ADDENDUM #1

STATE OF LOUISIANA
DIVISION OF ADMINISTRATION
OFFICE OF GROUP BENEFITS (OGB)

NOTICE OF INTENT TO CONTRACT (NIC)
FOR
ADMINISTRATIVE SERVICES ONLY (ASO)
FOR

HEALTH MAINTENANCE ORGANIZATION PLAN (HMO)

AND

PREFERRED PROVIDER ORGANIZATION (PPO)
AND

HIGH DEDUCTIBLE HEALTH PLAN (HDHP)
WITH HEALTH SAVINGS ACCOUNT (HSA)

AND

LACHIP AFFORDABLE PLAN (LACHIP)

ISSUED
MAY 22, 2012

SECTION I REVISED
GENERAL INFORMATION:
INSTRUCTIONS OF PROPOSAL FORMAT / CONTENT

A. Instructions on Proposal Format

All Proposals must be prepared in accordance with the provisions of this NIC. Proposer must agree to meet all requirements as delineated in the Requirements Section below.

Proposers should respond thoroughly, clearly and concisely to all of the questions set forth in the NIC. Answers should specifically address current capabilities.

1. Submit an original (clearly marked "original"), a redacted copy, and ten (10) copies of a completed, numbered proposal placing each in a three-ring binder. Please include a copy of the proposal response in CD format with your "original" version.

2. Use tabs to divide each section and each attachment. The tabs should extend beyond the right margin of the paper so that they can be read from the side and are not buried within the document.

3. Order of presentation: (include in 3 ring binder)

   Cover Letter & Executive Summary

   Your Executive Summary should not exceed three (3) pages. Please highlight in your Executive Summary what sets you apart from your competitors and state the reason(s) you believe you are qualified to partner with OGB.

   Tab 1 - Confirmation of Cost Requirements
   Section I

   Tab 2 - Confirmation of Program Requirements
   Section I

   Tab 3 - Audited Financial Statements
   Section 1

   Tab 4 - Membership Satisfaction Survey
   Section I

   Tab 5 - Management Reports
   Section I

   Tab 6 - SAS-70/SSAE-16 Type II Audit Report
   Section I

Tab 7 - HMO/PPO/LACHIP – Requirements/Questionnaire
Section III

Tab 8 - HDHP w/ HSA – Requirements/Questionnaire
Section IV

Tab 9 - Disease Management – Requirements/Questionnaire
Section VI

Tab 10 - Proposer Information
Section VIII

Tab 11 - Mandatory Signature Page
Section IX

Tab 12 - Administrative Fee Quotation Form
Section X

Tab 13 - Provider Network – Hard Copy List and CD
Section III and Appendix A-8

Tab 14 - Re-Pricing Claims CD (Health Plans/MHSA)

Tab 15 - Disease Management CD – Savings Methodology

Tab 16- GANTT Chart

Tab 17 - MHSA – Requirements/Questionnaire
Section V

SECTION II REVISED
SCHEDULE OF EVENTS

A. Timeline

NIC Issued - Public Notice by Advertising in the Official Journal of the State/Posted OGB Website/Posted to LAPAC	Monday, April 30, 2012
NIC Mailed or Available to Prospective Proposers Posted to OGB Website; Posted to LAPAC	Monday, April 30, 2012
Deadline to Notify OGB of Interest to Submit a Proposal (MANDATORY)	Monday, May 7, 2012
Electronic Data Sent to Interested Proposers	Wednesday, May 9, 2012
Deadline to Receive Written Questions	Tuesday, May 15, 2012
Response to Written Questions	Friday, May 18, 2012
Proposer Conference- Attendance in Person (MANDATORY)	Tuesday, May 22, 2012
Deadline to Receive Additional Written Questions	**Tuesday, May 29, 2012**
Response to Additional Written Questions	**Friday, June 1, 2012**
Proposals Due to OGB	**Monday, June 11, 2012**
Finalist's Interviews/Site Visits	TBD
Probable Selection and Notification of Award	TBD
Contract Effective Date	TBD

NOTE: OGB reserves the right to deviate from this schedule.

