pennsylvania
DEPARTMENT OF PUBLIC WELFARE

May 28, 2014

RE: *Responses to questions submitted under Request for Application (RFA) #04-14*

The Department of Public Welfare (Department) is issuing responses to questions received on or before May 28, 2014. Any questions submitted that do not appear in this posting remain under review. The Department intends to issue responses to all remaining questions that have not been formally addressed in this posting on May 30, 2014 and June 5, 2014.

Please note that the Department intends close the question submission period for RFA #04-14 on June 2, 2014 at 12:00pm. Any additional questions submitted after that deadline will be considered as part of the discussions with selected applicants.

The Department is pleased with the positive response regarding the Healthy Pennsylvania Program and RFA # 04-14.

Barry Bowman,
Project Officer—RFA #04-14
Department of Public Welfare
Office of Medical Assistance Programs
Bureau of Managed Care Operations

RFA #04-14

Questions by Topic

As of 05/28/2014

Section 1 - RFA/Draft Agreement/Participation

1. Q. We are wondering why there is no Small Diverse Business (SDB) requirement for this RFA?

   A. Given the nature of the procurement and resulting agreements, the Department was not required to, and opted not to include SDB requirements in this RFA.

2. Q. Why is a RFA treated differently than other PA procurements (RFPs, RFQs) that have a standard 20% of points awarded based on SDB Submittals?

   A.The Department determined that the Request for Application (RFA) procurement method was best suited to achieve the Department's Healthy Pennsylvania Program objectives. For this procurement, the Department will determine whether an applicant is qualified and will select for negotiations all applicants determined to meet the criteria set forth in the RFA. See Part III of the RFA.

3. Q. For Section II-5 of the RFA is DPW seeking Geisinger Health Plan's 2015 QHP self-certifications to prove compliance with state and federal laws regulating health insurance coverage? Or is DPW seeking the 2015 self-certifications? Or both?

   A. The 2015 plan form filing, with the updated Compliance Checklist and Certification, should be refiled to comprise a complete product filing with PID. The Compliance Checklist and Certification should be substantially identical to the form provided in the.

4. Q.If a plan chooses not to respond to an RFA, is there a possibility that a plan can come in at a later date?

   A. Yes. The Department may choose to issue a solicitation at a later date. See RFA Part I, Section I-4.

5. Q. When is the bid "opening" date? (there is no reference to such a date on the Healthy PA RFA home page on the general services website)

A. Applicants will not be submitting bids. An applicant can file an application up to the submission deadline of June 10, 2014 at 12:00 p.m. Please refer to the RFA "Calendar of Events" on page 4.

6. Q. What is the desired font type and font size for the submission? Also, can the submission be 2-sided?

   A. Arial 12 is the preferred font type and size for the submission; however, if not used, the font type and size must be easily readable. Double-sided submissions are acceptable, but not required.

7. Q. Is a cover letter permissible to go along with the submission? If so, is there a specified maximum length?

   A. A cover letter is permissible. If an Applicant chooses to include a cover letter, it still must submit a properly completed Attachment C, Application Cover Letter Template. See Part I, Section I-12 for these requirements. Please follow the Part I, Section I-13 of the RFA, Economy of Preparation standard.

8. Q. On page 17 of the PCO agreement, there is a reference to "qualified providers." However, in the definitions section they only have the term "providers" defined. Can you provide a definition for "qualified providers?"

   A. Qualified Providers are providers who meet all of the state and federal regulatory requirements of the specified provider type and meet the qualifications of the PCO Agreement.

9. Q. On page 40 of the PCO agreement, what is considered a non-emergency medical condition?

   A. The commercial definition of emergency services will apply to the Healthy Pennsylvania Program. Emergency services are defined at 40 P.S. §991.2102 and 28 Pa. Code §9.602.

10. Q. While we would have experience incentivizing healthy outcomes, does the Department intend to provide direction and/or support to PCOs on the Encouraging Employment requirement in the DRAFT PCO Agreement (see Section V(G)) consistent with the Healthy Pennsylvania Program as proposed by the Commonwealth?

    A. Pending Federal approval, the Department will work with PCOs to develop and implement these types of initiatives.

11. Q. Will a Health Plan be considered if the NCQA Interim Survey Accreditation is in process but not completed at the time of readiness review?

A. Applicants must meet the NCQA requirements set forth in Part III, Section III-3D by August 4, 2014. For purposes of applications, applicants should submit its most recent accreditation and the Department will consider interim survey accreditations.

12. Q. Does the Healthy Pennsylvania Program only cover the population below 133% of the Federal Poverty Level excluding Medicaid eligible, or are Medicaid eligible individuals also able to join the Healthy PA program?

    A. Medicaid eligible individuals will not be enrolled in Healthy PA, with one exception. If a Member who is enrolled in a PCO becomes pregnant while enrolled, she will become MA eligible and have the choice of enrolling in Medicaid or continuing her enrollment with the PCO.

13. Q. Will preference be given to PCOs that cover the entire state?

    A. No, the Department will select for negotiations every applicant who meets the criteria set forth in the RFA. See Part III of the RFA, "Criteria for Selection".

14. Q. Will there be a minimum and maximum number of PCOs selected for each Region?

    A. The Department intends to have at least two PCOs operating in each Region. The Department will select for negotiations every applicant who meets the criteria set forth in the RFA. There are no pre-established maximums.

15. Q. The RFA requires that applicants provide a copy of the certification submitted to the PID with the plan form filing. Are plans required to file as an on or off exchange plan? (Reference RFA)

    A. The certification must certify that the coverage that will be provided meets all applicable federal and state laws regulating health insurance coverage offered in the individual market. See Part II-5 of the RFA, "Compliance with Insurance Requirements." Both the Market Reform and QHP portions of the certification should be filled out and submitted with the plan form filing. An Applicant is not required to offer its PCO product on the exchange, but must specify its intentions (whether it is offering the product on or off the exchange) at the time of filing.

16. Q. Section I-6 of the Request for Application refers to the discretionary rejection of applicants. What are additional reasons that can cause the rejection of an otherwise acceptable applicant?

    A. The Department is unable to speculate as to what additional reasons may cause it to reject a submitted application.

17. Q. For 2015, will members under FPL 133/138% lose their Federal subsidies for exchange coverage?

    A. A Member who is enrolled in Healthy PA is not eligible for Federal subsidies on the exchange.

18. Q. Will a PCO need to compete with others within each region? If so, how many competitors can be anticipated?

    A. The Department intends to have at least two PCOs operating in each Region. The Department will select for negotiations every applicant who meets the criteria set forth in the RFA.

19. Q. We understand this section to be subject to Sections II-5 and III-B(3), which also state that Applicant must provide documentation that each plan through which coverage will be provided meets all applicable federal and state laws regulating health insurance coverage offered in the individual market, but adds that if the Applicant does not possess documentation at the time of application, the Department may provisionally qualify the Applicant conditioned upon its acquiring the necessary documentation by August 4, 2014 or such later dates as may be specified by the Department. Please confirm and clarify.

    A. Part IV, Section IV-3.D sets forth the Agreement requirement that an HMO certify that each plan for which PCO coverage will be provided meets all applicable federal and state laws regulating health insurance coverage offered in the individual market. For purposes of its Application only, if an Applicant has not made its final certification at the time of application, it must provide a statement describing its plan to have its certification in place by August 4, 2014 or such later date as may be specified by the Department. See RFA Part II, Section II-5.

20. Q. To the extent an Applicant may not control what entities purchase shares of an ultimate parent company that is publicly traded, or therefore be able to make representations regarding such entities, would the State consider revising this sentence to clarify that Affiliate does not include institutional investors with no control over the Applicant or its parents or subsidiaries by adding the phrase ", and with control over," after the words "ownership interests of", as follows? "Without limitation, all officers, or persons, holding five percent (5%) or more of the outstanding ownership interests of***, and with control over,*** PCO or its parent(s), directors or subsidiaries of PCO or parent(s) shall be presumed to be Affiliates for purposes of the RFA and Agreement."

    A. The Department will not consider changing the definition because it wants to keep the definition consistent with federal regulations. The federal regulation prohibits a knowing relationship with these entities.

21. Qa. Could the state please clarify the intent of including this statement in the definition of "Affiliate"?

    Aa. The Department has defined Affiliate as a person with an employment, consulting or other arrangement for the provision of items and services that is significant and material to the PCO's obligations under this Agreement.

    Qb. Would the State consider striking or moving to the definition of subcontractor?

    Ab. No. Federal regulations at 42 C.F.R. §438.610 encompass this type of relationship. These persons may also be encompassed by the definition of Subcontractor set forth in RFA Attachment A, Draft Agreement, Section II, Definitions.

22. Q. "A PCO Health Care Provider who has a written contract with and is credentialed by a PCO and who participates in the PCO's Provider Network." We understand this to mean that Network Providers may be credentialed by a subcontractor of PCO, provided PCO maintains oversight of the subcontractor. Please confirm and clarify.

    A. A PCO's credentialing of its provider network must comply with 40 P.S. §991.2121 and 28 Pa.Code §§9.761-9.763.

23. Q. Must the PCO meet all the qualifications contained in the Insurance Department's "Affordable Care Act; Guidance for Compliance Submissions; Notice 2014-04," including the QHP requirements? Or must the PCO meet only those requirements applicable to the plans being offered? For example, would guaranteed availability and renewability apply, if this product is only offered to eligible enrollees during the term of their eligibility? If only a subset of the requirements in Notice 2014-04 apply, which ones are inapplicable?

    A. For purposes of the Compliance Checklist and Certification filed with PID, if an Applicant believes a requirement is not applicable to the PCO product, it may note that in its certification.

24. Q. Same questions submitted regarding Section II-5. (Must the PCO meet all the qualifications contained in the Insurance Department's "Affordable Care Act; Guidance for Compliance Submissions; Notice 2014-04," including the QHP requirements? Or must the PCO meet only those requirements applicable to the plans being offered? For example, would guaranteed availability and renewability apply, if this product is only offered to eligible enrollees during the term of their eligibility? If only a subset of the requirements in Notice 2014-04 apply, which ones are inapplicable?)

A. For purposes of the Compliance Checklist and Certification filed with PID, if an Applicant believes a requirement is not applicable to the PCO product, it may note that in its certification.

25. Q. In order to meet this requirement and offer the product described in this RFA, must Applicant submit a PID plan form filing, if Applicant is only submitting this certification for purposes of offering the product described in this RFA?

A. Yes, an Applicant should submit a plan form filing as well as a Compliance Checklist and Certification. The Applicant should submit its policy form via SERFF as a Form Schedule document. If assistance is needed regarding SERFF, the Applicant may contact the Insurance Department. (Please contact Ms. Tracy Bixler, Life & Health Insurance Policy Examiner Supervisor, 717.783.2112, tbixler@pa.gov.)

26. Q. Same question submitted regarding Section II-5. (In order to meet this requirement and offer the product described in this RFA, must Applicant submit a PID plan form filing, if Applicant is only submitting this certification for purposes of offering the product described in this RFA?)

