| Date | Question | Answer |
|---|---|---|
| 12/28/2005 | Can the child and adolescent doctor work in services (also crisis operated by SER - and possibly work with providers - as our employee? | There must be a firewall between the service functions and LME functions. The doctor should not be involved in the service side and also be involved in the UR side for the same consumer. |
| 12/28/2005 | Can we contract with other LMEs in our alliance for staff that we do not have - example: psychologist? | Yes, but no UR staff can be involved in UR related to consumers to whom he/she provided any services. |
| 12/28/2005 | Are the physicians counted in the 1 staff per 35,000 covered lives - or outside that number? | counted in the 1/35,000 ratio |
| 12/28/2005 | Do all authorizations have to be reviewed or will it be a percentage? | Per the service definitions, all have to be reviewed. |
| 12/28/2005 | What would the credentials look like for the care coordinator? | Care coordinator must meet qualifications required to maximize Federal Financial Participation (FFP) |
| 12/29/2005 | How many copies of the UR application should be submitted? | One original and one copy. |
| 12/29/2005 | We are working on our UR application now and in Criteria 5.4 it requests a sample of the Prompt Pay Provision Report. I've never heard of such a beast. There is a review as part of our annual Medicaid audit but no report. Way back in 2002, there was a call for the report but it was cancelled before it even got started because it didn't make a lot of sense. Maybe someone is operating off that? Anyways can you let me know whether I've blanked out on the last three years or how to respond to the criteria or perhaps give me some guidance on who to confirm this with? I'm sending the memo from 2002 that killed it off in a separate e-mail. | 5.4 Says The LME must submit annual, quarterly and monthly reports to DMA as specified including varying comparative analyeses by service code, diagnosis, denials, authorizations, respone ttime and appeals. Additional information about specific reports that may be required was listed in on page 17, # 3.14.2 Reporting, in the 6/16/05 DMA RFP |

| Date | Question | Answer |
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| 1/2/2006 | The RFA repeatedly refers to the application being for "regional UR and after hours STR" yet the Q&A states, "The Regional LME will do all telephonic STR for its coverage region". This is a big difference; please clarify. | **NOTE CHANGE:** For telephinc screening , triage, and referral, this may be done either for the region 24/7/365 or it may be done for the region to cover only after hours including holidays and weekends and by individual LMEs during regular working hours. |
| 1/3/2006 | If all telephone STR is to be done by the Regional UR, then that means more staff, are those staff part of the 1/35,000? | Staff for STR are not counted in the 1 to 35,000 population ratio that applies to UR. |
| 1/3/2006 | If an LME has a facility-based crisis center that performs face to face assessments 24/7, does this meet the standard? | Yes having at least one local location where people can have initial face to face contact is required. |
| 1/3/2006 | Why the requirement for a Master's degree for CAP approvers? Where did that come from? Is that a DMH issue, or did it derive from the CMS review? Those folks are going to be almost impossible to find. If the requirement holds, will there be a grandfather period for existing staff? | **NOTE CHANGE:** Master's degree for CAP approvers will not be required. |
| 1/3/2006 | Regarding Appeals: Once the Medical Director has reviewed for denial, reduced, terminated - does the Regional UR conduct the appeals or is it sent to the Local LME to conduct the appeal? If it's regional will the Regional staff be expected to go to all the counties in the region to conduct appeals? | The regional UR LME is responsible for sending out the required notices regarding denial, reduction, or termination and must be able to meet all Medicaid requirements for participation in any appeal process.. |

| Date | Question | Answer |
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| 1/3/2006 | 1.4 "UR staff who will be doing UR for Medicaid services and UM/UR for state-funded services for the staff listed below" Does this mean the Regional staff will be doing UR for all service including the initial? VO doesn't do intial, they only do reauthorizations once the initial 8 and 26 have occurred. Are UM functions only for state dollars or both state and Medicaid? | 1.4 Addresses the submission of names, vitas and copies of current licenses or certifications for the Medical Director and specific staff who will be doing UR for Medicaid and UM/UR for state-funded services. The LMEs whose applications for UR and STR will begin doing UR for Medicaid services on 4/1/06 and for State funded services on 7/1/06. The requirements for initial authorizations for Medicaid are as specified in the service definitions. For Medicaid outpatient services, the first authorization to be done by the Regional UR LME would be after the initial 8 adult sessions and after the 26 child sessions. For State funded outpatient services, the first authorization would be done after the initial 8 sessions for both children and adults. Regional STR functions are scheduled to begin 6/1/06. |

