

# MERCER

Government Human Services Consulting

<b>Questions</b>	<b>Answers</b>
<p>1. What relationship does the Partnership envision between the Administrative Service Organization (ASO), Case Management, and Intensive Case Management systems?</p>	<p>The ASO would have a utilization management (UM) unit with <b>care managers</b> that conduct notification, prior authorization, and concurrent review. In addition, the ASO would have a dedicated intensive care management unit with <b>intensive care managers</b> that provide intensive management and oversight for the services of persons with complex disorders. Care managers and intensive care managers would not work directly with clients. The intensive care managers would use state-of-the-art techniques to identify individuals who require intensive care management (persons whose service profiles are outside of the expected range or persons who experience barriers to recovery), and manage their care to obtain better outcomes. It is expected that care managers would make referrals to the intensive care managers as necessary. The criteria to identify persons who require intensive care management would be developed by the ASO, with the participation, review, and approval of the Partnership.</p> <p>The Department of Mental Health and Addiction Services (DMHAS) has contracts with provider agencies for field-based case management services. <b>Case managers</b> work directly with adult clients to develop recovery oriented service plans. The Department of Children and Families (DCF) also has contracts with provider agencies for field-based case management services. However, the individuals who provide case management services for DCF are referred to as <b>care coordinators</b>. Case managers and care coordinators perform essentially the same function.</p>

Questions	Answers
	<p>DMHAS providers will manage access to their own case management services. However, when the ASO identifies an adult as needing case management services, that individual will be granted priority access to case management services within available capacity.</p> <p>Also, it is anticipated that when the ASO identifies a child or family that is in need of care coordination services, that child or family will be granted priority access to care coordination services within available capacity.</p> <p>The Partnership does not use the term <i>intensive</i> case management.</p>
<p>2. What access line response standards will the Partnership require?</p>	<p>For the purposes of responding to the Response for Information (RFI), respondents should assume general industry standards for telephone responsiveness.</p>
<p>3. What are the timely claims submission standards that will be required of providers? Also, please provide the standards that will be required for the timeliness of claims data for the trending of provider profiles and for mailing the Member Handbook that is required after eight sessions.</p>	<p>Requirements for timely filing of claims for different coverage groups vary. The Partnership is considering introducing uniform claims submission standards that would approximate industry standards. Medicaid currently allows 365 days while the General Assistance Behavioral Health Program (GABHP) claims submission standard is 120 days. Pending a decision by the Partnership to introduce uniform timely filing standards, notification and authorization data may be used to prompt Member Handbook distribution.</p>
<p>4. What is the claims vendor's file format flexibility regarding a provider file extract that will need to be uploaded to their system?</p>	<p>The claims vendor extract specifications are not available at this time. There is a standard extract file format. However, the claims vendor has some flexibility in customizing this format.</p>

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<p>5. Please specify the frequency with which Network Provider Profiling Reports will be required. What mechanism will be provided to the Behavioral Health Managed Care Organization (BHMCO) to retrieve the data warehouse information (i.e., extracts, linkage into the data warehouse)?</p>	<p>Provider profiling would be required annually. Utilization trends by provider, level of care, and region would be required on a monthly basis.</p> <p>The claims vendor will provide the BHMCO data extracts no more than twice per month to perform these and other requirements. The BHMCO may have direct access to the Department of Social Services (DSS) data warehouse with security provisions to meet the contractual and ad-hoc reporting requirements.</p>
<p>6. Will the claims vendor be required to be compliant with Health Insurance Portability and Accountability Act (HIPAA) authorization file record layouts (277/278) by the projected go-live date of July 1, 2003?</p>	<p>The ASO will be permitted to require that providers send requests in HIPAA authorization file record format. Although it is anticipated that the claims vendor will be able to accept electronic batch authorization files, they will not be in the HIPAA format. The specifications for batch authorization file transactions between the ASO and the claims vendor are not available at this time.</p>
<p>7. Will the eligibility feeds from DSS be HIPAA compliant (834) by July 1, 2003?</p>	<p>As an administrative agent of DSS, the eligibility feed from DSS to the ASO is not required to be HIPAA compliant. The eligibility feed will be in ASCII text file format. The file will contain multiple fixed length records.</p>
<p>8. The RFI indicates that two separate warehouses will be maintained by the Connecticut Behavioral Health Partnership (CTBHP), and that the BHMCO will be required to provide data feeds to (and download data from) both of those data warehouses. Is the data stored on these data warehouses mutually exclusive, or are they parallel data warehouses (i.e., contain synonymous information)? If the data warehouses are parallel, are the record layouts for the file extracts expected to be</p>	<p>The data on both warehouses are not mutually exclusive, and the warehouses are not parallel. Assume for the purposes of this RFI that the record layouts are different.</p>