A. Yes, an Applicant should submit a plan form filing as well as a Compliance Checklist and Certification. The Applicant should submit its policy form via SERFF as a Form Schedule document. If assistance is needed regarding SERFF, the Applicant may contact the Insurance Department. (Please contact Ms. Tracy Bixler, Life & Health Insurance Policy Examiner Supervisor, 717.783.2112, tbixler@pa.gov.)

27. Q. The PCO must comply with Sections 2102 and 2116 of the Insurance Company Law of 1921 40 P.S. §991.2102 and 991.2116, and 28 Pa. Code §9.672 and 31 Pa. Code §154.14 pertaining to coverage and payment of Emergency and Stabilization Services. For this population funded through title XIX, we suggest that payment for out-of-network emergency stabilization services be required at Deficit Reduction Act levels.

A. The PCO will need to comply with applicable law and regulation.

28. Q. May the Applicant modify its application by sealed written notice after the date specified for application receipt in order to remove Regions on which Applicant has bid, and without Applicant's application being rejected or its offer to negotiate an Agreement being rescinded, if rates applicable to the Regions proposed for removal are either not available for Applicant's review or are not approved by Applicant in writing?

A. After an Applicant has been selected for negotiations, it may modify its application to remove those Regions for which it is unable to reach agreement on

rates, or meet all RFA requirements for those Regions without affecting its application for other Regions.

29. Q. What rate should we expect to pay for out of network emergency services?

    A. The PCO will need to comply with applicable law and regulation.

30. Q. May we be provided with a zip code based / geographic view of the prospective Medicaid expansion eligibles?

    A. The Department does not possess a zip code-based distribution. An estimated population distribution based upon county of residence is provided as an attachment to this response document. The Department has prepared the estimate based upon the assumption that the Healthy Pennsylvania Program's beneficiary population of 500,000 will be geographically distributed similar to the population of the HealthChoices Program.

    Please note that this information represents the Department's estimate and may not reflect actual distribution following commencement of the Program.

31. Q. What actions can a PCO take prior to the August readiness review period to ensure the applicant is positioned to increase the efficiency of the readiness review period? (i.e. Will the Department readiness review include analysis of documentation on current policies and procedures, benchmarks, and/or applicable processes?)

    A. The Department will provide guidance to assist in preparation for the readiness review at a later date.

32. Q. May Applicants follow-up directly with the Pennsylvania Insurance Department (PID) contact with any questions regarding the PID filing in addition to the Project Officer for the Healthy Pennsylvania Program?

    A. Applicants may follow-up with the PID with plan-specific questions related to its PID policy form filings. (Please contact Ms. Tracy Bixler, Life & Health Insurance Policy Examiner Supervisor, 717.783.2112, tbixler@pa.gov.) Any questions related to the RFA or its Attachments should be directed to the DPW Project Officer identified in Part I, Section I-2.

33. Q. Please clarify that Applicants responding to this RFA and not intending to offer their Healthy Pennsylvania product as a qualified health plan on the Exchange need only to complete the Compliance and Checklist for the PID submission portion of the RFA.

    A. An Applicant should submit a plan form filing as well as a Compliance Checklist and Certification. The certification must certify that the coverage that

will be provided meets all applicable federal and state laws regulating health insurance coverage offered in the individual market. See Part II-5 of the RFA, "Compliance with Insurance Requirements." Both the Market Reform and QHP portions of the certification should be filled out. An Applicant is not required to offer its PCO product on the exchange, but must specify its intentions (whether it is offering the product on or off the exchange) at the time of filing.

34. Q. If Applicant has not made a final certification at time of application, they must submit a statement describing the plan to have certification in place by August 4, 2014. Please clarify whether this pertains to those items on the PID's Compliance Checklist and Certification where Applicant has indicated "No" under "Certification of Compliance."

    A. The certification must certify that the coverage that will be provided meets all applicable federal and state laws regulating health insurance coverage offered in the individual market. See Part II-5 of the RFA, "Compliance with Insurance Requirements." Both the Market Reform and QHP portions of the certification should be filled out, though an applicant is not required to offer its PCO product on the exchange. A "No" answer will not prevent a certification from being final, though it may impact the final approval of the PCO plan, A Compliance Checklist and Certification should be submitted to the PID by August 4, 2014 or such later date as may be specified by the Department.

35. Q. The RFA states that "if covered services or Beneficiaries are expanded or eliminated, the PCO will implement on the date the PCO is notified by the Department to continue or discontinue services." Will the Department provide PCOs with advance notice of possible changes in order for them to effectively implement the programmatic changes?

    A. The Department will provide notice of changes and potential changes as information becomes available to the Department.

36. Q. Does the Department have any example of or specific requirements related to the member incentives program that a PCO is responsible for developing and implementing as part of the Healthy PA initiative?

    A. Pending Federal approval, the Department will work with PCOs to develop and implement these types of initiatives. Please see Section V.G.

37. Q. What is the Department's expected process or procedure for communicating the status of PCO application after the readiness review but prior to the final approval into the Healthy PA program?

    A. The Department plans to notify PCOs if they have met the qualifications on or about June 20, 2014. After selection and through implementation, the Department will communicate with selected PCOs as needed.

38. Q. Does Option A [of Healthy PA 1115 Waiver, Section5.3 Section A] require a PCO to offer the plan through the FFM?

    A. PCOs are not required to offer a plan on the FFM.

39. Q. Will CMS review the PCO plans that will be included in the Healthy PA Private Coverage option?

    A. CMS approval of each DPW/PCO agreement is required.

40. Q. Will the state publish FFM plans in addition to private and ESC plans on the Department's enrollment portal?

    A. No. Only Healthy PA PCO plans will be available through the Department's enrollment contractor.

41. Q. Is there a minimum and maximum number of PCOs in each region? The answer provided in the conference was "All successful applicants will be accepted. There is no limit or specific number of PCOs that will be accepted by region." We would like confirmation of this in the form of a written response.

    A. The Department intends to have at least two PCOs operating in each region. The Department will select for negotiations every applicant who meets the criteria set forth in the RFA. There are no pre-established maximums.

42. Q. The RFA requires that Applicant provide documentation that it has a valid Certificate of Authority as an HMO. Provided Applicant meets the other applicable submission requirements, would Applicant be precluded from applying using a Certificate of Authority that Applicant also uses for a Medicaid program?

    A. In order to qualify to offer a PCO product, an Applicant must have a Certificate of Authority jointly issued by PID and DOH pursuant to The Health Maintenance Organization Act, 40 P.S. §1551 et seq. to operate as an HMO in Pennsylvania. For the product(s) proposed to be offered, an Applicant should also submit a plan form filing as well as a Compliance Checklist and Certification to the PID, and the certification must certify that the coverage that will be provided meets all applicable federal and state laws regulating health insurance coverage offered in the individual market.

43. Q. If Applicant already has a Certificate of Authority to operate an HMO for a Medicaid program in the counties for which Applicant submits an application, is it necessary for an Applicant to submit a modification to its HMO license?

    A. In order to qualify to offer a PCO product, an Applicant must have a Certificate of Authority jointly issued by PID and DOH pursuant to The Health Maintenance

Organization Act, 40 P.S. §1551 et seq. to operate as an HMO in Pennsylvania. For the product(s) proposed to be offered, an Applicant should also submit a plan form filing as well as a Compliance Checklist and Certification to the PID, and the certification must certify that the coverage that will be provided meets all applicable federal and state laws regulating health insurance coverage offered in the individual market.

44. Q. At the bidder's conference, it was stated that PCO plans must satisfy PID criteria for commercial HMOs. Which PID criteria must the PCO plan satisfy?

A. The Department is not sure the context of the response that was given at the pre-application process. To the extent that the question and response refers to the criteria to be used for determining whether an Applicant is qualified, PCO entities must comply with all PID regulatory requirements. For the product(s) proposed to be offered, an Applicant should also submit a plan form filing as well as a Compliance Checklist and Certification to the PID, and the certification must certify that the coverage that will be provided meets all applicable federal and state laws regulating health insurance coverage offered in the individual market.

45. Q. To the extent there is any conflict between the Department's responses to questions submitted by prospective Applicants regarding this RFA, does the later response always control?

A. The Department is bound only by information contained in the RFA or as issued as an addendum to the RFA. Please see Section I-9 of the RFA Part I-9.

46. Q. Regarding compliance with insurance requirements, will the form filing and compliance checklist that were submitted to PID last year be sufficient documentation for purposes of the RFA?

A. The 2015 plan form filing, with the updated Compliance Checklist and Certification, should be refiled to comprise a complete product filing with PID. The Compliance Checklist and Certification should be substantially identical to the form provided in the Pennsylvania Bulletin for use in 2015. If the plan has a 2014 self-certification, it should also submit it to the Department, as well.

47. Q. Will applicants have to do a form filing with the PID regarding Compliance with insurance requirements? We would like more clarity on the Compliance with insurance requirements section.

A. To assist DPW, for any plan (or product) through which an Applicant intends to offer the PCO, the Applicant should submit the policy form, along with a Compliance Checklist and Certification, to PID via SERFF. A form Compliance Checklist and Certification is available on the Department's website, in SERFF in the "general instructions", and in the PA Bulletin as linked in the RFA. Both the Market Reform and QHP portions should be filled out, and the Certification

executed by an authorized representative of the insurer. PID asks that these documents be submitted with the policy form via SERFF as a Form Schedule document. Also, if the policy form an Applicant intends to use for the PCO is substantially identical to a policy form the Applicant intends to use in the Marketplace, it would be helpful to note that in the submission, as it will facilitate the review process.

48. Q. Please confirm that Attachment A of RFA #04-14, Section VII (D) (4) allows a plan to provide network only services and deny coverage of services that are received from out-of-network providers except for emergency services, access and continuity requirements under Pennsylvania laws.

    A.The PCO is required to provide coverage of services received from an out-of-network provider as may be required by law, which includes but may not be limited to emergency services, and services as defined in the access and continuity of care requirements.

49. Q. Please confirm that as this program was submitted for approval as a Section 1115 demonstration project, the Healthy Pennsylvania Program qualifies as an extension of the Medicaid program and existing Medicaid network contracts can be used to support the program.

    A. The Healthy Pennsylvania Program is not an extension of the MA Program. In terms of the provider network, the applicant must ensure that its network of providers will meet the DOH adequacy standards and have the capacity to serve the numbers and demographics of the population to be served through the Healthy Pennsylvania Program.

50. Q. Will the PCO be responsible for performing casualty related recoveries?

    A. Yes, the PCO will perform all casualty related recoveries including but not limited to workers' compensation, motor vehicle accidents, slip and falls, medical malpractice, etc. The Draft Agreement will be changed to reflect this responsibility

51. Q. Will the PCO be required to pay for prenatal services and then chase any potential primary coverage post payment?

    A. Yes, the PCO should pay for prenatal services and pursue any recovery from a primary insurer post payment.

52. Q. In reference to paragraph II-4 of this RFA regarding County Operational Authority, the HMO's intent is to provide documentation of our existing DOH licensure, as we will use this legal entity for our proposed Healthy PA product. In terms of building our Healthy PA provider network, HMO's intent is to provide a statement indicating that we will have a provider network, specific to Healthy PA,

in place by August 1, 2014. Because we are not proposing to expand into any counties/regions outside of our current service area, we do not see the need to submit a Service Area Expansion (SAE) request as part of this RFA. Is our understanding of what is required to demonstrate DOH County Operational Authority accurate and complete?