SECTION V - REVISED
MENTAL HEALTH AND SUBSTANCE ABUSE
ADMINISTRATIVE SERVICES AND QUESTIONNAIRE

Contractor will provide a Managed Mental Health and Substance Abuse Program for OGB plan members that participate in its PPO, HMO, HDHP/HSA and LaCHIP Affordable Plan of benefits. This program should be integrated within the contractors medical program and be compliant with Mental Health Parity legislation. Program will include both in and out of network benefits.

Contractor will be responsible for providing and managing MHSA benefits through a network of providers and services to provide effective treatment and outcomes. In order for a plan member to receive full benefits, he or she must utilize the network for initial assessment and counseling as well as for ongoing MHSA treatment, both inpatient and outpatient. Contractor will provide all professional, technical, and administrative services in connection with the MHSA benefits, including, but not limited to, medical management, medical necessity reviews required under applicable laws and regulations, care management, claims adjudication and payment, customer services, and provider relations.

Contractor shall administer medically necessary managed mental health and substance abuse treatment services which are integrated within OGB's overall plan of benefits, subject to the deductibles, copayments, co-insurance, limitations, and exclusions set forth therein.

A. General

1. Please provide an overview of your proposed MHSA strategy for OGB participants in lieu of Mental Health Parity legislation.

2. How have you helped other employers manage their MHSA utilization while adhering to Mental Health Parity requirements?

3. Please provide how Mental Health Parity has impacted your clinical management on both outpatient and inpatient clinical protocols?

4. Indicate any accreditations you currently hold SPECIFIC to your Behavioral Health/ Substance Abuse program.

5. Do you provide all Behavioral Health/ Substance Abuse services internally or are any services subcontracted? If you subcontract all or some of your Behavioral Health/ Substance Abuse services, please specify the service and vendor(s).

6. What are minimum credentials of staff on 24-hour intake/admissions line?

7. What is the percentage of cases reviewed by the medical director?

B. Services

1. As it applies to your intake and assessment process, please address the following in your response: Live answer vs automated, Credentials of person responding, Does one person handle all presenting issues?, If treatment referral is warranted, are names of clinicians given out (how many) or does "intake person" call for member to make an appointment?

2. Please provide inpatient and outpatient utilization statistics for your managed behavioral health services over the last two years. Please provide the average number of visits per treatment episode for each category below?

    a. Mental Health Inpatient
    b. Substance Abuse Inpatient
    c. Mental Health Outpatient
    d. Substance Abuse Outpatient

C. Communications

1. How do you propose to educate plan members and their dependents about the plan and your services? Describe the approach you would use for initial and ongoing communication.

2. a. What communications materials do you propose to provide to plan members and OGB staff and how often?

    b. Keeping in mind that OGB will have final approval, please provide samples of initial and ongoing communication materials you would suggest.

3. You must agree to make appropriate members of your organization available to meet with OGB staff, employee groups, etc. as needed and agree to attend meetings of the OGB Policy and Planning Board and its committees, as requested.

4. What website capability is available to members? Please provide information necessary to access a demonstration website (i.e. URL, logon ID, password).

D. Intake and Member Services

1. For the following services, list the days and hours of accessibility as well as staffing information, i.e. who answers the phone and their qualifications.

a. Intake and Referral/crisis line
b. Provider relations
c. Member service
d. Utilization review

2. Do you use an automated attendant to route callers? If yes, how many choices is the caller offered (i.e. buttons to press) before speaking with a live staff member? Can you customize the auto-attendant message for OGB?

3. How do you handle after hours and weekend emergency calls? Who handles the calls and what are their qualifications?

4. Describe the screening and referral process starting from the moment the patient contacts you. Provide a flow chart.

5. For a typical, non emergency assessment/referral call, what information is taken over the toll free line and by whom?

6. When calls to member service require transfer to a licensee clinician, do you transfer callers to voicemail or to the clinical queue – If to the clinical queue, what is the average wait time in queue to access a licensed clinician?

