizing LTSS including 1915(c) waiver services, LHD payment requirements, and additional costs for requirements related to Healthy Opportunity initiatives?	See the response to Question #318 above.
320	Section IX (Executive Summary), bullet #1	7	Please identify the individuals in Tailored Plan for the Base Data Exhibits	The base data exhibits only include individuals identified as BH I/DD Tailored Plan eligible according to the Mercer simulation process outlined in the Draft Rate Book.
321	Section IX- Rate book questions -COVID-19	7	<p>How does the Department / Mercer plan to consider the impact of COVID-19 in the final capitation rates in terms of its impact on the following?</p> <ul style="list-style-type: none"> • Medicaid enrollment • The impact of reduced utilization on the underlying data from which rates are developed • The impact of reduced utilization on the claims used to identify members eligible for Tailored Plans • Historical and projected service utilization and cost trends • Service mix (use of telehealth) • Policy or program design changes • Other impacts 	The parameters related to COVID-19 will be evaluated during the final capitation rate development in order to produce actuarially sound rates. The Department will provide additional details during the final rate development process.
322	Section IX- Draft Nature of Rates -COVID-19	7	<p>Many factors are developed as DRAFT and subject to further updates. This includes not only assumptions about numerical values, but also key decision points such as how the following will be incorporated:</p> <ul style="list-style-type: none"> • withholds • value based purchasing requirements • risk corridors • foster care <p>What is the timeline of the Department for decisions on these key points? What is the Department's timeline for final rate development?</p>	The Department intends to have capitation rates finalized at least ninety (90) days prior to the beginning of each rate year. The Department intends to share its proposed approach to coverage for the foster care population in the coming months. The Department is not prepared to commit to a timeline for the other requested items at this time.
323	Section IX (Executive Summary), bullet #9	8	The draft Rate Book indicates that certain individuals who are eligible for the BH I/DD Tailored Plan may be able to opt-out of the BH I/DD Tailored Plan and enroll with a Standard Plan or, in some circumstances, receive BH and I/DD services through Medicaid Direct, and that "these opt-out scenarios may have a potential cost impact that is not yet reflected in the draft capitation rates." Please provide the Department's/Mercer's assumption(s) of the percent of member opt-out.	No opt-out assumptions were made in these draft rate materials. The assumptions and methodology are under development and will be communicated as part of final rates.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
324	Section IX (Executive Summary), bullet #11	8	The draft Rate Book indicates that "care management oversight for high fidelity wraparound was considered in the care management costs outlined in Section 15," but it was not considered in the draft rates. How will utilization for these two different sections be aligned?	State Plan changes for coverage of high-fidelity wraparound services were not considered in draft rates, though care management oversight for existing utilization of high-fidelity wraparound was considered in the care management costs outlined in RFA Section IX. Medicaid Tailored Plan Draft Rate Book, Section 15. Final rates will consider any updates and more recent experience related to high fidelity wraparound services.
325	Section IX (Executive Summary), bullet #17	9	The draft Rate Book indicates that the draft rates "do not include any consideration for the COVID-19 pandemic." Please describe the Department's/Mercer's expectations of COVID-19 impacts - e.g., telehealth assumptions, impact of delayed physical health procedures/treatments, etc.	The Department will provide additional details during the final rate development process.
326	Section IX, 7	21	Base Data Adjustments - Were these adjustments developed /applied at the State or regional level? If State may we obtain the regional level analysis?	Base data adjustments with available regional data and region-specific considerations were applied at the regional level.
327	Section 7; Sub- Section 7.2 – Table 5	22	Adjustments to Historical Data - of the rate book mentions that Table 5 shows results by COS. This currently shows results by region. Can the Department and Mercer provide the impact of adjustments by COS?	Mercer acknowledges the disconnect between Section IX. Medicaid Tailored Plan Draft Rate Book, Table 5: Combined Impact of Retroactive Eligibility Period and Application Period Adjustments by Region and its description. The Department will consider providing additional details in the final rate development process.