A. Questions regarding DOH County Operational Authority should be directed to the Department of Health. Documentation of DOH County Operational Authority, or a written statement outlining the PCO's plan to have DOH County Operational Authority in place by August 4, 2014, is required for Applicant's submission on June 10, 2014.

If DOH approved a plan to operate in certain counties, the approval meets the operating authority requirement in the RFA. However, from a network adequacy standpoint, DOH will still want to review the network the company plans to use for the Healthy Pennsylvania population to ensure that there are enough providers to handle the influx of new business.

Section 2- Enrollment related

1. Q. Will Maximus be the enrollment broker utilized for Healthy PA enrollment?

   A. Maximus is the current enrollment broker engaged by the Department and the Department anticipates that it will be the enrollment broker for the implementation of the Healthy Pennsylvania Program.

2. Q. What is the expected enrollee coverage duration? Are enrollees likely to move to and from Private Coverage Organizations (PCO) to Individual Commercial Coverage throughout a calendar year period?

   A. The Department does not possess a zip code-based distribution. An estimated population distribution based upon county of residence is provided as an attachment to this response document. The Department has prepared the estimate based upon the assumption that the Healthy Pennsylvania Program's beneficiary population of 500,000 will be geographically distributed similar to the population of the HealthChoices Program.

   Please note that this information represents the Department's estimate and may not reflect actual distribution following commencement of the Program.

3. Q. Can you provide a breakdown of eligible enrollees by rating region?

   A. The Department does not possess a zip code-based distribution. An estimated population distribution based upon county of residence is attached. Please note this information represents the Department's estimate and may not reflect actual distribution.

4. Q. It's stated that any requests for enrollment and disenrollment must be referred to the Department. What types of changes would the carrier be permitted to process (i.e. address change within the same rating region, contact information)?

   A. The PCO will report information as specified in RFA Attachment A (Draft PCO Agreement) in Section V.K "Change of Status" found on page 25.

5. Q. Will enrollment and disenrollment (including Automatic Assignment) be effective only on the first of a future month? Will either take place with a retroactive effective date? If either date is other than the first of a month; is it expected that proration of the capitation payment will take place?

   A. Enrollment will be effective on either the 1st or 15th of a future month. Disenrollment is effective at the close of the applicable month. Proration of capitation will occur. The Department is still considering the issue of retroactive coverage in limited circumstances.

6. Q. Please clarify the process for eligibility determinations and enrollment. Can individuals apply through the Federally Facilitated Marketplace as well as through the State's COMPASS system (like CHIP and Medicaid today)? Will there also be paper applications for the program? Will the PCO's be responsible to enter the paper applications into COMPASS as is done today for CHIP? Will families be able to use one application and the system will determine which programs all family members are eligible for (Medicaid, CHIP, Healthy PA Program, marketplace subsidy)?

   A. The PCO will not be involved in the eligibility determination or actual enrollment process. The Department is responsible for eligibility determinations and enrollment into the Healthy Pennsylvania Program.

7. Q. Will the enrollees be equally divided among all plans in each Region?

   A. Beneficiaries are able to choose a PCO. Only those Beneficiaries who do not choose a PCO will be distributed evenly amongst the PCOs in a Region. Please see Exhibit E Automatic Assignment of Attachment A (Draft PCO Agreement) to the RFA.

8. Q. Would Healthy PA consider moving the identified medically frail enrollees mid-year, similar to the CHIP process?

   A. The Department is currently evaluating how newly identified medically frail individuals will be handled.

9. Q. What is the open enrollment period, and are there any special election periods throughout the year?

A. The initial enrollment period begins December 1, 2014, subject to Federal approval. Beneficiaries, who become eligible for this program throughout the year, have an opportunity to choose a PCO. Beneficiaries are only able to change PCOs once a year or in limited circumstances.

10. Q. Is the distribution directly with the insurance carriers?

    A. The Department does not understand this question.

11. Q. In the Agreement it states that enrollee auto-assignment will be divided equally among all PCOs in an Exchange Region. Do you envision keeping that methodology for the next several years?

    A. Any changes to the Healthy Pennsylvania Program, including changes to auto-assignment process will be communicated to and negotiated with the PCOs.

12. Q. Would DPW consider allowing PCOs to automatically transfer enrollees into a qualified HealthChoices MCO when they have been assessed as Medically Frail?

    A. The Department is currently evaluating how newly identified medically frail individuals will be handled.

13. Q. We note no mention of an enrollee's shopping experience or product pricing display. As such, it is assumed that no online tools are required. Please confirm.

    A. The Department's enrollment broker will provide the shopping experience. PCOs are to engage enrollees in better understanding the cost of health care through Explanation of Benefits (EOBs) and other paper or online tools.

14. Q. Please clarify whether there is any need to file the Healthy PA program on the marketplace.

    A. An Applicant is not required to offer its PCO product on the exchange, but must specify its intentions (whether it is offering the product on or off the exchange) at the time of filing its plan form filing and Compliance Checklist and Certification. Also, if the policy form an Applicant intends to use for the PCO is substantially identical to a policy form the Applicant intends to use in the Marketplace, it would be helpful to note that in the submission, as it will facilitate the review process.

15. Q. Does an applicant have the option to pick Healthy PA if they are deemed medically frail at the point of initial application, or will they exclusively be eligible for Medical Assistance?

A. No, if determined to be medically frail at the time of application, the individual will exclusively be eligible for MA.

16. Q. If a member is covered by Healthy PA and their health deteriorate and become medically frail, can you confirm at what point in time that member will become eligible for Medical Assistance?

    A.The Department is currently evaluating how newly identified medically frail individuals will be handled.

    Please note: A change in an individual's category of assistance at any time could qualify an individual for MA coverage

17. Q. Exhibit E Automatic Assignment describes briefly the auto-enrollment process that occurs when a beneficiary does NOT select a PCO. Are there any more details regarding how are members assigned to the PCO? How does the member choose the PCO?

    A. The initial enrollment period begins December 1, 2014, subject to Federal approval. Beneficiaries, who become eligible for this program throughout the year, have an opportunity to choose a PCO. Beneficiaries are only able to change PCOs once a year or in limited circumstances. The enrollment broker will assist Beneficiaries in their selection of a PCO.

18. Q. Is the member automatically re-enrolled each year?

    A. If this question refers to a Member's choice of a PCO, if the Member continues to be eligible for the Healthy Pennsylvania Program, the Member will be automatically re-enrolled in the same PCO, unless the Member makes a different PCO selection during the annual enrollment period.

19. Q. Is there a defined open enrollment period for this program to avoid anti-selection?

    A. Yes, there is an annual enrollment period during which Beneficiaries are able to choose or change PCOs. Beneficiaries, who become eligible for this program throughout the year, have an opportunity to choose a PCO. Beneficiaries are only able to change PCOs once a year or in limited circumstances. The target initial enrollment period will be December 1, 2014, subject to Federal approval.

20. Q. Can Healthy PA enrollees enroll through the federal exchange or through the PCO's own channels?

    A. Individuals who apply for health care coverage through the federal exchange and appear to meet the eligibility requirements for Healthy PA will be transferred

to the Department for final eligibility determination and enrollment. The Enrollment Broker will be responsible for enrollment activities.

21. Q. How are incomes determined and what are the timeframes for gathering that information?

    A. The PCO is not responsible for income determinations or compliance with timeframes related to gathering that information. The Department will be responsible for determining eligibility for the Healthy Pennsylvania Program, including determinations related to income.

22. Q. Is there a timeframe associated with this provision [Provision concerning eligibles who lose and regain eligibility in RFA Attachment A, Draft Agreement Exhibit E, Automatic Enrollment], for example, regains eligibility within 6 mos and will be enrolled in previous PCO?

    A. The 6 month period does not apply to individuals who lose and regain eligibility. Beneficiaries may only make a new PCO selection in the prescribed annual enrollment period otherwise, they will remain in the same PCO for the program year including situations where eligibility has been lost and re-gained.

23. Q. Will participant eligibility be reflected on the daily eligibility file provided by the Department to the PCO, or will there be a separate identifying file to determine participant eligibility? Since the daily eligibility file has not yet been approved by CMS as a definitive file, PCO would remain at risk for adjudicating claims for participants who would no longer be eligible.

    A. Participant eligibility will be reflected on the daily eligibility file. Please see RFA Attachment A, Draft Agreement, Section V. L.2, page 25. The Department will use a HIPAA compliant 834 format that will closely resemble the PA Medicaid file format.

24. Q. If an individual is employed and is eligible for the Healthy Pennsylvania Private Coverage option, is the individual required to choose the ESC plan option or will they be able to choose between private coverage options as well?

    A. The Department will determine the most cost effective program and the enrollee will receive coverage through that program.

25. Q. How will a consumer enroll into a plan? Will a participant enroll in a state website that includes all plan options or would they be enrolling through healthcare.gov for FFM, private issuers' consumer channels.

    A. The enrollment broker will facilitate the selection and enrollment of a Beneficiary into a PCO.

26. Q. If an individual is eligible but does not choose a plan the Department will auto-assign the participant to a private market plan. How will the department determine which private plan to choose for an individual?

    A. The initial enrollment period begins December 1, 2014, subject to Federal approval. Beneficiaries, who become eligible for this program throughout the year, have an opportunity to choose a PCO. Beneficiaries are only able to change PCOs once a year or in limited circumstances. Please refer to Exhibit E to Attachment A of the RFA, Draft Agreement.

Section 3- Network Requirements/Development

1. Q. Can we use our PA Dept. of Health adequate network approval letters, which we have received for our Medicaid line of business (by county), for this Healthy PA population?

   A. In terms of the provider network, the applicant must ensure that its network of providers will meet the DOH adequacy standards and have the capacity to serve the numbers and demographics of the population to be served through the Healthy Pennsylvania Program.

   If DOH approved a plan to operate in certain counties, the approval meets the operating authority requirement in the RFA. However, from a network adequacy standpoint, DOH will still want to review the network the company plans to use for the Healthy Pennsylvania population to ensure that there are enough providers to handle the influx of new business.

2. Q. Do the Healthy PA participating providers also have to be Medicaid participating providers?

   A. No, Healthy PA providers do not have to be MA participating providers.

3. Q. Will this program be following the ACA network adequacy and Essential Community Providers standards?

   A. Yes. In terms of the provider network, the applicant must ensure that its network of providers will meet the DOH adequacy standards and have the capacity to serve the numbers and demographics of the population to be served through the Healthy Pennsylvania Program. Compliance with the network adequacy and essential community provider standards should also be indicated in the Compliance Checklist and Certification filed with the PID.

4. Q. Will a Health Plan be considered if the Certificate of Authority is in progress, but has not been completed by the RFA due date of June 10, 2014? In the RFA document, Section III-3 Criteria for Selection, the requirements seem to indicate

that a plan will be considered if the Certificate of Authority is completed in a timeline acceptable to DPW.

A. A PID/DOH Certificate of Authority, or written statement outlining a plan how the Certificate of Authority will be in place by August 4, 2014 or such later date as may be specified by the Department, is required for submission on June 10, 2014. See RFA Part III, Section III-3.A.

