OPASS 20-18319 ASO for the PBHS
Pre-bid Conference
Q&A
12/18/2018

Comment	Department Response
Due to the holiday (Martin Luther King Day, 1/21/2019), would the department be amenable to postponing the RFP closing data to 1/25/2019?	Yes. Following internal discussion the new closing date will be **Thursday, January 31st at 2pm**. This will be communicated in an update.
Does the state have a preference for a former vendor of their service?	No. The State does not have a preference. As shared during the pre-bid meeting, while this contract retains some existing services it also moves towards incorporating the needs identified by providers and stakeholders and is looking for innovative approaches to the behavioral health system. Additionally this is an opportunity for the State to be open to technological advances and further national expertise on a wide range of issues impacting the PBHS.
What new service or supports are you looking for that are not currently being delivered under the contract in place at this time?	This contract contains project specific information including managing the Health Homes, lab utilization, and other updated programs under the Special Projects section of the RFP. As shared in the conference based on feedback from providers, the State is interested in very robust provider relations team that is well versed in Maryland specific knowledge and in general, the Department will work closely during the implementation period focusing on streamlining provider and recipient responsiveness through the ASO. In addition this contract has unique opportunities to implement a value based purchasing system that may be designed with the Department as well as other optional projects and services which are listed in the RFP.
Regarding 2.3.11: Special Projects/ New Initiatives. What is the technology supporting these applications? (Assuming these are owned by the state and continue through the new contracting period) o Some kind of survey forms? o Web applications/ workflows?	It's not clear from this question which of the special projects are being referred to, however, unless specifically cited, these would be developed and obtained by the contractor. For example, under the Health Homes, there are specifications / requirements that need to be incorporated to reflect a workflow similar to MDH's existing eMedicaid, but other than the specs, this would be built by the contractor in collaboration with MDH. Other such specialty designed would need to be configured into the Contractor's system and could be modified based on the Contractor's experience in other markets and expertise. **Please feel free to add more detail to this question within 5 days of this posting so we can be sure to add to our responses expeditiously.**

Regarding Section 5.2.9. 6.2 indicates a desire for resumes of key personnel. It will be a challenge for any entity other than the incumbent to hire key personnel for a prospective contract. Will MDH accept position descriptions and/ or recruitment process in lieu of resumes?	Yes. At the time of submission job descriptions would be appropriate as well as the recruitment process. Once recruited, resumes would need to be made available to the Contract Monitor prior to a final offer by the contractor.
Regarding pg. 25, 2.3.41. For individuals without Medicaid eligibility, is an automated workflow to determine eligibility available today and available to any selected vendor?	No, this would be part of the design/build to accommodate an uninsured workflow process. The Department was part of the original design of this process but any vendor that does not currently have this built in would need to make accommodations to incorporate such a workflow.
Regarding pg. 12, 2.3 C- Manage a seamless system of care for eligible individuals regardless of payer Who will provide and how often will the eligibility for the non-Medicaid participants be updated? Is there a standard file format for each funding source?	Medicaid eligibility is updated nightly. For the uninsured eligibility: The ASO is required to set up a workflow for the providers for uninsured registration with a set of eligibility criteria questions developed by the Behavioral Health Administration that trigger the automated approval/denial of uninsured eligibility based on the data input. The system must also include an ability to override the uninsured registration process to create uninsured spans for individuals that are denied uninsured eligibility but for which the BHA or its agent has made an exception (exception process).
Regarding pg. 24, 2.3.4.1. For after hour call center services including authorizations, can non-Maryland licensed physicians and clinicians be used for both mental health and SUD authorizations?	Yes, for after-hours, non-Maryland licensed physicians and clinicians may be used for reviewing medical necessity but all determinations must be based on Maryland's MNC criteria.
Regarding 2.7.5.13. How critical are the Mars-E 2.0 requirements for this contract? Per NIST 800-53 rev 4, if a system is classified as moderate and has decent security policies in place, would that be acceptable?	*This question is unable to be resolved prior to publishing the initial minutes but will be included in the follow up posting of questions that were submitted for Q&A.*

