NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Solicitation Addendum

Solicitation Number:	30-2019-052 DHB
Solicitation Description:	Healthy Opportunities Lead Pilot Entity Request for Proposal (RFP)
Solicitation Opening Date and Time:	February 14, 2020 at 2:00 PM ET
Addendum Number:	6
Addendum Date:	December 23, 2019
Purpose of Addendum:	Department Response to Questions
Contract Contact:	Deidra C. Jones, Contract Specialist Medicaid.procurement@dhhs.nc.gov | (919) 527-7236

NOTICES:

1. The Request for Proposal opening date is hereby extended to February 14, 2020 at 2:00 PM ET.

2. Letters of Community Support as required in First Revised and Restated Attachment B: Offeror's Response to Technical Evaluation Questions, question #4, and Attachment J: Letters to be Submitted with Response **must be submitted by the Offeror as part of its proposal**. Any letters sent by supporting organizations directly to the Department or by any means other than inclusion with a formal response to this RFP will not be considered.

INSTRUCTIONS:

1. Return one properly executed copy of this Addendum with response. Failure to sign and return this Addendum may result in the rejection of Offeror's proposal.

2. Carefully read, review and adhere to all notices, instructions and responses to questions in this Addendum.

3. Following are questions received for this solicitation and the Department's responses to the questions.

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No.	RFP Section	RFP Page Number	Offeror Question	The State's Response
1	General question	N/A	Can the state please provide a list of pre-proposal attendees, including those entities that participated on the phone?	The state will not be releasing a list of the attendees.
2	General question	N/A	If a company/organization missed the opportunity to submit a Letter of Interest/Intent to be considered an HSO during DHHS' outreach in July, does the Department have a mechanism for potential HSOs to submit such a letter now?	The statement of interest (SOI) was aimed at organizations interested in serving as a Lead Pilot Entity (LPE). It was voluntary and non-binding. It closed in August 2019 and will not be re-opened. Organizations interested in serving as a Human Service Organization (HSO) in the Pilots should reach out to an LPE applicant in their region. Organizations that do not want to submit a proposal to serve as an LPE should not submit a proposal in response to this LPE RFP.
3	General question	N/A	Can the state provide a list of certified and/or qualified LPE's that HSOs can contact to connect potential HSOs with potential LPEs?	The state does not have a list of certified and/or qualified Lead Pilot Entities (LPEs). However, organizations that submitted a voluntary and non-binding statement of interest (SOI) in serving as an LPE are listed on the Healthy Opportunities website under Stakeholder Feedback Request, item 3 Healthy Opportunities Pilot LPE Statement of Interest Submissions. Link: https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/healthy-opportunities-pilots#stakeholder-feedback-request.
4	I.A.2	7	Like many others we are following the budget news or lack thereof. If a budget is not agreed upon by the state legislators, could the pilot be stopped or delayed?	To move forward with managed care, the Department needs a budget that grants it new spending and program authority. While it is possible that the LPE pilot awards could be impacted, we are continuing with the

				competitive solicitation process and strongly encourage interested agencies to submit proposals.
5	1.B.2. (b)	10	Is the timing or funding of this RFP contingent on the timing of Medicaid reform?	See response to Question 4.
6	1.B.2. (b)	10	Is the $650mm funding amount a total distributed over the 5-year time frame?	Yes. North Carolina's section 1115 Medicaid Demonstration Waiver provides the Department up to $650 million in expenditure authority to establish and operate the Healthy Opportunities Pilot program in the State from November 1, 2019 through October 31, 2024. This $650 million can be used for capacity building, administrative costs, and pilot services.
7	I. B. Background on HOP	10	How much is each region eligible for through the LPE? Of the $650M, if there are 3 pilots, is it an equal distribution, per Medicaid life, or other formula?	The Department's funding decisions will depend on numerous factors. It cannot guarantee that each selected Offeror will receive an equal share of Pilot funds.
8	I.B.5.d.i	11	We understand PHPs' key Pilot-related responsibilities and that the Department may modify Pilot-related responsibilities. Is DHHS open to a modification to the model contract based on an LPEs ability to facilitate faster service payments to HSOs for delivering authorized Pilot services?	In general, modifications to the model contract may be made with Department approval. However, one component of the model contract that may not be modified is the PHP's responsibility to pay HSOs for authorized pilot services. Contract modifications that authorize Lead Pilot Entities to pay HSOs for pilot services will not be approved by the Department.
9	Section 5.e	12	The RFP states that PHPs are to "Ensure Pilot Participants, if eligible and resources are available, are enrolled in other existing federal, state and local programs (e.g., Supplemental Nutrition Assistance Program and Low-Income Home Energy Assistance Program) to maximize the value of Pilot expenditures." Then later, on page 12, it states that Care Managers are responsible for "…ensuring and facilitating enrollment in other federal, state and local programs prior to recommending related pilot	a. The PHP is the entity accountable for ensuring that pilot participants, if eligible and resources are available, are enrolled in other existing federal, state, and local programs. If a care manager (whether at the PHP or delegated to an Advanced Medical Home, Local Health Department, Care Management Agency, or other care management entity)