328	Section 10; Sub-Section 10.1	116	Maternity Event Development Methodology - Are maternity event payments adjusted for members that were not enrolled in the Tailored Plan for the entire duration of the event?	Maternity event payments will be made for all qualifying birth events. More details on the maternity event rate development will be provided as part of final rate documentation.
329	Section 11- TREND Assumptions Sub-Section 11.1	117	Trend Development Methodology - Describes the methodology by which trend rates were developed. Can the Department and Mercer provide more clarity (weights) about the degree to which the fitted historical slopes were used, as opposed to the secondary sources mentioned? How did the reliance on more than historical experience vary by service category?	The trends assumptions were developed based on a review of the historical trends and evaluation of future trend expectations. These assumptions will be revisited for the final rate development.
330	Section IX, 12, 12.2	124	Physician Services Fee Schedule Change - As Outpatient Hospital Reimbursement is percent of charges, what controls will limit excessive charge master growth?	Outpatient hospital reimbursement is based on a percentage of costs, which utilizes a ratio of cost to charges (RCC). Each year, the RCC will be adjusted. Additional information related to hospital reimbursement is outlined in Section IX. Medicaid Tailored Plan Draft Rate Book, Appendix F - Approach to Medicaid Hospital Payments After the Transition to Managed Care.
331	Section IX, 13	132	Managed Care Assumptions - Was a rural vs urban utilization variance considered in the manage care factors?	No assumption for rural vs. urban utilization variance was made for the managed care savings.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
332	Section IX, 13, 13.2	135	Non-Pharmacy Benefits - We expect hospital reimbursements to exceed the FFS reimbursement levels by up to 8.5%. We engage with several significant hospital provider that dominate the market. We strongly encourage provisions for reimbursements exceeding FFS.	The Department intends for final capitation rates to assume reimbursement to providers at levels similar to FFS which align with minimum fee schedule requirements of the RFA.
333	Section IX, Section 15, 15.4.1	138	Tailored Care Management - Please provide the distribution of member acuity levels utilized for Table 33	The acuity levels are currently under development by the Department. More information will be shared once these have been determined.
334	Section IX, 15, 15. 6	147	Underwriting Gain and Premium Taxes - Please expand on the 1.9% consideration for premium taxes, particularly when BH I/DD Tailored Plans are operated by LME/MCOs which are otherwise exempt from state taxation.	The premium tax under G.S. 105-228.8 is applicable to prepaid health plans as defined in G.S. 108D-1 which includes the BH I/DD Tailored Plans. The insurance regulatory charge under G.S. 58-6-25 is not applicable.
335	Section IX, 16	148	CAPITATION RATE DEVELOPMENT EXHIBITS - The general administrative percent's for Innovations (Non-Dual & Dual) are substantially lower than the other rate cells in the capitation rate development exhibits. Was this intended?	As discussed in Section IX. Medicaid Draft Rate Book,15.5, the non-benefit load was evaluated from a fixed and variable administrative perspective. The fixed admin is applied as a PMPM across rate cells (rather than as a percentage), thus the rate cells with higher cap rates (like Innovations) will have lower fixed admin as measured as a percentage of total capitation.
336	Section IX. Sub-Section 17.2.1	213	MLR: How does the Department / Mercer plan to incorporate the 88% MLR requirement in the final capitation rates? (The draft rates appear to have considered an 85% requirement rather than 88% - see section 17.2.1.)	As illustrated in Section IX. Medicaid Tailored Plan Draft Rate Book, Table 34: Statewide Implied MLR Calculation by Rate Cell Utilizing Base Capitation Rates, Row G, all estimated, implied MLR results by Region exceed the 88% threshold. Additionally, these results do not consider the impact of any credibility adjustment or Tailored Care Management revenue/expenses which would both likely result in increases to the implied MLR.