5. Q. Part II-3 and 4 of the Request for Application describe at length the requirement that the applicant have valid HMO authority in the regions it intends to provide coverage. Can a gatekeeper PPO or EPO be used to administer Health PA instead of an HMO? Is a gatekeeper/PCP required?

   A. The Department requires an HMO model and an HMO Certificate of Authority as specified in RFA Section II-3.

6. Q. Can the provider network change after the Request for Application is submitted?

   A. Yes, the provider network may change; however, the PCO must comply with applicable DOH regulations and maintain DOH Operational Authority in its Regions of participation.

7. Q. Can the PCO have backend agreements with Medicaid MCOs to subcontract the provider network?

   A. In terms of the provider network, the applicant must ensure that its network of providers will meet the DOH adequacy standards and have the capacity to serve the numbers and demographics of the population to be served through the Healthy Pennsylvania Program.

8. Q. How is network adequacy determined? Timing – go-live vs, readiness review Documentation needed – contracted vs. letter of intent

   A. For readiness review purposes, the Department requires DOH County Operational Authority as evidence of network adequacy by August 4, 2014. Applicants must submit Service Area Expansions by July 11, 2014 to the Department of Health. Please refer to RFA Part II, Section II-4.

9. Q. The PCO and its Network Providers must have written provider agreements that comply with 28 Pa. Code §9.722 requirements. We understand this provision to mean that Provider Agreements may include existing provider agreements already contracted with one or more Applicant plans that have been amended or otherwise modified to meet the program requirements as set forth in this RFA. Please confirm and clarify.

A. PCOs must have the appropriate network contracts to obtain and maintain applicable DOH Operational Authority. Applicants may use existing provider agreements and modify them to meet the program requirements so long as the amended agreements continue to meet the regulatory requirements of 28 Pa Code §9.722 of the DOH managed care regulations.

10. Q. If the Applicant does not have operating authority from the State for those counties the Applicant intends to operate by the time they submit their application. According to the RFA the Applicant must "provide a statement regarding its plan to have operating authority for each county in place by August 1, 2014 or such later date as may be specified by the Department." Can the Department please clarify at what point in the application process they would specify any "later date" for obtaining Operating Authority?

    A. By the Application due date of June 10, 2014, an Applicant must provide either documentation of DOH County Operational Authority, or a written statement outlining its plan for having DOH County Operational Authority in place by August 4, 2014, unless the Department specifies a later date. Given that the Department is implementing a new program, we are unable to specify if and when we may extend the date for obtaining DOH Operational Authority.

11. Q. During the contracting process, if a provider wants to know what the fee schedule for the Healthy PA program is based upon, what should we tell them?

    A. The Department does not have requirements for the fee schedule to be used by PCOs to pay their providers. The PCO will have to determine what it communicates to providers during its negotiations with their providers.

12. Q. By what date will provider networks be due for approval by the state?

    A. PCOs must have the appropriate network contracts to obtain DOH County Operational Authority for the Regions in which they have applied by August 4, 2014. July 11, 2014 is the deadline to submit the SAE to DOH to expand its Operational Authority.

16. Given the short time-line, is deeming of current contracts acceptable?

    A. Contracts will not be deemed. Changes and amendments to the standard provider contracts must be submitted to the DOH for review and approval. If DOH approved a plan to operate in certain counties, the approval meets the operating authority requirement in the RFA. However, from a network adequacy standpoint, DOH will still want to review the network the company plans to use for the Healthy Pennsylvania population to ensure that there are enough providers to handle the influx of new business.

17. Q. The RFA requires Applicant to possess a valid Pennsylvania DOH Operational Authority for all counties in the Regions for which the Applicant submits an application. Provided Applicant meets the other applicable submission requirements, would Applicant be precluded from applying using DOH Operational Authority that it has received in such counties for a Medicaid program?

    A. Network adequacy for purposes of the PID Compliance Checklist and Certification depends on DOH approval of the network.

    In order to qualify to offer a PCO product, an Applicant must have a Certificate of Authority jointly issued by PID and DOH pursuant to The Health Maintenance Organization Act, 40 P.S. §1551 et seq.to operate as a HMO in Pennsylvania. For the product(s) proposed to be offered, an Applicant should also submit a plan form filing as well as a Compliance Checklist and Certification to the PID, and the certification must certify that the coverage that will be provided meets all applicable federal and state laws regulating health insurance coverage offered in the individual market.

    In terms of the provider network, the applicant must ensure that its network of providers will meet the DOH adequacy standards and have the capacity to serve the numbers and demographics of the population to be served through the Healthy Pennsylvania Program.

    If DOH approved a plan to operate in certain counties, the approval meets the operating authority requirement in the RFA. However, from a network adequacy standpoint, DOH will still want to review the network the company plans to use for the Healthy Pennsylvania population to ensure that there are enough providers to handle the influx of new business.

18. Q. Sections II-4 and IV-3.C of the RFA explain that if an Applicant does not have current DOH Operating Authority for a Region or county areas within a Region, they must submit a Service Area Expansion ("SAE") request to DOH Bureau of Managed Care (BMC) no later than July 11, 2014. Our understanding from the bidder's conference is that the deadline for having the network contracted is August 4. Would the State permit an Applicant to supplement its SAE filings on or before August 4, to reflect the extended network submission deadline?

    A. The August 4, 2014 deadline applies to the deadline for submitting documentation of DOH County Operational Authority for all counties for which the Applicant has applied to provide services. July 11, 2014 is the deadline to submit the SAE to DOH to expand its Operational Authority.

19. Q. May Applicant use existing network provider agreements that have been amended to include the applicable provider agreement requirements described in

the RFA in order to fully or partially satisfy the network adequacy requirements for this program?

A. In terms of the provider network, the applicant must ensure that its network of providers will meet the DOH adequacy standards and have the capacity to serve the numbers and demographics of the population to be served through the Healthy Pennsylvania Program. Applicants may use existing provider agreements and modify them to meet the program requirements so long as the amended agreements continue to meet the regulatory requirements of 28 Pa Code §9.722 of the DOH managed care regulations.

20. Q. May Applicant do so if those existing network provider agreements also satisfy network adequacy requirements for a HealthChoices health plan offered by Applicant?

    A. In terms of the provider network, the applicant must ensure that its network of providers will meet the DOH adequacy standards and have the capacity to serve the numbers and demographics of the population to be served through the Healthy Pennsylvania Program.

21. Q. May Applicant do so if those existing network provider agreements also satisfy network adequacy requirements for a commercial health plan offered by Applicant?

    A. In terms of the provider network, the applicant must ensure that its network of providers will meet the DOH adequacy standards and have the capacity to serve the numbers and demographics of the population to be served through the Healthy Pennsylvania Program.

22. Q. Has DPW discussed with DOH their willingness to accept letters of intent in lieu of contracts by the August 1, 2014 to begin the process of meeting operational authority? August 1, 2014 is a challenge because of contracting, rates, amendments etc. This timeline presents a problem, especially given the fact that DOH will have a 30 day review period before granting operational authority.

    A. A letter of agreement is acceptable for the June submission date. However, a fully executed contract must be in place by July 11, 2014 when the network is submitted to the DOH for review.

23. Q. Do Healthy PA providers (physical health and behavioral health) need to have a Promise ID number?

    A. As currently designed, no, they are not required to have a PROMISe™ ID number.

24. Q. If an applicant's network is not currently contracted at this new, hybrid rate, but the applicant has or will have Department of Health Operating Authority in an applicable county, may an applicant apply on the basis of that authority while in the process of contracting providers for the Healthy PA product at the intended rate?

    A. For Application submission on June 10, 2014, DPW requires either documentation of DOH County Operational Authority, or a written statement outlining the PCO's plan to have DOH County Operational Authority in place by August 4, 2014.

Section 4- Covered/Non-Covered Services

1. Q. In regard to the recently released RFA pertaining to the Healthy Pennsylvania Program, should wrap around benefits, including non-emergency medical transportation, be included in the benefit package of applicant companies? If not, will the state provide coverage of these benefits through Pennsylvania Medicaid?

   A. As in-network covered services, the PCOs will be required to provide access to Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) as part of their benefit packages. PCOs must also include free choice of a Family Planning Provider and possibly Non-Emergency Transportation (still under consideration). PCOs will be required to provide benefits consistent with any changes to the Healthy Pennsylvania Program benefit package.

   The MA Program will not provide wraparound benefits to Healthy Pennsylvania Program Beneficiaries.

2. Q. The proposed Agreement makes the point about coverage for pregnant women. Why wouldn't pregnant women automatically be transitioned into HealthChoices where they will receive better benefits?

   A. A woman who becomes pregnant while enrolled in a PCO has the choice to transition into the MA Program or to remain in the Healthy Pennsylvania Program.

3. Q. The proposed Agreement states that the PCO must cover Medicare deductibles and coinsurances for any Medicare-covered services for qualified Medicare beneficiaries. Please explain when you believe that Medicare beneficiaries would be in Healthy PA.

   A. The Department does not plan to enroll individuals with Medicare coverage into a PCO. If a PCO Member becomes eligible for Medicare, the Department will prospectively disenroll the Member from the PCO and place in the MA Program. During the period of transition (the Member notice of Medicare eligibility

until the next PCO disenrollment date,) Beneficiaries will remain in a PCO. Medicare beneficiaries may also be eligible in the Healthy Pennsylvania Program and enrolled in a PCO due to the possibility of retroactive Medicare eligibility.

4. Q. The plan design provided excludes pediatric dental. How will enrollees meet the Federal individual shared responsibility requirements for their coverage? Is this Essential Health Benefit service provided through another source?

   A. Children will not be enrolled in the Healthy Pennsylvania Program. Children, if eligible, will be enrolled in MA.

5. Q. Is DPW going to be publishing a list of the specific Private Coverage Option benefits, including Behavioral Health? Health insurers need to specify for providers what services they will be contracted to provide.

   A. Please refer to Exhibit B to Attachment A Draft Agreement of the RFA. Exhibit B serves as a broad description of the minimum benefits required. An Applicant should include in each PCO product form filing Physical and Behavioral Health benefits packages that include amount, duration and scope of all benefits provided by its product. Additional details may be required to be provided to DPW.

6. Q. Please clarify if newborns will be enrolled with the related party MCO (if present) in Medicaid?

   A. All newborns are enrolled in MA. Parent of the MA newborn will have the opportunity to select a HealthChoices MCO. The MA auto-assignment rules also apply.

7. Q. Regarding compliance with insurance requirements, will the form filing and compliance checklist that were submitted to PID last year be sufficient documentation for purposes of the RFA?

   A. The 2015 plan form filing, with the updated Compliance Checklist and Certification, should be refiled to comprise a complete product filing with PID. The Compliance Checklist and Certification should be substantially identical to the form provided in the

8. Q. Will applicants have to do a form filing with the PID regarding Compliance with insurance requirements? We would like more clarity on the Compliance with insurance requirements section.

   A. In order to qualify to offer a PCO product, an Applicant must have a Certificate of Authority ~~is~~ jointly issued by PID and DOH pursuant to The Health Maintenance Organization Act, 40 P.S. §1551 et seq.to operate as a HMO in Pennsylvania. For the product(s) proposed to be offered, an Applicant should

also submit a plan form filing as well as a Compliance Checklist and Certification to the PID, and the certification must certify that the coverage that will be provided meets all applicable federal and state laws regulating health insurance coverage offered in the individual market.