			services…" a. Is the function truly the responsibility of both the PHP and the Care Manager? Or is there a delineation between how entity (PHP and Care Management) are to ensure that the participant is enrolled in other services? Please clarify b. Also, the requirement of exploring eligibility in other federal, state and local programs can cause a delay in providing pilot services to members. Is there a plan for the PHPs or Care Management entities to design and implement (via partnership with local organizations) a streamlined, accelerated eligibility process for pilot members to mitigate the risk of pilot service delays?	identifies that the member has needs that may be addressed by other federal, state or local programs and that the member may be eligible for those programs, the care manager may facilitate enrollment of the member directly. b. The Department is exploring ways to accelerate the eligibility process for pilot-eligible members to mitigate the risk of pilot service delays and intends to release more information when available.
10	Section 5.e	12	The RFP speaks to the Care Manager providing follow-ups and a 6-month reassessment for eligibility. For a population of people with fluid living situations/occurrence of adverse life events there is a need for frequent follow-up to ensure true person-centric care/services are authorized and delivered. Here's an example: Female member enrolled in the pilot due to substance abuse, congestive heart failure and housing instability. After enrollment and servicing has begun for housing, she now experiences food insecurity which is compounded by the enhanced nutritional needs due to her pregnancy. a. Is the expectation that the member can receive additional support from her Care Manager to get linked to non-pilot services such as WIC, SNAP, etc.? b. As the pilot is currently defined, how would this individual get the additional support needed? c. Would the HSO providing housing services be able to send a NCCARES360 referral to the Care Manager to notify him/her that the member may need to be evaluated for new services? d. Would there be a delay in providing pilot related food services until the eligibility determination is made for the other services?	a. and b. PHPs and their delegated care managers will be required to address Medicaid managed care members' physical, behavioral and non-medical needs. The LPE is not responsible for this requirement. The Department is unable to provide additional information on these responsibilities at this time. c. NCCARE360 will generally allow communication between HSO staff and care managers who are working together to serve a Pilot enrollee. The Department is unable to provide additional information at this time. d. PHPs and their delegated care managers will be responsible for the eligibility, enrollment and service authorization process. The LPE is not responsible for this requirement. The Department is unable to provide additional details at this time.
11	I.B.7.a)	13	If applicable, please explain how the LPEs will be responsible for program evaluation beyond submitting data to the Cecil G. Sheps Center for Health Services Research.	LPEs will play an important role in collecting and submitting data to support the Pilot program evaluation and the Department's oversight and monitoring responsibilities. LPEs will participate in Pilot program oversight and evaluation efforts by collecting and reporting

				on qualitative and quantitative data to be used for periodic assessments (e.g., on capacity building expenditures), overall program evaluation, and ongoing program monitoring and oversight, and by actively engaging with the Department and Pilot-participating entities in Pilot program assessment, quality improvement, learning across Pilot regions, and evaluation. The Department is unable to provide additional information at this time.
12	I.B.7.a)	13	Please explain what data should be collected exclusively for Sheps Center and what internal data is expected for program evaluation specific to each funded program.	The Healthy Opportunities Pilot design was approved by CMS in August 2019. The evaluation design is located at: https://files.nc.gov/ncdhhs/nc-medicaid-reform-eval-des-appv-ltr-20190815.pdf. See Section V. Scope of Services F. Quality Improvement and Pilot Program Evaluation 2. Quality Improvement and Pilot Program Evaluation Scope of Services h) Submit Timely, Accurate, and Complete Date for Pilot Program Evaluation for further information regarding data an LPE is responsible for submitting.
13	7. Quality Improvement and Pilot Program Evaluation	13	On page 13, the link for the Medicaid evaluation information does not work and return a "Error 404: page not found" message.https://www.medicaid.gov/Medicaid-CHIP-Program-Information/ByTopics/Waivers/1115/downloads/nc/Medicaid-Reform/nc-medicaid-reform-eval-desappv-ltr-20190815.pdf Can you provide a new link for the information?	See response to Question 12.
14	I.B.5.g	13	LPEs will contract with PHPs using a model contract and establish and manage a network of HSOs providing Pilot services to the PHPs' Members within a Pilot region. Does DHHS envision the model contract(s) will provide LPEs with optional access points into the PHP Non-Emergency Medical Transportation (NEMT) provider network via their existing and future Transportation Broker contracts?	No. The model contract between LPEs and PHPs will only address requirements of the Healthy Opportunities Pilot Program. See Section V.B. 2) Lead Pilot entity and PHPs Scope of Services.

15	C. Purpose of Request for Proposal	16	On page 16, one of the LPE functions states, "Supporting Medicaid Managed Care program care managers in performing Pilot activities and quality improvement, by providing them with assistance using and navigating the contracted HSO network and connecting Pilot Participants to an appropriate HSO service." Can the Department details of the expected volume/number for this type of support. A trackable means/solution for receiving, tracking and working these type of support requests would be best. What mechanism will be used for Care Managers to request this support? Does the Department plan to provide a solution for this or will NCCARES360 provide service support requests functionality, which routes from the Care Manager to the LPE? How many Care Managers can the LPE expect to support/interact with? Is there a specific number per county or PHP?	The Department is unable to provide information on the expected number of care managers at this time. The Department expects the Lead Pilot Entity to be in close communication with Pilot-involved Care Managers to understand areas and topics in which they require support and/or training. The Department has not mandated a system to support this functionality. For details on the LPE's responsibilities related to providing training and technical assistance to care managers, see V. Scope of Work F. Quality Improvement and Pilot Program Evaluation 2. Quality Improvement and Pilot Program Evaluation Scope of Services e) Provide Training and Technical Assistance to Care Managers. Further details are not available.
16	II. GENERAL PROCUREMENT INFORMATION AND NOTICE TO OFFERORS, D. Schedule and Important Events, 1., Table 1: RFP Schedule	22	4) Can you confirm the deadline to submit proposal date as January 21st, 2020 at 2:00pm? It is stated on the website as January 15th. https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/healthy- opportunities-pilots	The deadline for Offerors to submit a proposal is being extended to February 14th, 2020 at 2:00 PM ET. The Healthy Opportunities Pilots webpage will be updated to reflect the correct deadline.
17	Section 3.b	26	Copies of the templates were requested about a week ago on 11/13/2019 but have not been provided. Can you please publish them on the Pilot Website?	The templates will not be published on the Pilot Website. Requests for templates must be emailed to: Medicaid.Procurement@dhhs.nc.gov. The Department will forward updated templates, upon their completion, to those who previously made a request via the Medicaid.Procurement@dhhs.nc.gov email address.
18	II.F.4.	29	For purposes of equity in the competitive nature of the RFP, can you provide a list of vendors that Offerors should not include in their regional discussions for provision of services while the procurement is active?	The Department will not provide a list of vendors. Offerors should not work with contracted vendors that were part of the Healthy Opportunities Pilots design. Offerors can ask potential partners if they fall into this