337	Sub-Section 13.1 Overall Managed Care Findings	132-135	Savings Factors - Can Mercer provide more documentation regarding their expected Tailored Plan Savings Factors? We would like to see the sources of any assumptions or factors used in determining these savings factors, as well as the process used to arrive at the factors based on the information that Mercer relied upon.	As noted in the Draft Rate Book, Mercer evaluated the managed care opportunities by performing a series of data analyses and comparing the utilization statistics for services to metrics in other states. The assumptions were developed based on Mercer's clinical and actuarial experience related to Medicaid managed care programs.
338	This issue was not specifically address in the RFA	N/A	<u>Regarding:</u> Hospital inpatient / outpatient rates Will Tailored Plans be provided or have access to current hospital specific Medicaid FFS, non-BH Inpatient rates? Asking because of the confusion in 2019 around inclusion of supplemental payments in the revised hospital's IP rates and would not want this to be a barrier to contracting with hospitals.	BH I/DD Tailored Plans will be provided or have access to current hospital specific Medicaid FFS, non-BH Inpatient rates. Hospitals will receive IP rate letters; PHPs will have access to hospital specific rates via a secured link (PCDU). The DRG weight table, Non-Distinct Par Units Post-Acute Care rates, and Out-of-State Hospital Inpatient and Outpatient rates will continue to be posted on the DHB public website.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
339	This issue was not specifically address in the RFA	N/A	<p><u>Regarding:</u> Gap fill/Default payment rates</p> <p>Question: What happens if a provider bills a tailored plan for a service that does not have a Medicaid FFS payment rate? Is the payment \$0, or can tailored plans include a provision for default payment rates (e.g. % of billed charge) or "gap fill" protocols?</p>	The BH I/DD Tailored Plan should pay a provider the appropriate reimbursement rate for the covered service per the BH I/DD Tailored Plan's contract with the provider. If the provider or service is subject to rate floors or special payment provisions as defined in the contract with the Department, then the BH I/DD Tailored Plan must follow the contract with DHHS for minimum payment standards or other requirements. If the contract with the Department is silent in regard to payment rates for the provider or services, then the BH I/DD Tailored Plan should negotiate an appropriate reimbursement with the provider.
340	Section IX in Excel	N/A	<p>Please provide exhibits 1 – 145 from Section IX in Excel.</p> <p>May we receive the detail data (claims level) to support the summarized base data experience that is summarized in 9 FY2018 Base Data Exhibits?</p> <p>Please confirm there will be no physical health expense for Dual rate cells, including Prescribed Drugs and Transportation – NEMT.</p>	<p>The base data and the rate development exhibits can be provided in excel format, if requested. Additional data will not be provided in excel format at this time.</p> <p>Confirmed, no physical health expenses for Dual rate cells are included in the Draft Rate Book</p>
341	IX.16	149	Will Mercer be providing a rate summary by Category of Service and if so, when may we expect it?	Category of Service detail is provided in Section IX. Medicaid Tailored Plan Draft Rate Book, rate exhibits 83-145.
342	IX	9	Per the RFA " The withhold program will be effective 18 months following the date of SP launch...". Should this be within 18 months of TP launch?	NC Session Law 2018-49 allows for withhold arrangements after the first 18 months of the demonstration, which the Department interprets to occur at the launch of Standard Plan PHP contracts.
343	IX 7.5	25	Can you provide TPL adjustment amounts by COS?	The Department will consider providing additional details in the final rate development process.
344	IX 15.2	142	The rate book describes how program management and administrative operations personnel and other non-personnel costs were determined but it does not mention any consideration of current LME MCO administrative cost for that region so will that be considered?	Administrative costs will be modeled as outlined in Section IX. Medicaid Tailored Plan Draft Rate Book, 15. Non-Benefit Expense Considerations based on the requirements to operate and administer a Medicaid managed care program including all required staff outlined in the RFA.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
345	IX 15.3	142-143	The rate book describes assumptions for increases in non-personnel costs for capturing the administrative costs associated with contracting with PBM but there is no mention of the administrative costs associated with contracting with a PHP. There are expenses associated with monitoring the delegation as well as the sharing and reconciling data. There are significant expenses associated. Will there be an adjustment for this work in the final data book?	The administrative load was developed based on the administrative function requirements outlined in the RFA without explicit consideration for which entity performs which function(s).