9. Q. Can the Department provide the expected incidence of Hepatitis C and the expected coverage population?

   A. The Department does not specifically track this condition. The Centers for Disease Control CDC) may have statistics that can assist you. Please contact the CDC for additional information. Information may be available on the CDC website.

Section 5 - Operations/Compliance/Oversight

1. Q. Will the DPW Managed Care Operational Memos, MA Bulletins and Systems Notices apply to PCOs? Will they be posted the same way and in the same place for PCOs?

   A. Please refer to RFA Part I, Section I-23, Information Technology, as well RFA Attachment A, Draft Agreement, Section V.S.5, page 31 addressing the application of information technology related bulletins and standards. PCO Operations Memos and System Notices will be issued in a similar format and using a similar process as that for the MA Program. See RFA Attachment A, Draft Agreement, Section I.C.

2. Q. Will DPW be the state department in charge of oversight for Healthy PA?

   A. Yes, but this program will be a partnership between DPW, PID, and DOH.

3. Q. When will the Department finalize their listing of additional Reports and Data requirements?

   A. The listing of reporting requirements is contained in Exhibit D of Attachment A to the RFA (Draft Agreement) and is comprehensive at the current time. There may be additions or changes to the list.

4. Q. Is there minimum incentive amount to be provided? Are there metrics by which the department will use to measure incentive effectiveness and or outcomes?

   A. PCOs are responsible for presenting ideas for Member incentives. The Department will review, approve, and work with PCOs to implement initiatives. . As part of their incentive program, PCOs should propose or define those health outcomes to be improved as well as the program design and measures. There are currently no set minimums. Measurement of effectiveness will be tailored to

the incentive proposed. Please see RFA Attachment A, Draft Agreement Section V.G.

5. Q. Can you please define health outcomes? Are incentives tied to changes in biometric measures in one period compared to the next time period? Or are these activities like Health risk assessments and online coaching that are presumed to have a positive impact on outcomes?

   A. PCOs are responsible for presenting ideas for Member incentives. The Department will review, approve, and work with PCOs to implement initiatives. As part of their incentive program, PCOs should propose or define those health outcomes to be improved as well as the program design and measures. Please see RFA Attachment A, Draft Agreement Section V.G.

6. Q. Is the program required to be available in formats other than online web-based?

   A. The Program has no specific restrictions for communication formats over and above those outlined in the Draft Agreement, and those requirements imposed by Federal and State laws and regulations. PCOs must take into consideration the population that will be served, and design a communication plan that suits the needs of that population.

7. Q. Is the program requirement just for the subscriber or all members on the contract?

   A. The Department does not understand this question.

8. Q. For incentives around employment – will the PCO be provided some type of data file or information to support employment efforts by the subscriber?

   A. The Department plans to provide guidance. Pending Federal approval, the Department will work with PCOs to develop and implement these types of initiatives.

9. Q. Are both wellness and employment incentives necessary or can the program just include incentives tied to wellness activities?

   A. See RFA Attachment A, Draft Agreement Section V.G. The PCO should propose incentive programs that meet the goals of the Healthy Pennsylvania Program.

10. Q. What is the expected turnaround for report development and delivery based on their requirements?

A. The Department will provide reporting specifications and timeframes at a later date.

11. Q. Are reports formats fixed or is there any flexibility?

    A. The Department will provide reporting specifications and timeframes at a later date.

12. Q. Can a PCO promote its products (Marketing) like any commercial plan or are there restrictions?

    A. The PCO must provide all outreach material to the Department 30 calendar days prior to its use. Please refer RFA Attachment A, Draft Agreement, Section V.F, page 23. PCOs will not be permitted to conduct "cold calls" as a marketing effort. PCOs must comply with all PID guidelines for written materials.

13. Q. Can other services (e.g. Dental, Life) be bundled with or sold with the core HPP product offering by PCO?

    A. If the question is referring to a PCO's ability to separately sell additional services to its Members at additional costs, the PCO is not prohibited from doing provided that those additional services do not include benefits required to be provided by the PCO as part of its PCO Agreement. In addition, a PCO may not deny enrollment based on a Beneficiary's purchase of the additional services or products

    If the question is referring to the PCO's ability to augment or improve the required benefit package by adding additional services at no cost, a PCO is not prohibited from doing so, provided that it provides all benefits as required by its PCO Agreement.

    In either case, the PCO is at full financial risk for any additional products and services.

    Any materials concerning additional services or products either separately sold or offered by the PCO are considered Member outreach material. As such, the PCO must provide this material to the Department thirty calendar days prior to its use. Please refer RFA Attachment A, Draft Agreement, Section V.F, page 23.

14. Q. Can members of Healthy PA automatically/compulsorily enrolled in a Care Management program of the PCO? Or would a care management program only provide an advantage for the PCO? Can this be different from the "Member incentive program" that is referred to on the RFA?

A. Care Management Programs address management of clinical Member care. Incentive Programs are not used to evaluate or provide clinical support for Members.

15. Q. “The PCO may not knowingly have a Relationship with the following….”[in RFA Attachment A, Draft Agreement, Section V.S.4.f] How is “Relationship” defined?

    A. Relationship is defined in a manner to be consistent with federal requirements set forth in 42 U.S.C. §1396u-2(d) and 42 C.F.R. §438.610. The Department will clarify this provision in a revision to the Agreement.

16. Q. The RFA states that "The PCO may not knowingly have a Relationship with … An individual who is an Affiliate." Does this preclude the PCO from subcontracting with affiliates? What does this mean in terms of subcontracting?

    A. Consistent with the requirements of 42 U.S.C. §1396u-2(d) and 42 C.F.R. §438.610, PCOs may not have relationships with individuals or entities who are debarred, suspended or otherwise excluded from participating in non-procurement activities or the affiliates of these individuals or entities. The Department will clarify this provision in a revision to the Draft Agreement.

17. Q. Can the Commonwealth provide the details of the readiness review requirements to allow plans to begin preparation? These would include, but not be limited to, any desk audit or system requirements.

    A. The Department will provide additional information concerning the readiness review process after PCO selection.

Section 6- Systems/IT

1. Q. Given that the list of required reports and files are, in general, the same for Healthy PA as HealthChoices, will DPW follow the same file layouts?

   A. The Department will use existing layouts where possible. However, final decisions and requirements may necessitate some changes.

2. Q. Please confirm that the monthly and daily 834 transmission files will follow the defined FFM 834 file format. There have and will continue to be updates to carrier’s eligibility transmission (i.e., federal Health Plan Identifier). It is assumed that the Commonwealth’s system is prepared to utilize all updated reporting fields. Please confirm.

   A. The Department will use a HIPAA compliant 834 format, but the format does not mirror the FFM 834 file format. The format will resemble the PA MA file format. The Department will comply with any future federally required changes.

3. Q. Has a timeline been established for testing of the 834 files with carriers?

   A. Not at this time.

4. Q. Noted in Attachment A, the Draft Agreement, section V.K (page 25) that Change in Status reporting will be required. Will the communication channel for reporting this information be an 834 file from the carrier to the Department? Or will another format/communication channel be defined?

   A. No. A DPW proprietary file will be used to communicate such changes.

5. Q. Request file format associated with the monthly Drug Rebate Supplemental File.

   A. Attached.

6. Q. Request file format associated with the daily/weekly Automated Provider Directory file.

   A. Attached.

7. Q. Is the encounter reporting requirement expected to be comparable to what is required by the Medicaid program?

   A. Encounter reporting will be required. Requirements are still being developed.

8. Q. A PCO is required to notify the department of any discrepancies after reconciliation of the Department's monthly membership file and a PCO's internal membership information. Does the Department have a defined or preferred method of membership discrepancy notification?

   A. Yes. Additional information will be provided during the readiness review process.

9. Q. Is the Department expecting a PCO and should the PCO expect the Department to comply with existing Management Information System SLAs specific to claim submissions, reconciliation, and reporting?

   A. Yes.

10. Q. Is a PCO permitted to submit Healthy PA claims within existing PA Medicaid claim submission files to the Department's PROMISe system or is a separate Healthy PA claims submission file required?

A. The files must be separate, and the PCO will have its own separate plan code.

11. Q. Should a PCO expect any modifications or impact to existing channels of claim processing or will the Healthy PA program require new and additional files between the Department and a PCO?

A. No new files are expected at this time.

12. Q. When will the Commonwealth expect the plans to begin system testing?

A. This will occur during readiness review, targeted to begin on August 5, 2014.

Section 7 - Premiums/Copayments/Cost Sharing

1. Q. Please advise if enrollees will be subject to premium billings. If yes, will the monthly premium be a fixed amount for all enrollees? Will enrollees make premium payment to the carrier or to the Commonwealth of Pennsylvania? Will there be any grace period for enrollees to pay premiums? For those that have to pay a premium, will there be an open enrollment period?

   A. The Department plans to implement premiums in 2016. The monthly premium will be a range, not a fixed amount. At this time, we are planning for premiums to be collected by the Commonwealth. There is no distinction between Members who do and do not pay a premium. Beneficiaries who are required to pay a premium will be subject to the same annual enrollment period as all other Beneficiaries.

2. Q. The plan design provided outlines a variety of cost-sharing components (deductibles, coinsurance, copays). Will enrollees receive any additional funding through this program to offset these cost-sharing responsibilities? If yes, please provide additional details.

   A. RFA Attachment B "Financial Terms" is for informational purposes only and reflects the assumptions and basis for Mercer's draft rates. The only cost-sharing responsibility of Members in 2015 will be the same as that contained in the DPW Medical Assistance copay schedule found at the link below: http://www.dpw.state.pa.us/cs/groups/webcontent/documents/bulletin_admin/d_005972.pdf

3. Q. What copay will PCOs be permitted to charge Members for the 72 hour supply of medication? … full copay vs. prorated copay?

   A. The only copays that will apply in 2015 are the same as those contained in the DPW Medical Assistance copay schedule found at the link below:

http://www.dpw.state.pa.us/cs/groups/webcontent/documents/bulletin_admin/d_005972.pdf

4. Q. The RFA notes the premiums in Attachment B have not yet been approved. 1. What is the approval process for these premiums? 2. What is the current status of the approval process? Is there an estimated date the Commonwealth expects to obtain approval? 3. Have there been any challenges obtaining approval to date? 4. What options are available to PCO's should the final, approved premiums be materially different than those presented? (Reference Attachment B)

   A. RFA Attachment B "Financial Terms" is for informational purposes only and reflects the assumptions and basis for Mercer's draft rates. The Department is not seeking approvals for the premiums contained in this Attachment.

5. Q. Is there a member premium? Who collects the member premium?

   A. Member premiums will begin in 2016. The Department plans to implement premiums in 2016. The monthly premium will be a range, not a fixed amount. At this time, we are planning for premiums to be collected by the Commonwealth.

6. Q. Is there any member cost sharing?

   A. In 2015, the Member cost sharing is exactly the same as the DPW Medical Assistance copay schedule found at the link below: http://www.dpw.state.pa.us/cs/groups/webcontent/documents/bulletin_admin/d_005972.pdf

   Member premiums are scheduled to begin in 2016.