Regarding 2.3.9- Claims processing- 2.3.9.m.14- claims payment history. Is it sufficient to house the data in a data warehouse/ data mart for reporting purposes or should that be available in a transactional data store?	Claims with service dates in calendar years 2018 and 2019 will need to be uploaded to the transactional system. The entire history will need to be housed in a data warehouse/data mart for reporting purposes.
When will answers to the questions be posted?	Questions asked at the pre-bid conference will be posted by December 28, 2018. Questions submitted electronically will be answered as soon as possible. MDH is extending the time for additional questions to **January 4th, 2019 by 2 p.m**. See attached Addendum #1
Do you have an established timeframe for the award?	This depends on the volume and complexity of proposals. Ideally the award will be made by June 2019.
For the Consumer Perception of Care survey it looks to be quantitative, the provider looks to be open in terms of the methods. Are you open to various methods for both? 2.3.7.2 Evaluation: As I understand the proposal, the consumer satisfaction survey is described as a quantitative survey while the methods for the provider evaluation are left open and could include multi-methods procedures. If I am correct that combined qualitative and quantitative data collection (multi-methods) could be proposed for the provider evaluation? Could qualitative methods also be added to the survey for the consumer survey?	Yes, MDH is open to the method of data collection and capture but will need to be similar in some regards to past collections for continuity of data. Past examples will be shared and the formation of the CPOC will be collaborative.
Several components that involve working with DORs, Ticket to Work. What about DDA given dual diagnosis. Can you talk about collaboration and what MDH is doing to ensure that these	MDH maintains staff to work with DDA representatives surrounding issues of mutual concern to both administrations. If the ASO were to experience concerns related to actions taken by any other administration that would impact the contractor's ability to meet performance measures of their contract with the Department, these would be

partners are working with the Contractor make things happen within timeframes? (Clarified by email): Activities involving DORS, DDA and ticket to work: Several activities described in the RFP involve collaboration with DORS and other agencies associated with ticket to work. Given significant levels of dual diagnosis for the IDD population, DDA cases are likely to be involved as well and interface with DDA and its provider agencies may be necessary. DDA would also be involved with the autism spectrum activities, both for children and as participants transition into the adult system. Please clarify how MDH would facilitate the relationships between the contractor and these entities and how outcome measures would be interpreted if waiting lists or other issues with DORS, DDA or social security impact on results?	brought to the attention of the MDH Contract Monitor who would work with the relevant MDH staff to identify a viable solution.
Because there is federal funding, there is a regulation that says 7% of staff at all levels have to have disabilities. What does the Department intend to do to monitor that? This question was further clarified via email: Federal disability staffing goals: Since this project uses federal funds, contractors hired for this project would be subject to Rehabilitation Act Section 503 2014 regulations which established a goal that federal contractors employ people with significant disabilities as 7 percent of their workforce in each job category, from professionals and managers to low	The Rehabilitation Act Section 503 2014 https://www.dol.gov/ofccp/regs/compliance/factsheets/NewRegsFactSheet_QA_508c.pdf pertain to federal contractors and subcontractors. MDH contractors are neither, so the regulation does not apply.

skilled manual or service workers. Subcontractors could fulfill this goal. How would MDH ensure that their contractors meet the federal guidelines in their hiring or contracting for the project? Is this a criteria that could be added to the RFP or contractors made aware of this as part of the amendments?	
Section 2.3.9 is not clear on whether MDH or the Contractor owns the bank accounts.	MDH owns the bank accounts. The money for claims payment is replenished by the State Controller's Office weekly from the state funded account.
With federal money being involved, is there no DBE requirements?	The State does not have a Disadvantaged Business Enterprise program.
Incumbent contractor: Could you please clarify if a contractor is currently performing some of the activities in this RFP for the state? If so, is it possible to name the incumbent firm?	The current vendor is Beacon Health Options. The primary components of this contract are currently being performed for the State: Provider Management and Maintenance; Participant Relations; Registration, Authorization and Utilization Management; Participant and Provider Assistance and Communication; Quality Management and Evaluation; Eligibility; Claims Processing; and Special Projects/New Initiatives.
Will the attendee list be published?	We plan to have it published by December 28, 2018 along with the minutes

Section #	RFP PDF Page #	Question	
Key Information Sheet	3	Given the numerous State of Maryland and Federal holidays falling throughout the RFP timeline, would MDH consider extending the proposal due (closing) date to January 31, 2019?	Yes. MDH has extended the closing date to January 31st, 2019 at 2pm. See attached Addendum #1

