

## ***Non-Bidders – RFA Questions and Answers***

### **1915 (b)/(c) Medicaid Waiver Request for Applications April 26, 2011**

<b>#</b>	<b>Source</b>	<b>Question &amp; Reference</b>	<b>Answer</b>
1	Ann M Wilson	Suppose certain counties are included in a particular LME's response to the RFP regarding waivers. Can the counties choose after the waiver has been approved to change waiver entities they are associated with? I was thinking it remains each counties decision, however, with the new 70,000 covered lives stipulation, changing could affect the whole waiver situation for LME's in the future. Lots of folks are trying to figure out how to best accomplish their mission under a statewide waiver scenario and this may come up.	<p>Currently 122C-115 (and -115.1-4) address the duties of counties either as a single county governance model or an Area Authority / LME (multiple county structure). Where a county aligns its LME partnerships is up to the Board of County Commissioners.</p> <p>Minimum RFA requirement #1 requires the Lead LME submitting the application to meet covered lives. The Lead LME would still be required to meet this requirement despite any county changes.</p> <p>If any county is considering alternative LME arrangements after submission of an RFA application, DHHS would need to work with the County and LME on a case by case basis.</p> <p>If, after successful waiver implementation and final approval by CMS, a county were to request a change in participation, then DHHS and CMS must approve the final county configuration related to Medicaid Eligible population as part of the MCO responsibility and oversight.</p>
2	Laurie Coker, consumer/ family rep	Unfortunately, in many communities, the CFACs have not been engaged in proactive ways that reflect external concerns, and they often are not informed of LME changes in time to give input. Therefore, unless administrators have made a targeted effort to gain community input, it is not adequate to assume that boards and administrators get such information. The quality of the outreach and responsiveness to communities served must be evaluated if we want to have waivers developed	This process is a formal application. The RFA serves as the single source document for LMEs to bid on being a MCO under the 1915 b/c option. The RFA requirements can't be amended at this point. We can consider your request as an amendment to the contract between the State and the chosen MCO/LMEs.

#	Source	Question & Reference	Answer
		<p>in a responsive manner.            In your discussion on Friday, please consider the value of adding <b>one more section to the waiver administrator application process</b> that allows DHHS staff to assess for effectiveness based on "results," (data conveying outcomes), management style, and the nature of the relationship between the LME and consumers, county government, and other important community stakeholders.</p>	
3	Saguaro Group	<p>The wording in the RFA re: Targeted Case Management is unclear.</p> <ul style="list-style-type: none"> <li>❖ Will <b>I/DD TCM</b> remain a separate billable service provided by network providers or will it become a MCO function?</li> <li>❖ Will <b>MH/SA TCM</b> remain a separate billable service provided by network providers or will it become a MCO function?</li> <li>❖ In the case of MH/SA TCM, the current state rate was established to support the infrastructure necessary to meet CABHA requirements. If MH/SA TCM is no longer a service that can be billed by CABHAs within Waiver networks, how will the state ensure that those costs are reimbursed?</li> </ul>	<p>See Appendix K of the Medicaid contract for a list of covered services. The LME-MCO is responsible for Care Management functions that include “Managed Care Treatment Planning.” Managed Care Treatment Planning requires that the LME identify Special Health Care Populations (listed in the contract) and ensure that they have assessments, linkage to care, and a treatment plan. All Innovations clients are considered “Special Health Care Populations.” As a result, I/DD TCM and MHSA TCM are not covered services under the 1915 b/c managed care plans since these services would be a duplication of payment for managed care functions. Agencies that currently offer Targeted Case Management (TCM) to people with I/DD will be able to offer the Community Guide service in place of TCM.</p> <p>The LME-MCOs have the ability to develop different payment methodologies with CABHAs. For example, they can pay an enhanced rate for psychiatric care and outpatient treatment or they can provide case rate payments for CST, IIH, DT, PSR, or other State Plan services. Payment methods are much more flexible under managed care. The State is committed to the success of CABHAs and managed care and will therefore offer special guidance and consultation to the new managed care sites as they develop their treatment networks.</p>