7. Q. For Demonstration Year 1, will a participant who is enrolled in an FFM Plan be required to pay a copayment just similar to a participant enrolled in a Healthy Pennsylvania Private Coverage Option?

   A. FFM plans are not part of Healthy PA.

Section 8 - Pharmacy

1. Q. For products with smallest unbreakable package size that provides for greater than 72 hours, what copay will PCOs be permitted to render?

   A. Copays do not vary based on the amount dispensed.

2. Q. The RFA states that "On a case by case basis, the Department may waive the seventy-two (72) hour supply requirement." Can the Department outline the process for the PCO to submit potential cases?

   A. Not at this time. This will be discussed during readiness review. Please see Section V.B. of RFA Attachment A, Draft Agreement.

Section 9- Behavioral Health

1. Q. Exhibit B list services broadly for MH and SUD services. Can the Commonwealth provide a comprehensive list of behavioral health benefits, including service definitions? (Reference Attachment A, Exhibit B)

   A. Please refer to Exhibit B to Attachment A Draft Agreement of the RFA. Exhibit B serves as a general description of the minimum benefits required. PCOs should include a Physical and Behavioral Health benefits package that include amount, duration and scope of all benefits for their Healthy Pennsylvania PCO product with their application.

2. Q. Is the behavioral health network adequacy requirement equivalent to that of the physical health network, or is another standard being used?

   A. County Operational Authority is also required for and applies to the behavioral health network adequacy requirements for Healthy Pennsylvania. The same adequacy standard is used for physical and behavioral health.

Section 10 – Financial

1. Q. Will the Medicaid fee schedule be the baseline for payment for the PCOs?

   A. Based on available information, DPW's actuary targeted a mid-point between Medicaid and commercial pricing when developing the draft potential 2015 HPA rates. DPW wants to increase access and provider capacity in this program and to lay the groundwork for a seamless transition by members to employer sponsored or exchange market coverage.

2. Q. What provider reimbursement rates did DPW/Mercer assume in their capitation rates?

   A. Based on available information, DPW's actuary targeted a mid-point between Medicaid and commercial pricing when developing the draft potential 2015 HPA rates. DPW wants to increase access and provider capacity in this program and to lay the groundwork for a seamless transition by members to employer sponsored or exchange market coverage.

3. Q. Is the revenue (denominator) in the risk corridor formula subject to the Health Insurance Providers Fee (HIPF)?

   A. DPW will improve the definition in the draft Appendix 3d to make it clear that "revenue" refers to revenue net of payments by DPW for HIPF.

4. Q. Since there is no risk adjustment in Year 1, would DPW consider a more robust risk corridor design, to protect carriers who may get higher risk recipients (for example, in addition to the wider corridor, a more narrow corridor within the wider range)?

   A. DPW will review the MLR that is specified in the draft Agreement Appendix 3d. Selected applicants may propose agreement terms, but DPW might be unwilling to agree to terms that differ from its proposal.

5. Q. Could a high risk pool be implemented as well, or alternatively a reinsurance program?

   A. DPW does not plan to include High Cost Risk Pools in HPA agreements. DPW does not plan to offer reinsurance to PCOs.

6. Q. Were emerging trends (such as the impact of new Hepatitis C drugs) factored into the trend assumptions? If so, how?

   A. Additional information related to the trends utilized in the Healthy PA rate development can be found in the updated Healthy PA Rate Methodology Narrative prepared by Mercer and provided with these questions and answers. Mercer leveraged available information to develop appropriate trends for this population. Due to the uncertainty surrounding this newly eligible adult population, and the uncertainty of the prevalence of the populations' existing disease conditions (taking into consideration that medically frail adults upon application will not be enrolled in Healthy PA), Mercer was not able to make additional, prospective changes beyond the adjustments found in the more detailed documentation for any specific disease condition. As data becomes available for this population, DPW and its actuary will monitor the program's performance, risk and expenditure patterns for consideration in future rate-setting cycles.

7. Q. What benefit design and induced utilization adjustments were made to the claims costs?

   A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

8. Q. How will premiums be set in year 2+? Will carriers go through a bidding process, or will carriers need to file for a rate change, subject to DPW and/or PID approval?

   A. The process will be similar to Year One. In the spring of 2015 DPW will provide a rate offer and schedule a negotiation.

9. Q. Can you share any details on how the Risk Adjustment Methodology will work?

   A. This planning will occur in the future.

10. Q. For the Risk Corridor Calculation, will expenses for Quality Improvement Initiatives be added to medical costs, similar to the Federal Minimum MLR calculation?

    A. Yes.

11. Q. Will there be an opportunity to discuss with Mercer the pricing assumptions in more detail?

    A. No, but DPW is providing a more-thorough Healthy Pennsylvania RATE METHODOLOGY NARRATIVE with these questions and answers.

12. Q. What is the benefit plan including cost sharing to be provided by the private insurer (PCO) to the private coverage option member for the 2015 capitation rates listed in Attachment B?

a. Is it the Attachment B Appendix C AETNA Silver Plan exactly as shown with the $1500 deductible, etc.?

b. Or is it the Attachment A Exhibit B list of benefits with limits? If so, is this the same as the Low-Risk plan outlined in the Healthy PA 1115 Waiver?

   A. DPW Medical Assistance cost sharing will be utilized in 2015 in Healthy PA. Attachment A Exhibit B (Draft Agreement) applies. RFA Attachment B "Financial Terms" Appendix C within the Mercer rate documentation was prepared by Aetna and includes a lot of information that is not relevant to Healthy PA. The Low-Risk Medical Assistance benefit package is not utilized in Healthy PA.

13. Q. If the 2015 capitation is to cover only the AETNA Silver Plan, does the private coverage option member actually receive the Attachment A Exhibit B benefits? If so, are the differences in the cost sharing and coverage reconciled between the member, provider and the State only? Or is the insurer involved and if so how?

A. Attachment A Exhibit B applies to Healthy PA. DPW's capitation payments include costs that would have been borne by the individual under the Aetna benchmark plan's cost-sharing design. In year 1 the existing Medical Assistance cost-sharing rules will apply and it will be the responsibility of the providers to collect those co-payments. In year 2 and beyond there may be adjustments made to individual cost-sharing obligations and any change will be appropriately reflected in the PCO's capitation payment.

14. Q. Are the 2015 capitation rates entirely set by the State and the same for all insurers? And again, if so, for which benefit plan/cost sharing?

    A. DPW will provide each selected applicant with a rate proposal. These rate proposals vary by region but will be the same for all selected applicants within a region. The benefit plan is found in Attachment A Exhibit B. The only cost sharing in 2015 will be DPW's Medical Assistance co-pay schedule.

15. Q. Is it correct that the Risk Corridor arrangement Attachment A Appendix 3d (p. 49) only looks at claims incurred in the calendar year and paid through November 30 of following year with no completion?

    A. DPW is reviewing the settlement terms included in the draft Appendix 3d.

16. Q. Would we be able to see quantifiable data on how:

a) Rates adjusted for keeping those in HPA until redetermination that meet medically frail definition
b) How much SSI data was used in rate development?
c) What factor was used to increase expected costs for newly identified population
d) What factors were used for pent up demand
e) Details of maternity costs included
f) Adjustment considered since population has not been medically managed yet

    A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

17. Q. The RFA indicates that rates are set based on paying providers between Medicaid and commercial rates. Where within that range, since it is so large?

    A. Based on available information, DPW's actuary targeted a mid-point between Medicaid and commercial pricing when developing the draft potential 2015 HPA rates. DPW wants to increase access and provider capacity in this program and to lay the groundwork for a seamless transition by members to employer sponsored or exchange market coverage.

18. Q. Can you give actual trend rates used?

    A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

19. Q. Please explain why it does not appear that any risk adjustment, like the Exchange products, is being utilized?

    A. DPW plans to implement risk adjustment in 2016. Earlier risk adjustment would be compromised by lack of data.

20. Q. How did Mercer do an adjustment to their rate reimbursement cells to include funding to pay providers above Medicaid levels?

    A. Based on available information, DPW's actuary targeted a mid-point between Medicaid and commercial pricing when developing the draft potential 2015 HPA rates. DPW wants to increase access and provider capacity in this program and to lay the groundwork for a seamless transition by members to employer sponsored or exchange market coverage.

21. Q. Would the Commonwealth consider using risk adjustment as well as risk corridors?

    A. DPW does not intend that the risk corridors will be permanent, but a decision has not been made on an end date.

22. Q. As indicated in Section I(5) of RFA # 04-14, please confirm that the Department will provide qualified Applicants an opportunity to negotiate the terms and conditions and financial rates set forth the DRAFT PCO Agreement.

    A. There will be an opportunity to negotiate, but DPW might be unwilling to agree to terms different than its proposal.

23. Q. The Capitation rate says that the Healthy PA program will not have a separate maternity payment in CY 2015. Pregnant women may stay in the program or move to HealthChoices. What happens if the pregnant woman stays in the Healthy PA program? How are maternity costs accounted for if there is no kick payment?

    A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

24. Q. The RFA notes the premiums in Attachment B have not yet been approved. 1. What is the approval process for these premiums? 2. What is the current status

of the approval process? Is there an estimated date the Commonwealth expects to obtain approval? 3. Have there been any challenges obtaining approval to date? 4. What options are available to PCO's should the final, approved premiums be materially different than those presented? (Reference Attachment B)

A. RFA Attachment B "Financial Terms" is for informational purposes only and reflects the assumptions and basis for Mercer's draft rates. DPW's discussion with CMS about Healthy PA is continuing. DPW will manage challenges as they arise.

25. Q. How was the impact of new and emerging specialty drug therapies accounted for in the pharmacy trend development? What was the magnitude? (Reference Attachment B)

A. Additional information related to the trends utilized in the Healthy PA rate development can be found in the detailed Healthy PA Rate Methodology Narrative provided by Mercer. Mercer leveraged available information to develop appropriate trends for this population. Due to the uncertainty surrounding this newly eligible adult population, and the uncertainty of the prevalence of the populations' existing disease conditions (taking into consideration that medically frail adults upon application will not be enrolled in Healthy PA), Mercer was not able to make additional, prospective changes beyond the adjustments found in the more detailed documentation for any specific disease condition. As data becomes available for this population, DPW and its actuary will monitor the program's performance, risk and expenditure patterns for consideration in future rate-setting cycles.

26. Q. Benefit adjustments – what specific benefit adjustments were made to the base data and what were the magnitudes of the changes? (Reference Attachment B)

A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

27. Q. Maternity - document states that "Pregnant women may choose to stay in the Healthy PA program or move to HC." What assumptions, if any, were made to account for the selection into or out of Healthy PA? (Reference Attachment B)

A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

28. Q. Pent up Demand – what is the pent up demand assumption and the basis for it? Document states that "The pent-up demand factor will ultimately be reduced

to zero as the Healthy PA program matures." What is the timeframe of this normalization? (Reference Attachment B)

A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

29. Q. Reverse MCS – What specific adjustments were made? What is the magnitude? (Reference Attachment B)

A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

30. Q. Provider Pricing - What specific adjustments were made? What is the magnitude? (Reference Attachment B)

A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

31. Q. Admin Loads – What are the admin/profit/risk/contingency loads? (Reference Attachment B)

A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

32. Q. Section VII C of the Healthy Pennsylvania Private Coverage Organization (PCO) Agreement refers to no appeal for actuarially sound rates. Can an issuer (PCO) terminate the contract if the PCO determines the rates are unacceptable for a given year?