346	IX 15.4.1	143-145	Per the rate book the Tailored CM rates were established based on estimated case load size by CM. Could you please share the estimated case loads sizes included? Acuity information by region would also be helpful in responding to estimated CMA and/or Tailored Plan TCM needed for work.	Additional information related to staffing and the BH I/DD Tailored Care Management program may be found at: https://files.nc.gov/ncdma/Tailored-Care-Management-Provider-Manual20200609.pdf . Additional details of the BH I/DD Tailored Care Management program are under development and will be shared at a later date.
347	IX		Could you please share the NCHC data by COA and COS? I assume based on the rate book it is included in the rates but I do not see specific data on these members.	The NCHC population is included in the TANF rate cells and will not be split into its own population grouping for rate setting purposes.
348	IX, 11.2, tables 15, 16, and 17	118-121	Mercer gives different trends by category for each region. Could the state provide more information to explain the differences in trends between each region?	Mercer varied trends by region based on observed emerging utilization and unit cost patterns within each region.
349	IX	117-121	Can Mercer please share how the Rx trends described in Table 15 of Section 11.2 of the Draft Rate Book are split between Generic and Brand drug categories? Section 11.2.2 has specialty vs. traditional splits, but it would be helpful to also know the generic vs. brand splits?	Mercer reviewed trends separately for traditional versus specialty drugs. The Department will consider providing further details on the pharmacy trends in the final rate documentation.
350	IX	122	Can Mercer please provide more detail around the 7.5% specialty pharmacy trend? This trend seems lower than the specialty pharmacy trend for other states and populations.	Trend was developed by rate cell and region based on a review of historical prescription drug utilization split between traditional and specialty drugs for each therapeutic class and known pipeline drugs at the time of rate development. The Department will consider providing further details on the pharmacy trends in the final rate documentation.
351	IX	134	In Table 30 of Section 13.1 we observed aggressive managed care savings factors for some of the categories of service. Please provide additional detail around what is driving the -18.8% savings factors for physical health ER and Specialty Physician services.	See the response to Question #367 below.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
352	Draft Rate Book	Page 4	Will the state please provide all available data within the draft rate book in an excel file format.	The base data and the rate development exhibits can be provided in excel format upon request.
353	Draft Rate Book	Page 4	Please include development of eligibility cohorts, member counts and the criteria used to define / estimate them as this impacts the rate development shared in the rate book.	The requested information can all be found within the Draft Rate Book. The provision of additional details can be discussed as part of the final capitation rate development process.
354	Draft Rate Book	Page 4	Please confirm that Tailored plan eligibles will be covered under FFS until the Tailored plan launch. After Tailored plan launch, these eligibles can opt into Standard plan. Would it be possible for DHHS to provide more detail on the assumptions around opt-outs, acuity, etc., and how opt-out costs flow from Tailored plan into Standard plan. Opt- out members shifting from the Tailored plan to the Standard plan would likely have the effect of increasing the overall acuity of both plans. For example, lower acuity Tailored plan members shifting to Standard plan would increase overall Standard plan acuity, but also the remaining members in Tailored plan would have higher acuity than the original pool of Tailored plan eligibles. Has this been considered in the draft Tailored Plan rates?	Beneficiaries enrolled in the Innovations or TBI waiver program will remain in FFS and the LME/MCO program until BH I/DD Tailored Plan launch. Other BH I/DD Tailored Plan Eligibles who would otherwise be part of the mandatory managed care group will remain in FFS and the LME/MCO program, as applicable, until BH I/DD Tailored Plan launch, unless they opt to enroll in a Standard Plan PHP. No opt-out assumptions were made in these draft rate materials. The assumptions and methodology are under development and will be communicated as part of final rates.