				category, and potential partners should be aware of any restrictions.
19	II.F.4.	29	If a list of vendors cannot be provided, what processes are in place to protect offerors from an unknowledgeable mistake?	See response to Question 18.
20	Section G	30-33	During the review process, if it is found that a possible synergy with two organizations, who would work together to better serve the area, would an award be given in this way, with joint award OR it is all to one particular organization?	See Section V. Scope of Work A. Administration and Management 2) LPE Eligibility b) Entity Eligibility Scope of Services. The LPE must be a single legal entity with one established governance structure so that there will be one source of accountability and contracting. If multiple organizations wish to come together to jointly form an LPE, it is strongly preferred that they apply together as one joint entity.
21	3-A-4	34	How do LPEs interact with care managers? How do the two connect and communicate?	Offerors awarded an LPE contract as a result of this RFP will play a critical role in connecting PHPs and care managers with HSOs. See Section V. Scope of Work D. LPE and HSO Network Management 1) Background and Goals Related to LPE and HSO Network Management. See Section V. Scope of Work F. Quality Improvement and Pilot Program Evaluation 2. Quality Improvement and Pilot Program Evaluation Scope of Services e) Provide Training and Technical Assistance to Care Managers.
22	III. A. Definitions, Contract Term, General Terms & Conditions, Other Provisions & Protections	34, #4 and #6	Can the state please clarify the difference between care managers and case managers? Is the intent that care managers will be employed/used by the PHPs or care management agencies only (primarily on the healthcare side), and that case managers will be employed/used by HSOs/CBOs only (primarily on the human services side)?	Please see the Definitions section of the RFP See (Section III. Definitions, Contract Terms, General, Terms and Conditions, Other Provisions & Protections A. Definitions. Yes. Care managers will be used by the PHPs or care management agencies, and case managers will be used by HSOs and CBOs, as described in the question.

23	Section III	34-40	Can an Offeror be considered as an LPE and also be included in another Offeror's HSO network? That is can a potential Offeror submit to be an LPE if they also submit a letter of intent to participate in the LPEs HSO Network? Would this disqualify the Offeror in the process?	An organization may serve as both an LPE and an HSO in its own network or as an LPE and an HSO in another LPE's network. However, there must be organizational structures in place to separate the work, funding, and governance of the LPE portion of the organization. Additionally, the LPE must meet all of the requirements in this RFP, including the conflict of interest policies. See Section V. A. Administration and Management, 3) Lead Pilot Entity Governance, b) Governance Scope of Services, ii) A. 6.
24	Section III	36	Regarding the Local Pilot, does DHHS designate various entities to become a Local Pilot or does the Lead Pilot Entity (LPE) designate entities within its region to become a Local Pilot? How does an organization qualify and get recognized or become a Local Pilot? Can an entity be both a Local Pilot and be a part of an HSO Network in the LPE region?	The Department will determine which Offerors are awarded a contract to serve as a Lead Pilot Entity that will be responsible for a Local Pilot operating in particular geographic area. A Lead Pilot Entity is not precluded from delivering Pilot services as an HSO, as long as it complies with the conflict of interest requirements at V. Scope of Work A. Administration and Management 4) Staffing and Facilities b) Staffing and Facilities Scope of Services iii) Conflict of Interest. See response to Question 23.
25	III. A. Definitions, Contract Term, General Terms & Conditions, Other Provisions & Protections	37, #30 and #31	Can the state please clarify that pilot-eligible members are individuals enrolled in a Medicaid PHP and have been determined eligible for pilot services by the PHP, but have not yet accessed any pilot services; and that pilot participants are individuals enrolled in a Medicaid PHP, have been determined eligible for pilot services by the PHP and have accessed pilot services? Are there requirements for PHPs and LPEs to track and report both categories?	As defined in the RFP, a Pilot-Eligible Member is "an individual Medicaid managed care Member that meets the criteria to be eligible for participation in the Pilot program, as defined in Attachment L: Pilot Program Participant Eligibility Criteria." A pilot-eligible member is determined to be eligible for pilot services by their PHP but has not yet consented to participate in the Pilot program

				and is not yet enrolled in the Pilot program. Also as defined in the RFP, a Pilot Participant is "a Medicaid Member who has been determined by their Prepaid Health Plan to be eligible, consented to participate in the Pilot program, and has been enrolled to receive Pilot services." A Pilot Participant does not have to have received pilot services yet to be considered a Pilot Participant, but must have been determined eligible, consented, and enrolled in the Pilot program. PHPs will be required to track and report on Pilot-Eligible Members and Pilot Participants. LPEs will be required to report and track on Pilot Participants. The Department will provide additional information after Contract award.
26	III. C. Contract Term and Related Pilot Periods	40, #3	Can the state please provide additional detail on expectations for what LPEs must have operational in each pilot period noted in a - f? Are there aspects of LPE operations that can be implemented over multiple pilot periods, or are the periods simply structured to align fiscal years?	See Addendum 7 for related definitions. See Attachment N2: LPE Milestones and Due Dates for various operational milestones that must be met during the Implementation Period. During the Service Delivery Periods, the LPE will manage and oversee its network of HSOs, serving as an essential connection between HSOs and PHPs, and collecting and providing data to the Department as described in Section V. Scope of Services. The Department plans to release operational milestones the LPEs must meet during the Service Delivery Periods after Contract award.
27	5-A-1	68	Who will determine and approve the pilot services enrollees are eligible to receive? How will this approval/authorization process flow?	Either a PHP or a care manager may assess a Medicaid managed care member for eligibility for pilot services. The PHPs are ultimately responsible for approving eligibility for and enrollment into the Pilot and determining and approving the pilot services their members are