| Date | Question | Answer |
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| 1/3/2006 | Is there any room for negotiation on the LME review of the PCP components? Specifically, does the person served signature or that of a legally responsible party have to be viewed as an element of the PCP checklists or can it be done as a part of the monitoring and audit functions after the fact? This issue can create some inefficient systems as it relates to electronic interface due to the difficulty and expense of obtaining electronic signature capacity from consumers served in a community based system of care and handling paper through faxes and hard copies. Clearly these methods may work like faxes, and Provider Link but they also add expense in purchasing, maintaining and staffing just to name a few. If this must be done can you explain the rationale since we have endorsed these providers and trust them to meet medically necessary needs and adhere to client rights do we not also have the confidence that they can obtain a signature in accordance with rules without having to actually see the signature. | The issues regarding how the requirement to review signature of the diagnostic assessment and the PCP as it relates to electronic interface and the expense of obtaining electronic signature capacity will be explored further by the Division. |
| 1/3/2006 | On the new PCP checklist there is also a signature requirement for Diagnostic Assessment. It is unclear why we would need to view the signature of staff delivering a service under an endorsed agencies policies and guidelines for this service. Can this be also done after the fact during monitoring and review practices as it also creates additional system inefficiencies and cost? | The issues regarding how the requirement to review signature of the diagnostic assessment and the PCP as it relates to electronic interface and the expense of obtaining electronic signature capacity will be explored further by the Division. |
| 1/3/2006 | Will there be a new Division approved PCP format many of the elements requested on the Checklist do not currently exist in the approved PCP formats under the APSM 45-2? | A format for PCP will be provided by the Division and will be included in a revised Records Manual (APSM 45-2) |

| Date | Question | Answer |
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| 1/3/2006 | How many staff will be funded to provide the "care coordination role at the non regional UR LME (1: 35,000 for example)? Will there be any care coordination role for the Regional entities? | The Regional LME will be continue to be responsible for its local care coordination. |
| 1/3/2006 | Are we supposed to send Eric Johnson a copy of the file or are we suppose to include it for review with the other information systems documentation required? | The required IT file and other information systems documentation should be sent with the application. |
| 1/3/2006 | Can the STR after hours be subcontracted to a vendor like Protocol or Holly Hill to create better efficiencies in cost? | STR could be subcontracted, but all STR requirements must be met. |
| 1/3/2006 | If a warm transfer is required how will the provider on the Crisis line in the local community be reimbursed under the current fee for service structure since this will be a new requirement? | Crisis services require the ability to take calls 24/7/365. |
| 1/4/2006 | On page 6, 5.3 the LME must be able to receive authorizations via IPRS or other data system. I'm unclear about under what instances we would receive authorizations rather than issue the authorization. Also, will the file specifications for receiving authorizations be identical to those for sent authorizations? | The intent is that the (1) LME must be able to receive requests for authorizations from Medicaid providers and to send authorizations as required by DMA for Medicaid services and (2) LME must be able to receive requests from providers for authorizations for state funded services and send approved authorizations to the LME in which the consumer is being served. |
| 1/4/2006 | $4.2 million maximum bid - We were hoping you could ask someone from the state; Does the maximum bid include the one-time start up costs, or is it for the recurring annual costs only? | The regional application bid must represent the total cost of performance. |

| Date | Question | Answer |
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| 1/4/2006 | 4.1 (Application for UM/UR and STR) - "The LME must be able to accurately interpret and apply the UR guidelines for State and State-allocated federal funds developed by each LME .....". Question: Is the Div planning on developing one single set of guidelines for State and State-allocated federal funds for all LME's (I think I heard this was being developed) or is each LME still expected to develop their own unique guidelines? | The Division will be developing a UR policy guideline framework for use of State and State allocated Federal funds. However, each LME will still be expected to have a specific resource use plan and to adjust that plan on an ongoing basis throughout the year based on the demand for service and the availability of funds. |
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