355	Draft Rate Book	Page 31	Could Mercer share more quantitative details on the acuity vs. length of lookback mentioned in 8.2.1 once that analysis has been reevaluated in the final rates.	Additional information will be provided as part of final rate development.
356	Draft Rate Book	Page 120	Section 11.2.1 indicates, reimbursement will be based on a "hospital-specific percent of charges". Is there an annual updating of these factors? Could hospitals increase the reimbursement level by increasing the charge master schedule that applies to the hospital-specific percentage? Are there rules preventing the charge-master increase once the percent has been determined?	Outpatient hospital reimbursement is based on a percentage of costs, which utilizes a ratio of cost to charges (RCC). Each year, the RCC will be adjusted. Additional information related to hospital reimbursement is outlined in Section IX. Medicaid Draft Rate Book, Appendix F - Approach to Medicaid Hospital Payments After the Transition to Managed Care.
357	Draft Rate Book	Page 120	We request that Mercer provide detail on which specific Pipeline drugs are being considered in section 11.2.2? Some general categories are shown but no specific drug names were mentioned.	No additional information will be provided beyond the details included in the Draft Rate Book.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
358	Draft Rate Book	Page 120	<p>Higher drug trends have been driven recently by the introduction of specialty pharmacy drugs in the service mix.</p> <p>How did Mercer account for these high cost drugs introduced since the SFY 2018 base period. Could DHHS provide an additional breakout on how new high cost drugs were considered as part of the trend assumption, or if they are accounted for separately in the rate. Additionally, how are pharmacy drugs administered in a medical setting considered in the rates? How are increases in Long Acting Antipsychotics considered in trends?</p>	<p>Prescription drug trend was evaluated for all therapeutic classes including consideration for drugs in the pipeline. No additional information will be provided related to Rx trends for specific drug classes.</p>
359	Draft Rate Book	Page 120	<p>For Pharmacy, can Mercer provide a list of clinical edits that were not working correctly in FFS base data that PHPs could implement for managed care? Given there is an expectation of 2.1% savings on RX, fully-understanding the opportunities around these edits will be critical to meet savings expectations given the State mandated PDL.</p>	<p>The Department will consider providing additional details in the final rate development process.</p>
360	Draft Rate Book	Page 124	<p>Section 12.2 indicated a physician fee schedule floor at 100% of Medicaid with no consideration for contracting above 100%. Mercer mentioned a provider disincentive permitting reimbursement limited to 90% Medicaid for non- contracting providers. Are access requirements flexible enough to accommodate this leverage for contracting?</p> <p>Additionally, contracting on the Standard plan has indicated that the market may not support levels at 100%, especially in light of expectations on contracting for expanded access for after-hours access including urgent care. If Tailored Plans are required to contract at above 100% of the Medicaid FFS fee schedule to meeting access requirements, how will this be considered in the rates?</p>	<p>The Department intends for final capitation rates to assume reimbursement to providers at levels similar to FFS which align with minimum fee schedule requirements of the RFA.</p>
361	Draft Rate Book	Page 125	<p>Section 12.5.1 discusses a correlation that an increase in per diem leads to decrease in utilization, so Mercer lowered the utilization for State facilities. In Section 11.2.3, there is an assumption where "ICF trends do not consider any unit cost growth for State Facilities as fee growth to the SFY 2023 period". Could DHHS provide more background on what is driving the expected increase in per diems? What would cause the increase per diems to drive lower utilization? Would that utilization move to different facilities or services? If not, what is driving removal of that utilization from the system.</p>	<p>Historically, utilization declines have been observed prior to per diem increases. This pattern has been evaluated in the forecasting of this program change for SFY 2022. This adjustment will be evaluated using actual fee schedules for final rates.</p>

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
362	Draft Rate Book	Page 129	12.7 Additional Directed Payments - How can we obtain the historical data for our region to determine the cost that should be include in our rate?	The AUBPs are separate and distinct payments that are not included in base rates paid to providers. Payments for AUBPs from the Department to the BH I/DD Tailored Plans are separate from and in addition to the prospective PMPM capitation payments.