				eligible to receive. Therefore, if a care manager believes a Medicaid member may be eligible for pilot services, the care manager must receive approval from the member's PHP before authorizing pilot services for that member. See Section V. Scope of Services B. Lead Pilot Entity and Prepaid Health Plan Contracts 1) Background and Goals related to LPE- PHP Contracts b) and e)
28	V.A.3	69-70	Our organization has a parent/subsidiary structure, with our proposed pilot entity being a subsidiary of the parent company. Is it acceptable for the parent board to still hold reserve powers over the governing board of the pilot entity?	The governing body to oversee the Lead Pilot Entity must meet all the requirements enumerated in Section V.A. Administration and Management 3) Lead Pilot Entity Governance b) Governance Scope of Services. The Lead Pilot Entity's Governing Body must include authority over the LPE's program-related decisions and use of the LPE's Pilot funds. An organization's parent board may not impede the decision-making authority of the LPE's governance body.
29	V. SCOPE OF SERVICES, a. Administration and Management, 3) Lead Pilot Entity Governance, b) Governance Scope of Services, iv,v	71	Can you clarify that governing body always means of the LPE and the Pilot-specific refers to a subcommittee of the LPE board? See below. Contractor shall submit the following information to the Department as required in Attachment N2: LPE Milestones and Due Dates: A. Names of the individuals on the Pilot- specific governing body; B. The governing body's bylaws; C. Policies, procedures, and other information detailing the operations and authority of the governing body, including decisions or types of decisions subject to a vote of the governing body. v) In the event of a vacancy on the governing body, the LPE shall: A. Notify the Department in writing within five (5) State Business Days after the vacancy is identified. B. Take reasonable efforts to fill vacancies within 90 days after	The Pilot-specific governing body is equivalent to the Lead Pilot Entity governing body. See Addendum 7.

			the vacancy is identified. C. Submit the replacement individual's name to the Department Contract within thirty (30) days of the selection of a governing body replacement	
30	V.A.5. Administration and Management	72	Will DHHS provide a template and instruction/guidance manual for the standardized invoice requirements for all HSOs?	The Department will issue invoice requirements after Contract award.
31	5-A-5-b-ii-B	73	Specifically, how will LPEs utilize NCCARE360?	See Section I.B. Background on the Healthy Opportunities Pilots and Medicaid Managed Care Transformation, and Attachment P: LPE System Requirements, and Attachment N1: LPE Reporting Requirements.
32	V.B. Lead Pilot Entity and Prepaid Health Plan Contracts	77-78	Will there be requirements for the PHPs to share information with each other on members who move from one PHP's service area to another's, or choose to be in a different PHP, and to coordinate that information with the LPEs?	Yes. PHPs have multiple responsibilities related to transitioning a member's care when that member changes health plans. As a part of those responsibilities, PHPs will have specific transition of care responsibilities related to pilot enrollees, which will include notifying LPEs that the member changed health plans.
33	V.B. Lead Pilot Entity and Prepaid Health Plan Contracts	77-78, #1 and #2	Will it be the PHP's responsibility to notify the LPEs of members in their Pilot region who are potentially eligible for services, or only notify them of members who are enrolled to receive HSO services? Will the LPEs be required to do any outreach to potentially eligible members, or is that the sole responsibility of the PHPs?	The LPEs are not intended to be member-facing organizations and are therefore not expected to conduct outreach to potentially-eligible members.
34	5-C-1	78	Is there a maximum limit to the number of counties an LPE can serve?	There is no maximum limit to the number of counties an LPE can serve. The key criteria for the development of an Offeror's Local Geographic Pilot Region is detailed in Section V. Scope of Services C. Local Pilot Geographic Region.
35	V. SCOPE OF SERVICES, B. Lead Pilot Entity and Prepaid Health Plan Contracts, 2. Lead Pilot Entity and PHPs Scope of Services	78	Is there a conflict of interest for a Lead Pilot Entity to participate in all three roles (LPE, care management, HSO)?	An organization may serve as an LPE, an HSO, and a care management entity. However, there must be organizational structures in place to separate the work, funding, and governance of the LPE portion of the organization.

				Additionally, the LPE must meet all of the requirements in this RFP, including the conflict of interest policies.
36	V.C.2.d Local Pilot Geographic Region	79	The number in the RFP of 240,000 Medicaid Members is significantly different from the previous number of 105,000 Medicaid Members. Our issue with this change is that the application will benefit applicants who come from urban areas of the state and seriously disadvantage the rural part of the state which cannot bring those number of Medicaid Members. Our advocacy around this issue is that you reconsider this stipulation and revert to the initial required number of 105,000 Medicaid covered members. The RFP does provide an alternative scenario for applications where "The Department may consider a Local Pilot Region that does not meet the minimum Medicaid Member threshold if it is composed exclusively of counties with 45,000 or fewer Medicaid Members…" However, this alternative scenario is written as "MAY" consider. That word is concerning to us and we ask that you please consider both alternatives equally.	All proposed Local Pilot Geographic Regions that meet the requirements of Section V.C. Local Pilot Region will be given equal consideration in the evaluation process. See Addendum 7.
37	V.C.2.c)	79	Will Local Pilot Regions be expected to include a combination of urban and rural classified counties?	Local Pilot Geographic Regions are not mandated to include a combination of urban and rural classified counties.
38	V.C.2.c)	79	Please clarify if all counties within a Local Pilot Region must be contiguous or only three counties within the Region.	The Local Pilot Geographic Region must contain at least three contiguous counties. As described in Section V.C. Local Pilot Geographic Region, the Department intends that Local Pilot Geographic Regions will collaborate and work across county lines. While all the counties involved in the region do not need to be contiguous, the Department intends that Local Pilot Geographic Regions will offer a regional, community perspective to Pilot service delivery and administration.

