DEPARTMENT OF
BUDGET & MANAGEMENT

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Q & A #5
to
Request for Proposals (RFP)

BEHAVIORAL HEALTH & EMPLOYEE ASSISTANCE PROGRAM (EAP) BENEFIT ADMINISTRATION SERVICES

SOLICITATION NUMBER F10B0400011

June 18, 2010

Ladies and Gentlemen:

The following Questions, which were received by e-mail for the above referenced RFP, are being answered and posted for all Offerors. The numerical sequencing begins with question #85 since questions #63 through #84 were answered in Q&A #4 on June 10, 2010:

85. Question: The behavioral benefits are both in and out of network, but the data does not separate the two. What percent of the encounter units and distinct patient units are in and out of network for each setting level, IP, PHP, IOP, & OP.?

Answer: The following table shows approximate percentages for in-network and out-of-network utilization metrics based on reporting received from the current contractor. The data is unavailable by setting levels as requested (i.e. IP, PHP, IOP and OP).

	Paid Claims		Membership		
	In Network	Out of Network	% of Total Membership[1]	In Network	Out of Network
FY 2009	86.9%	13.1%	30.5%	76.2%	23.8%
FY 2010[2]	88.0%	12.0%	21.6%	77.1%	22.9%

[1] The percent of covered members and dependents utilizing the mental health benefits.

[2] July 1, 2009 thru March 31, 2010.

~Effective Resource Management~

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86. Question: Will meeting the required NCQA provider & facility access standards be acceptable for meeting the RFP network access requirements?

    Answer: The network access standards for this RFP are included in Attachment J-14: Performance Guarantees, PG-12. If you disagree with the Performance Guarantee as written please select disagree under the column heading "Willingness to Comply with the Standard/Goal". As indicated in the drop down list, please describe all deviations in Attachment J-16: Deviations Page. For each deviation include the section number, question number and an explanation for the deviation. The deviation will be reviewed and considered by the State. Please note, however, that deviations from the RFP may result in a proposal being rejected or evaluated lower if the State does not amend the RFP requirements.

87. Question: Do Performance Guarantees apply to both Behavioral Health and the EAP?

    Answer: Yes, the Performance Guarantees apply to both Behavioral Health and EAP.

88. Question: (Attachment J-14: Performance Guarantees) Related to PG-7, please define Automated System Availability.

    Answer: Please see response to question #41 on Q&A #3.

89. Question: May we have access to additional lines in J-16 Deviations Page? The worksheet is locked.

    Answer: Yes, Attachment J-16 Deviations Page has been expanded to include additional lines. Please see Amendment # 3, item 2.

90. Question: Intensive Outpatient Services are identified as a separate benefit. Could you please define the services that would be administered at this type of facility?

    Answer: Intensive Outpatient Services are defined as multidisciplinary, structured services provided at a greater frequency and intensity than routine outpatient treatment. These services range from 90 minutes to 4 hours per day, up to five days per week. Common treatment modalities include individual, family, group and medication therapies. The Intensive Outpatient Services are used to treat mental health conditions and chemical dependency disorders.

91. Question: Regarding Attachment J-7 –Tabs/sections: J-7b-e Item C, Column C reads: "Average distance to pharmacy" – should this instead read "Average distance to provider" as it does in J-7a, Item C, Column C?

    Answer: Please see response to question #71 on Q&A #4 and Amendment #2, item 4.

92. Question: Regarding Attachment J-9, can you please define what the State means by "Network Identifier"?

    Answer: At the top of Attachment J-9, "Network Identifier" is defined to be the Offeror's proposed network. Please enter the name of the network proposed for each county if a network exists in that county. If not, please enter "None."

93. Question: (Attachment J-4: Administrative Requirements) AR 74. Will the State provide a breakout of the subgroups on the eligibility file?

    Answer: Yes, on the eligibility file the subgroups (i.e. Active, Satellite, Direct Pay employees, State retirees under 65 and State retirees over 65) will be identified.

94. Question: (Attachment J-4: Administrative Requirements) AR 97. Since the state is asking for "no fault" insurance coordination & negligence, is the BH vendor required to provide transportation for Medicare members?

    Answer: To the extent permitted by state law, if there is primary coverage for the services/benefits provided by the auto coverage, then our plan will perform coordination of benefits with that coverage in determining payment. If you disagree with the response as written in Attachment J-4: Administrative Requirements, AR-97, please select disagree under the column heading "Response / Agree or Disagree". As indicated in the drop down list, please describe all deviations in Attachment J-16: Deviations Page. For each deviation include the section number, question number and an explanation for the deviation. The deviation will be reviewed and considered by the State. Please note, however, that deviations from the RFP may result in a proposal being rejected or evaluated lower if the State does not amend the RFP requirements

95. Question: Per RFP section 4.4.5 F. Attachment J-6: Subcontractor Questionnaire, kindly provide an additional four (4) copies of Attachment J-6a.