7. a. Indicate your standard business hours and days:
DAYS:
HOURS:
b. Indicate your "after" hours and days:
DAYS:
HOURS:

8. Provide the average time from a call being answered to a referral being given for both emergency and non-emergency assessment calls.

9. You must agree to maintain a sufficient number of toll-free lines which may be accessed by plan members on a 24-hour basis for emergency crisis intervention. A sufficient number of toll-free lines must be maintained to provide access during regular business hours for routine assessment and referral and for general questions. Describe how you plan to accomplish this for OGB.

10. Describe how you would handle urgent, emergent and calls requiring crisis intervention such as a threat of suicide or violence.

a. How call will be triaged to an appropriate clinician and then to an appropriate network resource?
b. List of risk screening questions that staff is required to ask?
c. Follow-up to assure member reaches and is seen by network resources to resolve crisis and appropriate intervention.

d. Indicate the qualifications of the person managing this call.

11. Describe any automated patient registration and referral technologies that your organization has available for members which will enhance access to services.

E. MHSA Provider Network

1. Address each of the following issues separately:

    a. Guidelines and software used for determining a cost-efficient provider
    b. Minimum requirements for practitioner and facility malpractice and liability insurance
    c. Methods for evaluating quality of care
    d. Profiling or metrics reported to network providers and facilities to provide feedback on performance.
    e. Any initiation, processing, or ongoing fees paid to you by providers in order to participate in the network.

2. Do you visit provider offices

    A) prior to credentialing or as part of re-credentialing?
    B) If yes,
        a) what percentage of network providers in Louisiana had a provider office visit,
        b) what are the criteria for deciding who will receive an office visit
        c) what are criteria reviewed when the office visit is made?

3. How large is your network? Provide the total number of providers for each category below.

Psychiatrists	
Masters level clinicians	
PhD level clinicians	
Nurse practitioners	
Facilities	

4. Provide number of specialists in your network for the following areas of practice.

Chemical Dependency	
Child/Adolescent Disorders	
Eating Disorders	
Family Therapy	
Marital Therapy	

Mental/Nervous	
Stress-related Disorders	

5. Describe specifically your process for removing, penalizing, or warning/counseling providers who do not meet performance and/or quality standards.

6. Does your provider contract contain language which requires the provider to comply with Utilization management and quality management protocol/procedures?

7. What qualifications are required of your in house professional staff? Describe by practice and provide information on required continuing education.

8. Please describe your standards and protocols for monitoring provider practice patterns, treatment outcomes and telephone responsiveness. Is there a profiling system for MHSA practitioners? If yes, briefly describe. Is profile data available to members? Indicate how profiling information is used in monitoring and improve quality.

9. With respect to your current book of business, describe current utilization in terms of:

	MH	SA		Combined
		Rehab	Detox	
a. IP Admits/1,000 members				
b. Inpatient days/1,000 members				
c. Residential admits/1000 members				
d. Res days/1000 members				
e. Partial Hosp admits/1000 members				
f. Partial Hosp days/1000				
g. IOP admits/1000				
h. IOP visits/1000				
i. Outpatient encounters/1,000 members				
j. Emergency Visits/1,000 members				
k. Avg paid claim rate per IP acute care day				
l. Avg paid claim rate per 90801 procedure				
m. Avg paid claim rate per 90806 procedure				

n. Avg paid claim rate per 90862 procedure				

F. Quality Management

1. What quality improvement and performance monitoring activities do you practice in order to ensure member access and quality customer service? (check all that apply)

	Check all that Apply
Audit Complaints	
Audits of intake records	
Average speed to answer	
Call abandonment rate	
Member satisfaction surveys	
Peer evaluation – staff pose as members	
Supervisory monitoring of calls	
Other, please specify:	

2. Briefly explain how you monitor treatment outcomes to ensure program effectiveness.

3. What performance standards must your providers adhere to for:
Urgent appointments (timeframes)

   1: 0 to 8 Hours,
   2: 8 to 12 Hours,
   3: 12 to 24 Hours,
   4: 24 to 48 Hours,
   5: Greater than 48 Hours