39	V.C.2.e)	79	Please explain the process by which proposals from Local Pilot Regions with fewer total Medicaid Members composed exclusively of counties with 45,000 or fewer Medicaid Members will be given equal consideration as proposals from Local Pilot Regions with 240,000+ total Medicaid Members.	See response to Question 36.
40	V.C.2.e)	79	If the Local Pilot Region is composed of counties with 45,000 or fewer Medicaid Members, do all of the counties included have to be classified as rural?	No. The only requirement is that a Local Pilot Geographic Region must either have a minimum of 240,000 total Medicaid Members across all counties or be composed exclusively of counties with 45,000 or fewer Medicaid Members, pursuant to Attachment G: County Medicaid Enrollment and Classification. See response to Question 36.
41	V.C.2.e)	79	With regard to the Local Pilot Region composed of counties with 45,000 or fewer Medicaid Members, does the 45,000 or fewer apply to each county in the Local Pilot Region or the total Medicaid Members in the pilot region? Please explain.	The 45,000 applies to each county in the pilot region.
42	V.C.2.c	79	Prior DHHS guidance issued around establishing a pilot geographic region stated as one of the requirements that one rural and one urban county must be included. Has this requirement been relaxed and, if so, will offerors who provide a mix of classifications receive extra consideration during the evaluation phase?	The Department is no longer requiring that proposed Local Pilot Geographic Regions contain at least one urban and one rural county.
43	V.C.2.d	79	It would be great to understand what if any DHHS projections exist for the numbers needing services in each domain per 1,000 recipients for each category (e.g. adult, women, children, etc.). We think this could be helpful for validating the appropriate HSO network size.	The Department does not have this information.
44	V. D. 1. LPE and HSO Network Management	80	Is there flexibility for an LPE to play a role beyond compliance in managing referral network?	The Lead Pilot Entity has multiple responsibilities for establishing, overseeing and working with a network of qualified HSOs. See Section V.D. LPE and HSO Network Management.

45	V. D. 1. LPE and HSO Network Management	80	Will care managers who are employed by care management entities and those employed by the PHPs both be required to use NCCARE360 to refer pilot participants to HSOs?	Yes.
46	Section V,D	80-89	Does an HSO have to be listed as part of an Offeror's HSO Network prior to the Offeror's submission as a potential LPE? During the preconference for the RFP, there was a lot of discussion on events that took place in July and August of 2019 and it appears that those discussions gave DHHS a list of potential LPEs it would consider for awarding contracts. Would you please publish a list of those LPE organizations DHHS identified in the early discussions, so that an entity can become a part of the regional HSO Network for those LPEs?	As required in *First Revised and Restated Attachment B: Offeror's Response to Technical Evaluation Questions*, the Offeror must include an initial HSO Network Plan with its response to the RFP. The initial HSO Network Plan will include a list of HSOs that have submitted a letter of intent to participate in the Offeror's initial network. If the Offeror is awarded an LPE contract, the LPE will conduct an application process and contract with HSOs to form its final HSO Network. An HSO does not have to submit a letter of intent and be listed in the initial HSO Network Plan to later apply and contract with an LPE to be included in the LPE's network. In July 2019, the Department released a request for a non-binding Statement of Interest (SOI) from organizations interested in submitting a proposal to serve as an LPE. Organizations were not required to submit an SOI in order to submit a proposal to this RFP. Additionally, submitting an SOI did not obligate an organization to submit a proposal to this RFP and will not impact the evaluation of RFP proposals. The list of organizations that submitted an SOI can be found on the Healthy Opportunities website: https://files.nc.gov/ncdhhs/Healthy-Opportunities-Pilot-LPE-Statements-of-Interest-20191010.xlsx. This list serves as a tool to promote community awareness and collaboration among organizations interested in bidding to serve as an LPE and other

				organizations (healthcare and human services organizations, among others) in its region wishing to participate in the pilots as HSOs or care management entities. It does not convey endorsement or certification of qualification in any way by the Department.
47	V.D.2. LPE and HSO Network Management	81,#iv	How does DHHS define "an unreasonable distance" for travel and "an unreasonable length of time" for waiting for routine Pilot services?	The Department has not defined these terms. In the *First Revised and Restated Attachment B: Offeror's Response to Technical Evaluation Questions*, question 28. c. Offerors must describe specific metrics used to develop the initial HSO network plan against the Department's efficiency and adequacy standards, including any specific time and distance standards.
48	V.D.2. LPE and HSO Network Management	83,e	Will HSOs that participate in more than one LPE be required to apply separately to each LPE using each LPE's application and process?	Yes. HSOs participating in more than one region will be required to apply separately according to each region's LPE's application process.
49	V.D.2. LPE and HSO Network Management	83,h	Will DHHS participate in the LPE's HSO readiness review process?	The Department expects to participate in the LPE's HSO readiness review process. The extent to which the Department will participate will be determined after Contract award.
50	5-D-2-f-1	84	How should potential LPEs communicate with potential HSOs regarding pilot service payment and the HSO's intent to provide services when the HSO fee schedule has not been published?	The Centers for Medicare & Medicaid Services (CMS) recently approved the Department's Healthy Opportunities Pilot Fee Schedule, and it is included in Addendum 7.
51	V.D.2.i.i	87-88	Will the department design and publish standard monitoring tools or should each LPE offeror draft their own version satisfying the requirements outlined?	The Department may release information on monitoring tools after Contract award. The *First Revised and Restated Attachment B: Offeror's Response to Technical Evaluation Questions*, question 38 requires Offeror to describe its approach to assessing and monitoring the performance of any contracted