A. The PCO may terminate its agreement at the end of any calendar year with notice to DPW by June 30 of the same year.

33. Q. How will the capitation payments from the State of Pennsylvania be funded? Page 19 of the Healthy Pennsylvania PCO Agreement indicates a limitation based on available funds. Why would funds not be available?

A. DPW anticipates that funds will be appropriated for the Healthy PA program, and that CMS will provide federal participation as provided by law. DPW is looking for federal participation to remain at the levels currently indicated in the ACA. If there is a change in the law that reduces the federal funding commitment, DPW will evaluate options including an end to the program for this population.

34. Q. Appendix 3d of the Healthy Pennsylvania PCO Agreement describes the Risk Corridor:

    Qa.The uncertainty surrounding the ultimate cost level for this population warrants more protection on the upper end of the MLR corridor in the initial years of the program. Will the Commonwealth consider narrowing the corridor to provide reasonable protections given that the PCOs aren't developing the rate?

    Aa.DPW will review the MLR used in the draft Agreement Appendix 3d.

    Selected applicants may propose agreement terms, but DPW might unwilling to agree to terms that differ from its proposal.

    Qb.How are taxes and fees handled in the risk corridor calculation?

    Ab. DPW will improve the definition in the draft Appendix 3d to make it clear that "revenue" refers to revenue net of payments by DPW for HIPF.

    Qc.How will the risk corridor program be funded?

    Ac.There is no difference between funding for capitation payments and risk corridor payments.

35. Section VII B of the Healthy Pennsylvania PCO Agreement refers to Risk Adjustment. Given the multi-year contractual period of the RFA, additional details on the risk adjustment program are necessary. Please provide details of any existing Risk adjustment programs that PA currently utilizes that may be used to model the Healthy PA approach.

    Ad.The HealthChoices Risk Adjusted Rates manual is provided with these questions and answers.

36. Q. Can bidders obtain a copy of the detailed Mercer Actuarial analysis? After review of the Mercer Actuarial analysis will additional questions be permitted?

    A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

37. Q. Apart from the capitation rates, is there an additional payment being contemplated to account for risk of enrollees with chronic conditions?

    A. DPW plans to implement risk adjusted rates in 2016. DPW does not anticipate making any additional payments for chronic conditions.

38. Q. The attachment provides the draft potential CY2015 capitation rates and a very general rate methodology narrative.
a. Please provide the base data that were used to develop the draft rates. The data may be de-identified to protect health plan proprietary data.

A. Base data used to develop the draft rates can be found at this link under the following bullets:
http://www.dpw.state.pa.us/provider/healthcaremedicalassistance/managedcareinformation/index.htm

- HealthChoices Lehigh-Capital Zone/SFY 13-14 Contract Year
- HealthChoices Southeast Zone/SFY 13-14 Contract Year
- HealthChoices Southwest Zone/SFY 13-14 Contract Year
- HealthChoices Expansion Zones and BCC/SFY 13-14 Contract Year

Qb. Please provide the actual development that includes the trends, benefit adjustments, provider pricing, pent-up demand and managed care adjustments.

Ab.Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

Qc. What is the administration/Profit/Risk/Contingency Load as a percentage of developed capitation rates?

Ac.Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

Qd. Should the amounts withheld for the Health Insurance Providers Fee be insufficient to cover the payment due, will the State provide any additional amounts required?

Ad. No.

39. Q. Will the capitation rates for members who become “medically frail” after enrollment into the Healthy PA program be “risk-adjusted” to recognize the potentially higher medical costs for such members?

A. DPW plans to implement risk adjustment that will cover all HPA members in 2016.

40. Q. In addition to age and geographic differences, will capitation rates be risk-adjusted for the covered population?

A. DPW plans to implement risk adjustment that will cover all HPA members in 2016.

41. Q. Is the risk adjustment methodology shared by the Department with the PCO subject to PCO's written approval?

A. DPW will share extensive information about the risk adjustment methodology and meet with the PCOs and discuss and attempt to achieve consensus on the risk adjustment methodology, which will be the same across all PCOs. DPW will make the final decisions.

Q. If not, does this provision bind PCO to prospectively accept rates before it has the opportunity to review them?

A. Yes.

42. Q. If services or Beneficiaries are added to the Healthy Pennsylvania Program, or if covered services or Beneficiaries are expanded or eliminated, or if the Department adjusts the rates as set forth in this section, will such modifications be subject to the prior written consent of the PCO? (If the response to this question differs from the response to the same question regarding Attachment A, Section V.A(1), which controls?)

A. The most likely vehicle for a change in base capitation rates is an agreement amendment that would need a signature from the PCO.

43. Q. Are any such changes to the capitation rates, amendments and modifications subject to the prior written consent of the PCO?

A. The most likely vehicle for a change in base capitation rates is an agreement amendment that would need a signature from the PCO.

44. Q. "By executing the Agreement, the PCO has had opportunity to review the rates set forth in Appendix 3f, Capitation Rates, and accepts the rates for the relevant Agreement period." Does "relevant Agreement period" mean the initial three-year term beginning January 1, 2015? If not, how is "relevant Agreement period" defined?

A. No, this does not cover the three-year period. This refers to the period covered by the capitation rates included in the agreement as set forth in Appendix 3f.

45. Q. Due to complexity and number of material adjustments, it is critical to be transparent to ensure success of this new initiative. Please provide additional exhibits that illustrate base costs used and their source as well as explicit

adjustments for benefits, maternity-newborn adjustments, regional factors, pent up demand, managed care factors, network and admin assumptions.

A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

46. Q. Please confirm our understanding that TANF and Healthy Beginning rates were used as a basis for rate development of Healthy PA Rates and SSI and other populations were used as a reference only in development of pent up demand and other adjustments. Please indicate how Federal GA, CNO, CMO rate categories from current Medicaid program were used as a reference, if any.

A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

47. Q. Please list all program changes factored in currently proposed rates and outline mechanism of reimbursement for future program changes materially affecting this population.

A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

48. Q. Please provide an outline of benefit comparison between Medicaid benefit set used as an initial pricing reference and resulting benefit set used for Healthy PA population. Please outline benefit adjustment factors for each benefit with rate-cell impact.

A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

49. Q. Please elaborate on the regional adjustment methodology used and need to vary regions relative to current Medicaid regions set and closer alignment to initial pricing references used from Medicaid TANF/ Healthy Beginning regional rates. Please list regional rate-cell specific factors and indicate if they varied by category of service.

A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

50. Q. Please indicate how mental health adjustment was developed, and what was the basis for this adjustment. Please indicate if pricing for mental health

component assumed pent up demand/ managed care adjustments specific to this category of service.

A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

51. Q. Please indicate how adjustments for copays/ deductibles and the methodology for a member or beneficiary's responsibility to pay were factored into pricing of these benefits.

A. Member cost sharing in 2015 is the same as Medical Assistance, so little adjustment was needed.

52. Q. Please elaborate on the methodology used for the administrative load and contingency and what specific references were used to form basis of these assumptions. Please elaborate how expected membership volume by MCO and uncertainty over morbidity and high degree of outreach and initial care coordination expected were factored in admin and contingency rate development.

A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

53. Q. Please elaborate on the expected lag in managed care factors and what categories of service specifically are expected to be affected and by what factors (inpatient, outpatient, ER, physician, mental health, Rx.)

A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

54. Q. Please elaborate your pricing expectations and mechanisms related to pharmacy benefits and ability of MCOs to manage and collect rebates and how it was adjusted in development of rates that used current Medicaid rates as a starting point.

A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers. The actuary assumed market share rebates similar to HealthChoices.

55. Q. Please elaborate your pricing expectations for Sovaldi and new high cost specialty pharmacy drugs that might be introduced and materially affect pricing of this program but that have limited claims data information at this point from

available references. Do you expect to establish any mechanisms to reimburse MCOs fully for cost of these uncertain and material elements currently not included in pricing for Healthy Pennsylvania?

A. Additional information related to the trends utilized in the Healthy PA rate development can be found in the detailed Healthy PA Rate Methodology Narrative provided by Mercer. Mercer leveraged available information to develop appropriate trends for this population. Due to the uncertainty surrounding this newly eligible adult population, and the uncertainty of the prevalence of the populations' existing disease conditions (taking into consideration that medically frail adults upon application will not be enrolled in Healthy PA), Mercer was not able to make additional, prospective changes beyond the adjustments found in the more detailed documentation for any specific disease condition. As data becomes available for this population, DPW and its actuary will monitor the program's performance, risk and expenditure patterns for consideration in future rate-setting cycles. DPW does not intend that PCO agreements will include provision for potential additional revenue specific to certain drugs.

56. Q. Please elaborate the process of estimating HIPF liability for each MCO, factoring in the draft and final rates and providing settlement for each MCO's actual HIF liability related to this product. Please specify expected timeframe of events from rate effective dates to settlements.

A. Please see the document titled *ACA Health Insurance Providers Fee, DPW Healthy PA Overview* and the draft agreement appendix that have been posted along with the Questions and Answers.

57. Q. Please specify assumptions about unit cost increases relative to current TANF/Healthy Beginnings rates, i.e. what were the unit cost adjustment factors by region and category of service that were factored in proposed Healthy Pennsylvania rates?

A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

58. Q. Please indicate how the APRDRG fee schedule and gradual APRDRG regional conversion were factored in as unit cost assumptions for Healthy Pennsylvania.

A. Based on available information, DPW's actuary targeted a mid-point between Medicaid and commercial pricing when developing the draft potential 2015 HPA rates. DPW wants to increase access and provider capacity in this program and to lay the groundwork for a seamless transition by members to employer sponsored or exchange market coverage.

59. Q. Please indicate final rate development process and rate agreement by participating PCOs;

    A. DPW plans to provide a rate offer to each selected applicant on June 20, 2014. A negotiation will be scheduled, probably during the week of June 30. Dates are subject to change.

60. Q. Please elaborate on the frequency, process and transparency of the future rate updates.

    A. DPW plans to provide a rate offer for the following year each spring. A negotiation will be scheduled.

61. Q. Please clarify if any high risk pools, quality incentives, or supplemental physician payments, similar to the current Medicaid program, will be in place for the Healthy Pennsylvania program as well and how they would operate and be defined.

    A. These elements are not included in Healthy PA.

62. Q. Would exhibits be provided that illustrate specific adjustments made and key assumptions?

    A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

63. Q. Can you specify the blending weight between TANF & SSI in base data for rate development?

    A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

64. Q. Can you provide more background and provide specific assumption about unit cost adjustment? What was the factor assumed relative to current unit cost structure embedded in the rate, separately, behavioral health network assumption?

    A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

65. Q. Can you specify if unit cost assumption factor varies by category of service and or regions?

A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

66. Q. Can you provide specifics about expected default non-par reimbursement for emergent services?

A. The PCO will need to comply with applicable law and regulation.

Q. Was an adjustment made for any changes versus current Medicaid program?

A. No.

67. Q. Can you clarify if all benefit and program adjustment factors will be outlined?

A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

68. Qa. Can you clarify how member cost sharing assumption was factored in?

Aa. Member cost sharing in 2015 is the same as Medical Assistance, so little adjustment was needed.