Questions	Answers
synonymous or different?	
9. What behavioral health services are provided by home health agencies?	<p>Home health agencies provide skilled nursing visits for the purpose of medication administration and behavioral or psychotherapeutic interventions to improve or maintain client functioning. These <u>and other</u> behavioral health services provided to Medicaid Fee-for-Service (FFS) enrollees have not been managed; thus they are not well understood with respect to their role and contribution to overall client functioning and recovery. The ASO will provide the experience necessary to better manage and coordinate all behavioral health services.</p>
10. Please clarify the relationship between the regional managers to be hired by the BHMCO and the ongoing responsibilities of DMHAS's Local Mental Health Authorities (LMHAs). An accurate understanding will assist the BHMCOs establish appropriate job classifications for these staff.	<p>The regional managers to be hired by the BHMCO will have separate roles and responsibilities from the LMHAs. These regional managers will serve as direct agents of each of the Departments (DMHAS and/or DCF). The regional managers will work directly for the ASO in conjunction with the Partnership to direct and manage the quality of the behavioral health system. Candidates should possess:</p> <ul style="list-style-type: none"> <li>▪ strong leadership in developing an effective behavioral health system,</li> <li>▪ familiarity with the managed care environment,</li> <li>▪ experience with best practices and treatment, and</li> <li>▪ proven operational ability and acumen.</li> </ul> <p>The Partnership will participate in the review of the candidates.</p> <p>It is anticipated that these individuals will interact on a daily basis</p>

Questions	Answers
	with senior and executive management within the provider network and within the Departments.
11. Does state law allow the CTBHP to hold BHMCO responses to the RFI confidential during the ensuing procurement process, or should BHMCOs responding to this RFI take additional steps to assure that their responses are handled as proprietary information and are not available to competitors? If additional steps are required, please provide the appropriate citations in the State code.	In general, responses to the RFI questions will be public information. However, Connecticut regulations (CGS Section 1-210 (5)) do exempt information, such as trade secrets and commercial or financial information, given in confidence. If the respondent would like any information that is provided as a response to the RFI to be exempt from disclosure, the respondent must so indicate by line or section and provide a justification for each for consideration by the State. The State will make the final decision as to whether such information shall be released.
12. Are there any restrictions that would prohibit a BHMCO from authorizing services that their organization provides as a direct service?	This may present a conflict of interest, but might be considered if sufficient safeguards were in place. Respondents are encouraged to propose a plan that would address this issue.
13. Please confirm the number of covered lives in the GABHP. The figure of 22,000 appears low. While that figure might reflect the number of persons eligible in a given month, our experience is that the General Assistance programs has many members adding and dropping each month (including retroactive eligibility decisions), such that the number of unduplicated persons eligible in a given 12 month period is likely to be much higher than 22,000; although the average number of persons in any given month might be around 22,000.	The average number is 22,000, and membership does change throughout the year. The unduplicated count of persons eligible in State Fiscal Year 2002 was 47,742. This number is particularly large because, unlike Medicaid, there is no continuous eligibility requirement for the GABHP program.
14. Item F3 in the RFI asked, “what type of shared risk, modified risk, or alternative funding arrangements would your organizations consider?”	

<b>Questions</b>	<b>Answers</b>
<p>14a. Please describe in more detail the type of risk arrangements being contemplated in this item. Specifically, are you exploring the option of creating a risk-based contract for the BHMCO for:</p> <ol style="list-style-type: none"> <li>1. Claims targets (e.g., a per member per month (PMPM) medical expense target with penalties for higher utilization and incentives for lower utilization).</li> <li>2. Performance targets (e.g., meeting implementation targets, speed to answer, etc.): <ul style="list-style-type: none"> <li>▪ will both penalties and incentives be acceptable in risk arrangements; and</li> <li>▪ will there be upper and/or lower limits set on penalties or incentives?</li> </ul> </li> </ol>	<p>The contract is planned as an ASO contract. The CTBHP is interested in exploring shared risk arrangements without a specified preference. Both of the items you list would be of interest to the CTBHP. Under an ASO arrangement, it is likely there would be upper and lower limits.</p> <p>The Partnership would like to receive proposed incentive and risk arrangements in the following areas:</p> <ul style="list-style-type: none"> <li>▪ access,</li> <li>▪ decreased reliance on institutional care,</li> <li>▪ development of additional, community-based services,</li> <li>▪ development of networks that provide access to psychiatric and medication management,</li> <li>▪ recruitment and retention of non-traditional care providers, and</li> <li>▪ innovative approaches to outlier management.</li> </ul>
<p>b. Will you provide additional utilization details on fee schedules and per diem rates, length of stays, admissions per thousand by level of care, and trend data for the last three to five years? If this is not available for the RFI, will this be available for the Request for Proposal (RFP)?</p>	<p>Additional information is not available for the RFI. CTBHP anticipates that much of this information would be available if an RFP is issued.</p>
<p>c. Will there be capital reserves or line of credit requirements for the</p>	<p>Yes. However, the specific dollar amounts will depend on the</p>