    Answer: Attachment J-6 (Subcontractor Questionnaire) contains 6 tabs Attachment 6a-6f. Please use these tabs first. If an Offeror proposes more than 6 subcontractors, Attachment J-6: Subcontractor Questionnaire 6(g-j) can be completed. See Amendment #3, item 1.

96. Question: For Attachment J-15: Optional Programs and Services, there is not enough space in one row to describe one program. Are we allowed to use more than one row to describe a particular program? In the event that we have additional deviations beyond what Attachment J-16: Deviations will allow, how would you like us to document those deviations?

    Answer: Yes, Offerors may utilize more than one row to describe a program, if necessary. The State requests that answers are complete and brief. Please refer to RFP Section 4.4.5 (page 25). As described, Microsoft Excel will only print the first 1,024 characters per cell. Please limit your response in each cell to that length.

Please see the response to Question #89 above. Attachment J-16: Deviations has been expanded as a part of Amendment #3, item #2.

97. Question: Per Amendment #2, there are approximately 64,706 State employees who are potentially eligible to be referred for EAP Benefits. When we follow the instructions in the Amendment and apply it to the census file, the count is 72,141. Q&A#4 also states that those eligible for the EAP include active, direct pay and satellite including those that have not elected medical coverage (PPO, POS or EPO plan) through the State of Maryland plans. Retirees and schools that make up the University of Maryland system employees are not eligible for EAP coverage. There are approximately 64,706 State employees who are potentially eligible to be referred for EAP benefits. When we follow the instructions in the Q&A, which are different from those in the Amendment, the count is 76,457. Please clarify. The numbers in the census file do not match the Q&A or the Amendment.

    Answer: Retirees and schools that make up the University of Maryland system employees (excluding University of Maryland at College Park and Baltimore Campus) are not eligible for EAP coverage.

    The census data provided does not include members who have not elected medical plan coverage. The census data provided also does not identify those members of the University of Maryland system who are not eligible for EAP coverage. Therefore, the census data provided will not match the 64,706 provided in the Amendment.

98. Question: (Attachment J-14: Performance Guarantees) PG7 - What is meant by Automated Claims System Availability? Does this refer to an Offeror's internal processing system? Or the method for submission of electronic claims?

    Answer: Please see response to question #41 on Q&A #3. This performance guarantee is referring to the claim system available to providers for the electronic submission of claims.

99. Question: (Attachment J-14: Performance Guarantees) PG8 offers an "or". We prefer the second option but are not clear on why there is an "or". Is this in fact a choice or is one for BH and the other one for EAP?

    Answer: The selected contractor can choose either method for measuring the claim processing time described in PG-8. The difference between the two options is that the first measure is based on the number of business days while the second measure is based on the number of calendar days.

100. Question: (Regarding the utilization data) For the period July 2006 though June 20009, for all enrollment types Attachment N shows a total of 6,167,976 member months and 24,424 Inpatient units of care. This calculates to 47.5 days per thousand members. In Bidders Q&A # 3, Answer number 30 shows 29.93 days per thousand members per year for the period July 2009 through March 2010. Can you advise bidders why utilization has declined so significantly?

Answer: Inpatient units of care as shown on Attachment N: Confidential Data are not a count of days but are encounters as defined by a count of distinct patients, a given service date, with a distinct provider and should not be interpreted to be a number of days.

101. Question: (Regarding the utilization data) Can you please provide the average percentage of claims units paid in vs. out of network by Inpatient, Intensive Outpatient, Outpatient, and Partial Hospital Plan?

Answer: Please see response to question #85 above.

102. Question: (Regarding the utilization data) Please confirm that retirees age 65 and older must sign up for Medicare parts A and B, and that all claims for age 65 and older retirees are paid on a secondary basis to Medicare?

Answer: Active Employees and their covered dependents do not have to sign up for Medicare Parts A & B when they become eligible because of age or disability as long as they continue to be Active Employees. Their State benefits coverage continues as primary coverage, as long as they are Active Employees. However, Retirees and dependents of Retirees must enroll in both Medicare Parts A & B as soon as they are eligible (due to age or disability) to have full Medicare claims coverage. Retirees or a covered dependent of a Retiree who are eligible for Medicare Parts A & B have Medicare Parts A & B become the primary insurance and the State health plan becomes a supplemental policy to Medicare. Some retirees, a very small population, who are not eligible for subsidized Medicare Part A & B coverage as a result of the State's Section 218 Agreement, are not included in this general rule for retirees. Such individuals can be identified as necessary.

Should you require clarification of the information provided, please contact me at (410) 260-7374 as soon as possible.

Date Issued: **June 18, 2010**

By: Andrea R. Lockett
<signed>
Procurement Officer