				or collaborating entity in meeting its contractual obligations.
52	V. E. 2. Flow of Funds Scope of Service	89	How is funding after year two sustained when the capacity building dollars end? After year two, how will administrative costs during Pilot service Delivery period be paid?	Funding for LPE administrative costs will be available for the length of the Pilot program through capacity building funds in Year 1, a mix of a capacity building and administrative funds in year 2, and ongoing administrative funding in years 3-5.
53	5-E-1	89	When will the HSO fee schedule be published?	See response to Question 50. See Addendum 7.
54	Section 4.C	93	The RFP mandates that "…using a form and format to be developed by the Department, if necessary." Why will the Department create and release the said form?	The Department intends to create a standardized form to expedite the review process. The standardized form should be released during the Pilot Implementation Period.
55	V.F. 2. Quality Improvement and Pilot Program Evaluation	99	Can the state please clarify that DHHS, not the LPEs will be responsible for conducting Rapid Cycle Assessments, Randomization of higher intensity services, and the Summative Evaluation efforts, and the LPEs' role will be to provide data and information, as directed, to DHHS to support its work on these evaluation components?	Yes. The Department is responsible for conducting Rapid Cycle Assessments, randomization of higher intensity services, and the Interim and Summative Evaluations. The LPEs are responsible for collecting, compiling, and sending data and information to support the Department in its evaluation efforts. The Department will communicate more information to LPEs on their role in facilitating randomization of services in the later years of the Pilot program.

56	V.F. 2. Quality Improvement and Pilot Program Evaluation	99	Are all quality improvement and Pilot program evaluation activities to be covered as part of the administrative payment from the PHPs to the LPEs, including convening Pilot-participating entities and community stakeholders, technical assistance, and training/training materials; and including all technical assistance and training for care managers?	All approved quality improvement and Pilot program evaluation activities will be paid for through a combination of capacity building dollars and administrative funds.
57	V.F.2.g)	103	Will LPEs be permitted to contract with an outside agency/organization for assistance with quality improvement? If so, please explain the restrictions or guidelines relative to the amount of funds that should be designated for such services.	Yes. LPEs may subcontract with outside agencies or organizations with assistance for their work, in accordance with all of the requirements of the RFP. See Section III. Definitions, Contract Term, General Terms and Conditions, Other Provisions & Protections D. Terms and Conditions. 39. Subcontractors and Attachment I: Proposed LPE Subcontractors. Please note the referenced sections may not address all requirements or guidelines relative to subcontractors.
58	VII. Attach B.B.#13.d	116	Will a standard form Letter of Intent be published or should each LPE offeror draft their own version?	The Department will not release a standard Letter of Intent. Each Offeror can create their own Letter of Intent for HSOs to sign or HSOs can write their own Letters of Intent and submit them to the Offeror.
59	7-C-1	121	Will reimbursement for LPE administrative funding be cost-based or will it be developed some other way?	LPE administrative funding will be based on cost-based budgets submitted by LPEs which will require Departmental approval. See Attachments C1: LPE Funding & Administrative Rate, C2: LPE Capacity Building Budget Proposal and C3: Offeror's Response to Funding and Budget Evaluation Questions.

60	Attachment C2.3.d	123	Capacity budget requests, including funding for the Lead Pilot Entity to spend on execution of its obligations and funding to distribute to HSOs, must not exceed $10 million per 12-month period. Please clarify whether these amounts are measured by when funds are encumbered or actually spent.	Capacity building budgets are based on when funds are spent. If the LPE has unspent capacity building funds at the conclusion of the 24-month period, the LPE may request to carryover the funds to be spent during the next twelve (12) month period. The request shall be submitted to the Department in a form and format to be determined by the Department. The Department, in its sole discretion, will approve or deny the request to carryover unexpended capacity building funds.
61	ATTACHMENT D: PERMITTED USES OF LPE CAPACITY BUILDING FUNDS, C. Developing necessary infrastructure/systems:	144	Can you clarify use of capacity building budget? Are you saying that a solution to support invoicing may either be provided by the state or required by the contractor? If we are required to develop such a system, we will be able to use capacity building funds, but not to put it in the budget at this point? See below. Developing necessary infrastructure/systems: 1. Staff time for procuring, developing, and/or preparing Lead Pilot Entity infrastructure and systems 2. Purchases needed to have functional systems for: a. Receiving invoices from HSOs b. Reviewing invoices for completeness and accuracy c. Analyzing invoices for outliers and discrepancies d. Submitting invoices to PHPs e. Receiving remittances from PHPs f. Tracking payment disputes and resolutions regarding invoice payments g. Tracking and distributing capacity building dollars to HSOs h. Assessing HSOs' performance i. Receiving administrative funds from PHPs j. Data collection and reporting related to services provided k. Data collection and reporting related to finances l. Systems to support program integrity monitoring and reporting The cost for any systems listed in C.2.a.-f. should not be included as part of its Capacity Building Budget. As provided in Section V.A. Administration and Management, the State will determine whether to provide a solution to support	At this time, Offerors should not include in their capacity building budget submissions any costs listed in Attachment D: Permitted Uses of LPE Capacity Building Funds Section C. Developing necessary infrastructure/systems: 2. Purchases needed to have functional systems for: a. through f. At a later date, the Department will determine whether the State will provide a standardized solution to support invoicing requirements or if the Contractor will be required to do so. If the latter, Contractors will be permitted to modify their capacity building budget request to cover these costs. See Section V.A. Administration and Management 5) Invoicing and Electronic System(s) of Record b) Invoicing and Electronic System(s) of Record Scope of Service i) Invoicing C, D, E and F.