4. What performance standards must your providers adhere to for:
Routine appointments (timeframes)

   1: 1 to 2 weeks
   2: 2 to 3 weeks
   3: 3 to 4 weeks
   4: 4 to 6 weeks
   5: 6 to 8 weeks
   6: Greater than 8 weeks

5. How often are your members asked to complete your standard Member Satisfaction survey?

   1: Annually,
   2: Semi-annually,
   3: Quarterly,
   4: Monthly,
   5: Members are not solicited on a regular basis

6. Do you include stakeholders, such as members, providers in a formal way to evaluate the quality of your services?

7. Please provide your target and actual 30-day inpatient readmission rate:

Target	
Actual	

8. Do you provide ongoing review of advancements in clinical practice? If you provide ongoing review of advancements in clinical practice, please describe what you do with findings.

   1: Yes [describe]
   2: No

9. Do you provide clinical practice guidelines to your providers?

   1: Yes,
   2: No

10. What is the percentage of denials by level of care (Denials/Authorized episode)?

Inpatient	
Residential	
Partial	
IOP	
Outpatient	
Percentage of denials appealed	
Percentage of denials overturned	
Percentage of denials overturned by state order	

11. Do you have mechanisms in place for coordinating the care of your members with co-morbid conditions? If you have mechanisms in place for coordinating the care of your members with co-morbid conditions, please describe your protocol.

1: Yes [describe]
2: No

12. Do you have a post hospitalization follow-up program for high-risk members? If you have a post hospitalization follow-up program for high-risk members, describe the program.

    1: Yes [describe]
    2: No

13. Are the clinical criteria and protocols used for inpatient review adjusted for regional practice variations?

    1: Yes
    2: No

14. How do you identify alcohol and substance abuse cases that are admitted through the emergency room on a secondary medical diagnosis? What outreach or other intervention is initiated for those cases that are identified?

    a. What is your procedure when a dual diagnosis (both psychiatric/medical and substance abuse) is apparent?
    b. Is this handled differently from when only one diagnosis is assigned?
    c. Please describe what criteria you use to determine medical necessity and appropriateness of care for dual diagnosis cases for each level of care.

15. Provide the criteria used to determine whether a patient should be treated for substance abuse on an inpatient basis or an outpatient basis.

16. List the clinical practice guidelines or evidence based practices adopted by your organization. Provide the name and source from which the guidelines/practices were developed.

17. How do you manage requests for alternative treatment and programs not specifically excluded or included in the benefit design, i.e. wilderness therapy, equestrian therapy, etc?

18. Describe any tele-psychiatry or tele-therapy services you have utilized with other customers and your approach for utilization of these and other technology products.

19. How does your organization track a patient's treatment and changes in the patient's condition during a hospital stay? Please be specific as to the responsibilities of the patient, hospital, physician and review organization.

20. a. What is reviewed during the concurrent review process: i.e. diagnosis, length of hospitalization, expected length of continued hospitalization, resources of the facility, alternative outpatient opportunities? Others?
    b. From whom do you receive the information?
    c. Is the review performed on-site at the facility or over the telephone or via secure web transmission or other?

21. a. How often are higher level of care concurrent reviews scheduled?
    b. When are high frequency reviews scheduled to focus on ongoing dynamic changes in the patient's status?
    c. What factors related to the patient's condition would increase this frequency of reviews, i.e., an unclear diagnosis?
    d. If concurrent reviews cannot be done because of MHPAEA provisions, how do you plan to ensure efficacy of treatment and appropriate length of stay?

G. Cases in Progress

1. There will be MHSA cases in progress at the time of implementation of the next MHSA contract. How would you handle existing inpatient and outpatient cases in progress during the transition? Specifically address the potential problems of non-matches of providers between your network and the incumbent MHSA firm's network.

H. Reporting

Refer to Attachment E, Required Reports.