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risk-based arrangements? If yes, what are the likely dollar amounts for such requirements?	overall contract cost, extent of risk, and associated limits.
15. Will the responses to the RFI be subject to “Freedom of Information (FOI)” reporting? If yes, will FOI requested information be released prior to completion of the full RFP process? Can we mark certain financial and operational responses to the RFI as “confidential” and/or “proprietary” to exempt these responses from FOI requests?	See response to question 11.
16. One of the key variables in determining the correct level of staffing for clinical, claims, and UM is the access rate for each level of service. Will more utilization data that includes access and volume become available?	See the response to question 14b.
17. Can Mercer clarify what is meant by "Hypothetical enrollment and expenditure" in appendix A? Can we use the PMPM derived from this exhibit as a starting point for claims payment?	Detailed utilization and claims experience by category of aid was not available at the time the RFI was released. The information in the RFI is an estimate of claims costs. Yes, it is intended to be the starting point for your cost analysis.
18. What are the eligibility requirements for the GABHP and Voluntary Services?	Eligibility for GABHP is granted under the State Administered General Assistance/General Assistance medical assistance regulations. Access to this program is income and asset tested. Eligibility for the Voluntary Services Program is clinically tested based on demonstrated complex or intensive behavioral health service needs.
19. Are there other companies responding to this RFI and if so, whom?	The RFI was issued publicly and as a result, multiple responses are anticipated. Mercer did not require letters of intent to submit a response to the RFI, so we are uncertain how many other companies will respond.

<b>Questions</b>	<b>Answers</b>
20. Does the CTBHP plan to have a bidders conference or conduct interviews?	Not for the RFI.
21. What is the anticipated duration of the contract?	Three to five years.
22. Are penetration rates by Coverage Band available?	Not at this time.
23. What is the proposed connectivity mechanism to the data warehouse?	At this time, the Partnership is proposing that the ASO would be provided with direct, real-time access to the DSS data warehouse for reporting purposes. It is anticipated the DSS data warehouse will contain complete claims data for all services subject to authorization by the ASO.
24. Is the CTBHP open to performance incentives?	Yes. See the response to question 14.
25. Page 5 — Regarding additional services for children: If services are added, will the BHMCO still only authorize care coordination? Or, will the BHMCO role be expanded?	At the start of the contract, the BHMCO would authorize care coordination. As child rehabilitation services are converted to the Medicaid plan under the rehabilitation option, the role of the BHMCO would be expanded to include the administrative services listed on pages 5 through 9 of the RFI. Accordingly, the pricing table allows respondents to price these services separately.
26. Page 5 — Regarding additional services for adults: Is it correct that the BHMCO will not manage any of the additional services included for adults?	DMHAS will manage access to case management services. As other adult rehabilitation services are added to the Medicaid plan under the rehabilitation option, the role of the BHMCO would be expanded to include the administrative services listed on pages 5 through 9 of the RFI. Accordingly, the pricing table allows respondents to price these services separately.
27. Page 8 — Regarding prior authorization for acute IP 24/7: Is a call center located outside of the State acceptable to handle after-hours	This may be acceptable, though not preferred. The State would also consider non-traditional/creative, local options for addressing

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prior authorizations?	this requirement.
28. Page 9 — Regarding 24/7 crisis call management: Same issue as previous question. Is a call center located outside of the State acceptable to handle 24/7 crisis call management?	This may be acceptable, though not preferred. The State would also consider non-traditional/creative, local options for addressing this requirement.
29. Page 9 — Regarding 24/7 crisis call management and claims processing: Are these two services separate from each other? Or, is the State interested in claims processing only for crisis call management services?	They are separate. Separate pricing for these services is requested under question F 11 in the RFI.
30. Is this RFI intended to be the first stage of a public procurement process, which will include a formal RFP at a later date?	RFI responses will be used in planning. It is not intended as a two step process.

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