			invoicing requirements or if the solution will be provided by Contractor. Systems applicable to this requirement are described as "To Be Determined" in this Attachment. The determination by the State may be after award of the Contract or prior to award. If the solution is required to be provided by Contractor, the cost to Contractor may be a permitted use for LPE capacity building funds as described in Section V.E.3. and Attachment D: Permitted Uses of LPE Capacity Building Funds. Any solution provided by Contractor must include any specifications or capabilities as required by the Department. The cost for any solution by Offeror should not be included as part of its Capacity Building Budget.	
62	Attachment E.H	148	"Other permitted uses" appear to provide flexibility for unanticipated HSO funding requests. As an example, would a future HSO request for an additional vehicle(s) to meet the demands of Pilot services for nutrition and/or transportation be a reasonable submission to the Department for approval?	Other than the uses specifically excluded or prohibited, HSOs may propose additional capacity building activities outside those listed under "ATTACHMENT E: PERMITTED USES OF HSO CAPACITY BUILDING FUNDS," to the LPE, subject to Department approval.
63	Attachment G	151	The Department has included data related to Medicaid Enrollment by counties. Does the Department plan to share additional data about Medicaid beneficiaries that will enable the LPE's ability to assess potential pilot volume and HSO service throughputs for their respective region?	The Department does not have this information.
64	Attachment M	162	As defined in Attachment M, there are sub-services changes and consolidation compared to earlier published Service Definition (July 2019). a. Is there an expectation that the pilot's service delivery is to be consistent with the guidelines set forth in Pilot Service Definition (July 2019) doc? b. If so, are revisions going to be made to the document to align it to Attachment M?	See response to Question 50. See Addendum 7.
65	7 M	162	Will there be a specific and individual fee for each dot point in attachment M? Does each dot point in attachment M represent a separate and individual pilot service and have a corresponding reimbursement rate?	See response to Question 50. See Addendum 7.

66	I.B.2.c III.D.5	10 and 43	Availability of Medicaid funding for the Pilot program is said to be contingent upon State funding. Please clarify whether these are Federal dollars and the nature of their 'continuing availability' through October 31, 2024.	CMS has authorized the Department to spend up to $650 million on the Healthy Opportunities Pilots for capacity building, administrative costs, and pilot services. This $650 million is a combination of state and federal funding. The Department must supply state dollars and CMS matches that amount with federal dollars. The Department's budget is subject to State appropriations authorized annually by the NC General Assembly. CMS's budget is subject to federal appropriations authorized annually by the U.S. Congress. See Section III. D. Terms and Conditions. 5. Availability of Funds.
67	I.B.5.d.iv V.B.1	12 and 77	PHPs have important responsibilities in the operation of the Pilot program, including ensuring eligible Pilot Participants are enrolled in other federal, state and local Programs. Is DHHS open to a modification to the model contract that allows LPEs to be appropriately compensated by PHPs for assistance with undertaking these efforts for their pilot enrollees?	As described in section I.B.5.d, ensuring that Pilot Participants, if eligible and resources are available, are enrolled in other existing federal, state and local programs is the responsibility of PHPs. However, in general, modifications to the model contract may be made with Department approval. An Offeror awarded an LPE contract may request modifications to the model contract from the Department.
68	I.B.5.e V.B.2.c.iii	12 and 78	This area describes the extensive responsibilities of Care Managers "who may be based at a PHP or care management entity." Is the LPE considered a care management entity? Furthermore, can an LPE that plans to organize/perform care management contract with PHPs to perform care management services including but not limited to providing "strategies to assist PHPs in identifying Pilot eligible populations?"	No, an LPE is not considered a care management entity. LPEs may serve as care management entities if they are contracted with PHPs to provide care management services. However, there must be organizational structures in place to separate the work, funding, and governance of the LPE portion of the organization. Additionally, the LPE must meet all of the requirements in this RFP, including the conflict of interest policies. Care management entities will include Standard Plans, Tailored Plans, Tier 3 AMHs, AMH+s, Local Health Departments, Care