Section #	RFP PDF Page #	Question	
2.3.2.3.L	16	Can MDH clarify the frequency of required on-site training to new providers?	Most training can be accomplished via webinar, but some providers/programs require more hands on assistance. There is not a clear number of programs needing on-site training on the vendor's system, but a robust webinar training design should keep this to a minimum.
2.3.2.6	20	Regarding the provider manual, can MDH please clarify what training materials, SOPs and FAQ's will be provided?	MDH owns all information pertaining to the system currently. All service, policy and reimbursement information would be transferred but contractor specific directions (registration, claims payment etc) would be unique to the contractor's system and would need to be ready for go live, and updated frequently. Separately, contractor needs to have a system that is able to be nimble in making updates or changes within a reasonable time frame.
2.3.5	General	Can MDH provide the 2017 and 2018 monthly call volume for participants and providers?	Yes, we will provide this information in a follow up Q&A document.
2.3.5	General	Can MDH provide the 2017 & 2018 average hold time (AHT) of calls?	Yes, we will provide this information in a follow up Q&A document.
2.3.9	General	Would MDH allow claims to be processed by staff in Puerto Rico?	It is the opinion of the Office of the Attorney General that Puerto Rico is an Island in the Caribbean and not part of the Continental United States.
2.3.9 C-G	36	It's not clear whether the state or the Contractor owns the bank accounts from which the claims expenses are paid. If the contractor owns the bank accounts, what is the timing of reimbursement for the claims expenses?	MDH owns the bank account and the account is replenished weekly from the Maryland State Treasurer's office.

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2.3.9.M.11	37	Please clarify the Contractor's responsibility regarding pharmacy claims. Is the Contractor required to pay claims or just house the data for reporting purposes?	The Contractor houses the data for reporting purposes but does not pay pharmacy claims. There are exceptions to pharmaceutical services (office based injections for example) that are carved out of pharmacy but these are reimbursed under CPT or H codes that already exist.
2.3.9.M.14.	37	Is it sufficient to house the data in a data warehouse/DataMart for reporting purposes?	This question may need to be more specific. See the question above about transactional data versus stored (reportable data).
2.3.9.M.15.	37	Is MDH expecting to send the claims files in other than HIPAA/EDI 837 format? If so, can you elaborate or provide structure of the claim file format?	For Medicaid claims that is the format. The contractor's system will need to be able to accommodate non-Medicaid claims that would have a format defined by MDH. This would be detailed during implementation.
2.3.9.M.24.	38	Who will submit claims using MDH's Maryland Medicaid Electronic Exchange (MMEE) web portal? Is this related to 837I or 837P? Will the State be able to accept 837I or 837P as file?	The Contractor submits all claims into MMEE. Yes the State accepts the 837I and 837) files. The Contractor pays claims from the State bank account to the providers then submits adjudicated claims to MMIS through the portal for Medicaid eligible claims to obtain Federal Match.
2.3.9.M.23 & 26	38	As the SLAs mentioned in these sections are directly/indirectly are related to number of claims processed per day, are there any peak loads in terms of number of claims proceed per day or week. (Reference Section#: 2.3.9.M.39)	In FY 18 the number of claims processed is about 15 million in Behavioral Health and an additional 65,000 in ABA claims. 1.5 to 2 percent of claims are processed by paper. The balance of the question will need to be answered in a follow-up Q&A due to need to internal discussions.
2.3.9.M.30	38	Please clarify the Contractor's responsibility for adjudicating cross-over claims.	None – the Medicaid program performs the adjudication for Medicare cross-over claims, but the Contractor may have a role in the submission or review process related to cross-over claims.

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2.3.9.M.39	38	Please confirm that 14.3 million is the total number of claims processed in FY 2017. Do you expect an increase in the number of claims per year beyond 14.3 million with the several new programs/initiatives introduced in this RFP?	The 14.3 million is what processed in FY 2017. Higher claims volume would be expected to occur. However this could also change based on CMS changes in payment and the Department's efforts to work on aligning payment systems.
2.3.9.N.1	39	What is the process for notifying the Contractor when an emergency petition has been filed for a Non-Medicaid claim?	This process is developed and will be identified during implementation but basically requests for coverage will come from the BHA or its designee and entered into an authorization system to be paid under state only dollars.
2.3.10.2	44	Please clarify what is meant by "augmentation in coding to differentiate whether the services performed individually and collectively equate to an evidence-based and/or promising practice".	In general terms this would refer to a modification code that would be an indicator that the service performed meets the EBP criteria and therefore may be reimbursed at a higher than standard rate. There is an existing process for this but also will be developed in conjunction with the BHA.