363	Draft Rate Book	Page 131	Can Mercer share details around the calculation of the Inpatient Liability in Section 12.9.4, and how immateriality was determined?	Mercer identified IP hospital costs for months in which a beneficiary was not eligible for Medicaid but was eligible in the next month. The adjustment was deemed immaterial due to the very low prevalence of this within the BH I/DD Tailored Plan eligible population.
364	Draft Rate Book	Page 132	Managed Care savings in CY1 is assumed to be 75% of ultimate savings. Can Mercer share a monthly break-out of MC assumptions to show a reasonable progression that achieves the annual total. This will be helpful for Tailored Plans to ensure their implementation plans align with Mercer's expectations.	Mercer developed the 75% assumption on an annual basis to align with the development of Year 1 capitation rates. This assumption aligns with expectations of the Standard Plans. Monthly detail of this assumption was not developed as there may be a number of ways that BH I/DD Tailored Plans implement care and utilization management strategies in their managed care programs. Different managed care strategies may result in different progressions of utilization change on a monthly basis.
365	Draft Rate Book	Page 136	How does the assumed managed care phase-in take into consideration that diversion programs do not result in instantaneous savings? Even when the program is running on an efficient scale, there is a lag between new members enrolling in the plan and the time which care management protocols can be enacted? This can be even longer if the new member does not have a history of a condition requiring care management since the underlying diagnosis will not be available until it presents itself in claim activity.	The managed care phase-in assumed lower managed care assumptions in the earlier months due to continuity of care requirements. The assumptions are non-zero in the early months as not all utilization that will take place in the first three (3) months is associated with existing authorizations and continuity of care.
366	Draft Rate Book	Page 136	Can Mercer provide a list of the care gaps identified in fee for service (FFS) data so that PHPs can focus their efforts and make a cost impact quickly?	The themes requested are included in Section IX. Medicaid Draft Rate Book, 13. Managed Care Assumptions.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
367	Draft Rate Book	Page 136	Can Mercer share more details around the assumptions for Emergency Room and Inpatient savings? In particular, what is the basis of methodology used to determine whether ER visits or IP admits can result in savings? If base data was used to determine savings opportunities, how did Mercer discount potential savings for situations where a lower cost and viable alternate service setting option was not available (i.e., night, weekend, holidays)? What replacement costs are assumed in the alternate service setting?	The methodology as outlined in Section IX. Medicaid Draft Rate Book, 13. Managed Care Assumptions was used. The utilization comparisons were made to other states based on rate cells or combinations of rate cells for these services based on available data. Managed care assumptions were developed considering a number of different analyses including the LANE and PPA as well as broader utilization comparisons. The managed care savings were not itemized into various components, but instead developed at an overall level considering the issues noted in the question.
368	Draft Rate Book	Page 136	Mercer indicated that they assumed a shift from Specialist to PCP for more management at PCP office visit delivery. How has Mercer considered PCP capacity to accommodate this? Please provide details on how Mercer adjusted the PCP unit cost to account for higher case complexity that transition from Specialist setting. Also how was any additional testing costs that the PCP may need to undertake to provide similar level of diagnostic assessment factored into cost estimate?	The methodology as outlined in Section IX. Medicaid Draft Rate Book, 13. Managed Care Assumptions was used. The Department will consider providing additional details in the final rate development.