				Management Agencies, or other Care Management Entities.
69	I.B.5.f.iii V.A.5.b.i.B	13 and 73	HSOs are submitting invoices to the LPE for Pilot services delivered. What if any acceptable payment terms (enforceable time standards) exist and what if any DHHS estimates have been modeled for HSOs in terms of accounts receivables?	The Department will provide this information after Contract award. See response to Question 30.
70	V E, 2. Flow of Funds Scope of Service; I B 5.e.	90 and 12	regarding flow of funding. "The Care managers are responsible for securing authorizations from the PHP and communicating authorizations to Pilot Participants." Can DHHS share the flow of authorizations across all entities, and the IT infrastructure that will be required to ensure a concise and timely authorization model? (Also, note on page 96 that LPEs are required to track service invoices from contracted HSOs - how will invoices be communicated to PHPs for reimbursement - via the LPE?) Will NCCARE360 be the method for authorizations, referral management, invoicing, and even payment between all entities?	
71	Attachment C1 Attachment C2.3.d	121 and 123	The Department anticipates dedicating approximately $2.3 million per service delivery year for each Lead Pilot Entity's administrative funding. Capacity building requests …must not exceed $10 million per 12-month period. Do Pilot funds have a Catalog of Federal Domestic Assistance (CFDA) number?	North Carolina's 1115 waiver gives the State flexibility to use Medicaid funds to test the use of evidence-based, non-medical services to improve the health and wellbeing of a subset of Medicaid enrollees. Offerors do not need to note or include a CFDA number with their proposal.
72	Attachment C2 and C4	122 and 132	How can we obtain the Capacity Building Budget Proposal Template as noted on Page 122 and described on page 132?	See response to Question 17.
73	Attachment C2.3.a-d	122 to 123	Capacity building dollars are time bound to the initial 24 months. How should an LPE plan to finance activities that may occur beyond the first 24 months and are associated with transitioning an HSO out of the network for a variety of reasons? Replacing HSOs with a new HSO may require appropriate capacity building efforts.	LPEs will receive ongoing administrative payments to finance Pilot-related activities that occur during periods when capacity building funds no longer are available.

74	Attachment D.I.3 Attachment E.I.3	145 and 148	Under LPE Capacity Building Impermissible Activities, "ongoing lease or utility payments" is listed as an excluded expenditure. Are ***new*** lease or utility payments necessary to complete Pilot services a permitted use of capacity building funds?	Capacity building funds may be used for administrative overhead costs, such as lease and utility payments for office space specifically used for the Healthy Opportunity Pilot. If a space is being used for other programs, the lease and utility payments must be appropriately cost-allocated.
75	8. NCCARES360: A Statewide Resource and Referral Platform & Attachment P	14 & 175	A high-level overview is provided for NCCARES360 on pages 14-15 and limited functionality descriptions are included in Attachment P: LPE System Requirements. a. To offer more details on NCCARES features and role-based functionality, can you provide use case and requirements in which the system is being built to?	Information on NCCARE360, including functionalities and role-based access, can be found at https://nccare360.org/content-library/. This information is relevant to the statewide rollout of NCCARE360 for all populations and providers. The Department is unable to provide additional information at this time.
76	Attachment J Attachment B Attachment M and Introduction	158 116 162-166 11	Attachment J provides instructions about letters to be submitted with each Offeror's Response. One requirement, in Attachment J, relates to Letters of Intent from potential HSOs attesting to participate in the Offeror's HSO network. That requirement (in Attachment J) cross references to related information in Question 13 of Attachment B (page 116). Our questions are about the information that HSOs should include in those letters. In Attachment J, the RFP states that the letters "shall include services to be provided in their attested domain and an estimate of the number of Pilot enrollees the HSO may be able to serve." 1. Regarding the requirement to describe the "services to be provided," should the HSOs refer to the original list of federally-approved services which is included in Attachment M (pages 162-166 of the RFP)? Or, should HSOs refer to the "Draft Service Definitions, Pricing	The Centers for Medicare & Medicaid Services (CMS) recently approved the Department's Healthy Opportunities Pilot Fee Schedule and it is being included as an addendum to this RFP. Please use the *First Revised and Restated Attachment M: Healthy Opportunities Pilot Service Fee Schedule* located in Addendum 7 of this RFP. The Department does not have estimates of Pilot-eligible enrollees in each county and does not plan to provide them prior to the date proposals are due.

			Methodology, and Pricing Inputs," which is described, with a link, on p.11 of the RFP? 2. Similarly, regarding the requirement to provide an "estimate of the number of Pilot enrollees the HSO may be able to serve," a. Should HSOs rely on the information contained in the "Draft Service Definitions, Pricing Methodology, and Pricing Inputs," which is described, with a link, on p.11 of the RFP? b. What other information could/should HSOs rely on to respond to this question? The RFP provides the estimate number of Medicaid enrollees in each county but does not provide estimates about the number of Pilot-eligible enrollees in each county. Can the State or PHPs provide those estimates now, before the Responses are due?	
77	Attachment C2 Attachment C4 Attachment D Attachment E Attachment C3, Evaluation Questions	122-128 132-142 144-146 147-149 130-133	Our question relates to the information that Offerors need to know in order to submit the narrative and budget information related to the HSO Capacity Building. We understand that LPEs will have time, after the selection process, to build their local HSO networks. However, we also understand that at the time of the Response to this RFP, it is in each Offeror's interest to have as much information as possible about the potential capacity-building needs of local HSOs that currently serve enrollees in the counties where the Offeror hopes to deliver Pilot services. Unfortunately, many HSOs do not know how to identify and contact potential Offerors. Many HSOs serve Medicaid enrollees in multiple counties. Unless they hear by "word of mouth," about each potential Offeror's plan to work in the communities that are served by their own organization, many strong HSOs will be excluded from the important (current) work related to developing the capacity-building elements of the Offerors' Responses. Even if HSOs were to rely on the (non-binding) list of potential LPEs that NC DHHS posted on its website in August 2019, that list does not name the counties that the potential LPEs planned (at that time) to include in their proposals. We ask the Department to consider adding a new step to the already long, thoughtful process it has used to develop the Pilot initiative. Please consider asking Potential Offerors to submit,	The Department does not plan to release publicly the counties included in each Offeror's Local Pilot Geographic Region.

			before a set date or as soon as possible, their contact information and the names of the counties that they expect to include in their submissions. This will help the Offerors and the HSOs that serve those counties to develop a better-informed budget and narrative related to capacity building needs of HSOs.	

Execute Addendum #6:

Offeror: _____

Authorized Signature: _____

Name and Title (Typed): _____

Date: _____