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2.3.11	46-62	With respect to the special projects/new initiatives listed in Section 2.3.11, will MDH please provide additional information on the timeline for these projects, the process for how MDH and the Contractor will work together to develop a project and implementation plan, and how the Contractor will be compensated for these projects?	These projects already exist either under the existing contractor or under MDH and have MDH designated staff support for the integration of these services under the new contract for developing the unique aspects of each program. The current provider manual has explanations of the existing projects and for projects such as the Health Homes, Medicaid has specifications, policy and reimbursement documents for integrating under the new contract. An implementation period of at least 4 months (September to December 2019) will address the specifics of implementing these projects. None are brand new to the Department. All projects need to be ready by go live of 1/1/2020 staffing and management of these projects should be included in the overall PMPM rate development and may also be included in the state only dollar benefit.
2.3.11.3	49	Is the OMS system owned by MDH and will it be made available to the awarded Contractor or is the awarded Contractor expected to build a comparable system?	The questions that make up the OMS will be made available to the contractor and the design will be a collaborative effort that may include the Department as well as stakeholders in the design. Changes in the questionnaire are necessary and will be part of the implementation period. This is a collaborative process.

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2.3.11.7	53-54	Can MDH provide additional information regarding the Emergency Psychiatric Care for Adults program?	Maryland was awarded a Psychiatric IMD demonstration project for 5 years. That program was not renewed by CMS. However, there is renewed interest in the program and it is anticipated that it may become a benefit for individuals in need. There already exists a model for this program in Maryland, therefore the intent of this instruction was to have flexibility in the design of the system to support this project's potential revitalization. In the interim, Maryland will likely be permitted to cover co-occurring SUD and psychiatric diagnosis in psychiatric hospitals, which is similar in the benefit design.
2.5.2	67	What type of data is expected to be interfaced? Ex: Claims, Participant Demographics or Provider Data?	2.5.2 MD THINK is still under development but likely would be patient demographics. It would not be used for claims data within the scope of this contract.
3.4.2	77	What is the average monthly cost of liquidated damages under the current contract?	Currently the most common liquidated damage results from missed call center metrics. The current assessment is 5% of the monthly invoice. A recent invoice reduced the payment by approximately 16k. MDH can provide total number of missed metrics and associated costs to the contract in the next update.

Section #	RFP PDF Page #	Question	
3.7.5.D	87	If a system is classified as Moderate and is gearing towards HiTrust Certification and has been implemented to support various government/Medicaid contracts, would that be acceptable? How critical is it to have the system tested and documented to be compliant with MARS-E Version 2.0 requirements.	*This question is unable to be resolved prior to publishing the initial minutes but will be included in the follow up posting of questions that were submitted for Q&A.*
3.8.3	89	Would MDH consider altering the PEP delivery of 10 business days after notice of recommended award?	There are certainly some items that would be difficult to capture directly after contract award. Would you please send your recommendations to the Department so that we can provide full consideration?
3.9.2.A	90	Our platform is deployed on Amazon Web Services (AWS) cloud and AWS will be providing 6 month coverage report with a 6 month bridge letter. Please confirm that this arrangement is acceptable. From the application and business control perspective we are planning to provide the 12 month report.	*This question is unable to be resolved prior to publishing the initial minutes but will be included in the follow up posting of questions that were submitted for Q&A.*

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5.2.9.G.2	119	In order to foster open and equitable competition for non-incumbent vendors, will MDH allow position descriptions rather than the names/resumes of those hired for key positions? The ability to substitute position descriptions is important because: • the proposal response period does not provide adequate time to recruit qualified candidates; • many top candidates will not consider a job until the contract is awarded; and • many candidates will not allow their names to be included in a public proposal because they are unwilling to put their current job at risk for a position with a prospective awardee.	Yes this is a reasonable expectation. Names of key positions and a full organizational chart would need to be furnished to the contract monitor 30 days prior to the Contract Go-Live date with confirmation of accepted positions. Please note that key, confidential information is not part of the public proposal. Although they may be included for the evaluation team, the contractor bids are significantly redacted to ensure privacy and proprietary protections.