369	Draft Rate Book	Page 136	In Section 13.2.2, Mercer indicates that members that are eligible for the Tailored Plan have higher acute care costs than similar members that would be eligible for the Standard plan. Did Mercer consider in developing managed care assumptions that it may be more difficult for members with significant behavioral health needs to manage a chronic condition, for example medication adherence may be affected? This might lead to higher acute care cost and may also make it more difficult to implement programs to achieve managed care savings.	Yes.
370	Draft Rate Book	Page 136	Mercer mentioned that certain populations such as the TBI waiver will utilize a proxy pricing approach to estimate costs for these groups due to relatively small population sizes lacking sufficient credibility to rate based on their own experience. We agree this is a reasonable approach, but request a comparison of the results with actual experience, if possible.	The Department will provide more details on the TBI rate development in the final rate development process.
371	Draft Rate Book	Page 138	14 Member Choice - Want to confirm that if a member opts out of Tailored Plan, they also opt out of State Services.	Yes. If a Member opts of the BH I/DD Tailored Plan they are not eligible to receive State-funded services. The BH I/DD Tailored Plan is the only plan that is allowed to administer State-funded services.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
372	Draft Rate Book	Page 141	Footnote 28 states that Tables 31 and 32 exclude payments for Tailored Care Management for Medicaid beneficiaries. Section 15.4.1 indicates that the CM payment for NC Health Choice members would be in the capitation. Could DHHS confirm whether costs developed in Section 15.4.1 are included within the information in Table 31 and 32, or excluded completely? Could Mercer provide clarity on what is included/excluded from Tables 31 and 32?	As outlined in Section IX. Medicaid Draft Rate Book, footnote 28, Table 31: Overall Non-Benefit Expenses PMPM/Payment by Region and Table 32: Overall Non-Benefit Expenses as a Percentage of Premium by Region exclude any Tailored Care Management consideration for Medicaid enrollees. BH I/DD Tailored Care Management considerations for NC Health Choice (CHIP enrollees) are included.
373	Draft Rate Book	Page 7	Please explain how COVID impacted trends and utilization will be factored in this update. If dates beyond February of 2020 are to be used, these are considered materially impacted by COVID. In alignment with the standard plans, recommendation would be to use data no later than February 2020.	COVID-19 considerations will be part of final rate development. More information will be provided once final rates are available.
374	Draft Rate Book	Page 19	– COVID 19 – Please confirm COVID affected data will not be considered in any future rate development adjustments to base, trend, and utilization	See the response to Question #373 above.
375	Draft Rate Book	Page 27	Hemophilia Recoupment – Please provide the methodology for this recoupment.	The time period affected by the recoupments overlapped with ten (10) months of the SFY18 time period. Those ten (10) months of recoupments were distributed by region and rate cell by clotting drug use and removed from the base data.
376	Draft Rate Book	Page 126	12.5.2 Transition to Community Living Initiative (TCLI) – Please provide the data used to come to the assumption of only 50% transition utilization	The Department will consider providing additional details in the final rate development.
377	Draft Rate Book	Page 130	12.9 Other Program Considerations – Please define what “other” programmatic/reimbursement changes were used in the additional rate considerations	The "other" programmatic changes consist of the programmatic changes outlined in Section IX. Medicaid Draft Rate Book, 12.9.1-12.9.6.
378	Draft Rate Book	Page 131	12.9.4 Inpatient Liability Adjustment – Please provide the data that led to no material impact on the Capitation Rates.C11	See the response to Question # 363 above.
379	Draft Rate Book	Page 131	12.9.5 Quitline Smoking Cessation Services - Optum is currently asking for \$.20PMPM on the standard plan and an annual increase. Please provide further information on how the department will handle the annual increases to assist plans with contracting efforts as plans will be required to contract for terms greater than 1 year.	Any updates to the Quitline costs will be considered as part of final rate development.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
380	Draft Rate Book	Page 131	12.9.6 AMH Medical Home Fees – Please provide the percentage of members attributed to a Tier 2 and 3 provider in the assumption.	The percentage of members attributed to Tier 2 or Tier 3 AMH providers does not impact this assumption. The AMH Medical Home Fees were assumed to be \$5.00 PMPM for all Tailored Plan members attributed to a Tier 2 or Tier 3 provider.
381	Draft Rate Book	Page 131	13.1 - Overall Managed Care Findings – Recommend reducing the 75% to 60% for managed care savings realized in the first 12 months. This would align with efforts on standard plan side.	The 75% Year 1 managed care phase-in assumption is consistent across programs.
382	Draft Rate Book	Page 136	13.2.1 Other State Medicaid Experience – Please provide the 10 states and their associated data inclusive of program model, benefits and eligibility, and date of the start of their managed care program and any adjustments made for managed care start date differentials referenced to compare to NC regarding potential savings under managed care	No data specific to each of the states considered will be provided. Mercer evaluated the managed care opportunities by performing a series of data analyses and comparing the utilization statistics of the NC Medicaid and NC Health Choice program to other states. In Mercer's opinion, the managed care assumptions are reasonable, appropriate and attainable for the NC program design.
383	Draft Rate Book	Page 136	13.2.1 Other State Medicaid Experience – Please provide the data on, and how the enhanced Primary Care Case Management model impacted the managed care assumptions.	The existence of CCNC/CA program were considered in the development of the managed care savings factors. The methodology included review of actual utilization statistics reflective of these programs compared to utilization statistics from other states.
384	Draft Rate Book	Page 145	15.4.1 Tailored Care Management - Last paragraph on page 145 - Please provide information on how will these AMH+ or CMA incentive payments be factored into rate development.	See response to Question #315 above.

No.	RFA Section	RFA Page Number	Offeror Question	The State's Response
385	IX. Medicaid Tailored Plan Draft Rate Book	Page 5	Can the Department provide additional clarification about how the Department and/or its actuarial vendor (Mercer) will consider administrative costs in the development of the maternity, TBI and pass through payments?	The administrative assumptions align with the needs to operate and administer a Medicaid program including all required staff outlined in the RFA. Final rate development may include the following approach for the Maternity and TBI rate cells. The overall estimated administrative costs may be allocated to the TBI rate cells using a fixed and variable approach similar to what is outlined in the Draft Rate Book; and while the maternity event payments may consider only the variable administrative cost considerations as the fixed administrative consideration is already factored into the mother's broader rate cell PMPM rate. No explicit adjustment will be made for pass through payments as the general administrative cost already consider staffing needs required for these and all other payment functions.
386	IX.15.4.1 Draft Rate Book	Pages 142-146, Table 33	During the November 18, 2020 Preapplication Conference, Julia Lerche stated that the Department is not able to share the acuity tiers at this time. Will the Department share acuity tiers in the future and if so, when? Similarly, will the Department share staffing build-up for development of PMPM and if so, when? If this information cannot be shared sufficiently in advance of the RFA Response Due Date of February 2, 2020, what data should the LME/MCO use for 3-year cost modeling?	<p>The Department is not prepared to commit to a timeline for release of the acuity tiering details at this time.</p> <p>The Department will share information about acuity tiers before BH I/DD Tailored Plan launch. The Department does not yet have an estimated timing of when this information will be released.</p> <p>The Department will share information about acuity tiers before BH I/DD Tailored Plan launch. The Department does not yet have an estimated timing of when this information will be released. The Department is not prepared to commit to a timeline for release of the acuity tiering details at this time.</p>
387	IX. Medicaid Tailored Plan Draft Rate Book	Page 239	What will the DSP reimbursement a) funding source; and b) methodology be for Innovations and TBI Waiver enrollees who use DSP services during acute inpatient hospital stays?	No changes to DSP reimbursement for the Innovations and TBI waiver enrollees were considered in these draft rates.

Execute Addendum #6:

Offeror: _____

Authorized Signature: _____

Name and Title (Typed): _____

Date: _____