Qb.How much was it affected by expected recoverability of member cost sharing?

Ab.No further adjustment.

Qc. Will PCOs have responsibility to collect member cost sharing or providers?

Ac.PCOs will not have this responsibility in Year One.

69. Q. Please elaborate on your pricing expectations of Sovaldi in draft rates.

A. Additional information related to the trends utilized in the Healthy PA rate development can be found in the detailed Healthy Pennsylvania RATE METHODOLOGY NARRATIVE provided by Mercer. Mercer leveraged available information to develop appropriate trends for this population. Due to the uncertainty surrounding this newly eligible adult population, and the uncertainty of the prevalence of the populations' existing disease conditions (taking into consideration that medically frail adults upon application will not be enrolled in Healthy PA), Mercer was not able to make additional, prospective changes beyond the adjustments found in the more detailed documentation for any specific disease condition. As data becomes available for this population, DPW

and its actuary will monitor the program's performance, risk and expenditure patterns for consideration in future rate-setting cycles.

70. Q. Please clarify if quality incentives or supplemental payments will be incorporated in this program and rate.

    A. The initial program design does not include quality incentives.

71. Q. Please elaborate on specifics of future program and the schedule changes and adjustment of premium rates.

    A. DPW plans to provide a rate offer for the following year each spring. A negotiation will be scheduled.

72. Q. Please elaborate on expectation for PCP reimbursement level since ACA PCP rate component was not included in draft rates.

    A. Based on available information, DPW's actuary targeted a mid-point between Medicaid and commercial pricing when developing the draft potential 2015 HPA rates. DPW wants to increase access and provider capacity in this program and to lay the groundwork for a seamless transition by members to employer sponsored or exchange market coverage.

73. Q. Please specify expected admin and profit margin expectation embedded in current draft rates. How do they compare to current Medicaid program?

    A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers. HPA is a different program with different expectations and medical costs.

74. Q. Please elaborate how target MLR was used for risk corridor and if there is any flexibility in setting it lower given risk and uncertainty of this new program?

    A. DPW will review the MLR used in the draft Agreement Appendix 3d. Selected applicants may propose agreement terms, but DPW might unwilling to agree to terms that differ from its proposal.

75. Q. Can you elaborate on pent-up demand and morbidity adjustment for this population? Does it vary by age and or region?

    A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

76. Q. Can you clarify your expectation of long term morbidity difference of this population versus current Medicaid for similar age bands?

    A. No.

77. Q. Can you specify magnitude of managed care adjustment and indicate if it varies by region or category of service?

    A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

78. Q. Please clarify if risk corridor settlement is expected to be based on encounter data or supplemental reports that reconcile to financial statements.

    A. This decision has not been made.

79. Q. Please clarify how requirement to pay PPS to FQHCs/RHCs was factored in draft rate development?

    A. This is under review by Mercer.

80. Q. Please clarify if any settlements are expected between PCOs and FQHCs/RHCs.

    A. If DPW changes the PPS rate, for dates of service after January 1, 2015 and forward, PCOs may be required to conduct settlements.

81. Qa. Please clarify if specific payment requirements apply to Critical Access Hospitals?

    Aa. No.

    Qb. Please specify if any settlements are expected?

    Ab. No.

    How are these requirements factored in draft rates?

    N/A

82. Q. What was the assumed rate to providers in the rate development, more specific provider payment assumption rather than the broad range indicated in rate methodology narrative?

A. Based on available information, DPW's actuary targeted a mid-point between Medicaid and commercial pricing when developing the draft potential 2015 HPA rates. DPW wants to increase access and provider capacity in this program and to lay the groundwork for a seamless transition by members to employer sponsored or exchange market coverage.

83. Q. What was the behavioral health adjustment added to the MAGI/SSI 2014 rates?

A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

84. Q. In your use of 2014 rates, were adjustments made to compensate for current abnormal pharmacy trends?

A. Additional information related to the trends utilized in the Healthy PA rate development can be found in the May 21st detailed Healthy PA Rate Methodology Narrative provided by Mercer. Mercer leveraged available information to develop appropriate trends for this population. Due to the uncertainty surrounding this newly eligible adult population, and the uncertainty of the prevalence of the populations' existing disease conditions (taking into consideration that medically frail adults upon application will not be enrolled in Healthy PA), Mercer was not able to make additional, prospective changes beyond the adjustments found in the more detailed documentation for any specific disease condition. As data becomes available for this population, DPW and its actuary will monitor the program's performance, risk and expenditure patterns for consideration in future rate-setting cycles.

85. Q. For Healthy PA population is there an adverse risk for Hepatitis-C?

A. DPW doesn't have data specific to the Healthy PA population.

86. Q. Can you provide examples of the risk corridor in years 1-3?

A. The potential applicant should be able to develop examples using the draft agreement language.

87. Q. It appears that no payment will be made in year 1 if the MLR > 95%.

A. The risk corridor will apply in Year One. If a risk corridor payment is owed, it will be made later.

88. Q. Is there any expectation of retroactivity and PCO responsibility for this period? How was this factored in rates?

A. DPW will provide details once there is an agreement on the standard terms and conditions of the waiver with CMS. If the PCO enrollment date is after the hospital admission date, the PCO is not responsible for the stay.

89. Q. Can you elaborate on expected provider payment process for members admitted to hospital while being enrolled?

A. DPW will provide details once there is an agreement on the standard terms and conditions of the waiver with CMS. If the PCO enrollment date is after the hospital admission date, the PCO is not responsible for the stay.
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90. Q. Is documentation required to be submitted for any FQHC/RHC that would not accept rate, and thus is not contracted?

A. DPW encourages full inclusion of FQHCs and RHCs in PCO networks. DPW has not decided on a requirement for documentation when an FQHC or RHC is not in a PCO's network.

91. Q. Does the PCO need to reimburse the FQHCs and RHCs at the Medicaid prospective Rate at time of processing or is a monthly or quarterly reconciliation acceptable?

A. The PCO must pay the PPS rate when the claim is processed.

92. Q. Will risk adjustment in 2016 be CDPS or the HCC methodology under the current FFM regulations vs. Medicare regulations?

A. This decision has not been made.

93. Q. Please clarify requirement to contract and pay PPS prospective rates for FQHCs/ RHCs and if it was reflected in presented draft rates. Please clarify is this was a separate base data adjustment or was included in overall unit cost adjustment factor. Please elaborate how the unit cost impact from this requirement was evaluated at the regional level and quantified.

A. This is under review by Mercer.

94. Q. Please provide additional information about current FQHC/ RHC listing by region and their current PPS rates and effective dates as well as prior PPS rates to allow for cost impact and trend evaluation of this new component relative to current Medicaid program.

A. A list of FQHCs and RHCs by region is provided with these responses, along with current PPS rates.

95. Qa. Please elaborate if MCOs are expected to provide settlements to FQHCs/ RHCs on top of the PPS rates and if this settlement can be both negative (i.e. FQHC/ RHC owing MCO funds) and positive (MCO owes additional funds to FQHC/ RHC).

    Aa. Yes.

    Qb. Please elaborate logistical and timing aspects of the settlement process, if applicable.

    Ab. We don't have additional information at this time.

    Qc. Please clarify if expected or historical settlement components on top of the PPS rates were already reflected in draft rates as presented and quantify regional adjustments for this component.

    Ac. This is under review by Mercer.

96. Q. Please clarify if similar contracting and / or payment requirements apply to CAHs (Critical Access Hospitals) with or without settlement components and how it was or will be reflected in premium rates. Please clarify regional consideration as well in rate development.

    A. There is no requirement specific to Critical Access Hospitals.

97. Q. Please clarify if prospective FQHC/ RHC PPS rate changes and settlement liability will be tracked from the cost and trend perspective and factored in future rate-settings given that this is a consistent cost increase item that will be completely outside of control of contracting PCOs.

    A. DPW will track PPS rate changes for the purpose of future HPA rate-setting.

98. Q. Please specify how APRDRG fee schedule changes that are partially reflected in some regions but are fully reflected in others, were factored in unit cost benchmarking (since APRDRG changes affect the level of Medicaid assumed versus currently paid or factored in Medicaid premium rates).

    A. Based on available information, DPW's actuary targeted a mid-point between Medicaid and commercial pricing when developing the draft potential 2015 HPA rates. DPW wants to increase access and provider capacity in this program and to lay the groundwork for a seamless transition by members to employer sponsored or exchange market coverage.

99. Q. Please clarify if the program will be marketed through hospitals as it affects expected morbidity of the population.

A. DPW doesn't plan marketing through hospitals, but a provider application taken by a hospital could lead to PCO coverage for an eligible individual.

100. Q. Please clarify why risk corridor target was setup at 90% MLR target given considerable additional risk and uncertainty of this new population and that draft rate structure does not control for such risks as difference in FPL level of membership assigned to any given MCO nor lack of risk scores in the first year. Other states recognize additional risk and uncertainty of this new population in setting target MLR lower to allow for additional risk contingency as well as additional administrative and outreach costs for new challenging populations.

A. DPW will review the MLR used in the draft Agreement Appendix 3d.

101. Q. Could the Department provide the assumptions used in estimating the percentage of pregnant women that will choose to go to Medicaid?

A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

102. Q. Could the Department provide the Mercer Data Books used in the actuarial calculations?

A. Base data used to develop the draft rates can be found at this link under the following bullets:
http://www.dpw.state.pa.us/provider/healthcaremedicalassistance/managedcareinformation/index.htm

- HealthChoices Lehigh-Capital Zone/SFY 13-14 Contract Year
- HealthChoices Southeast Zone/SFY 13-14 Contract Year
- HealthChoices Southwest Zone/SFY 13-14 Contract Year
- HealthChoices Expansion Zones and BCC/SFY 13-14 Contract Year

103. Q. A Healthy PA agreement with DPW may increase our HMO's capital requirement for RBC as administered by PID or for DPW's net worth requirement. Will the Commonwealth provide relief or assistance?

A. Risk-based capital requirements are set by statute; the Commonwealth does not have the flexibility to provide relief.

104. Q. Please provide additional information on the assumption to blend TANF and SSI/Disabled rates in development of the base data for the Healthy PA population. Given the significant difference between the two rate subgroups, it is critical to know how these population blocks were weighted during the blending step of rate development. Please provide specific details of this assumption as it materially affects results in expected cost.

A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

105. Q. It is our understanding that rates should be submitted solely through the application process. Please confirm if the Commonwealth wants rates submitted through the QHP SERF process as well.

A. There is no rate submission required for Applicant's in this program.

106. Q. According to section D.4 located on page 41 of the RFA entitled "Other Financial Requirements," the PCO must provide Members access to FQHCs and RHCs within its Provider Network. The PCO must pay FQHCs and RHCs rates no less than the Fee-for-Service Prospective Payment System (PPS) rate(s), as determined by the Department. When will the Department publish the PPS rates that should be used as reimbursement?

A. A list of FQHCs and RHCs by region is provided with these responses, along with current PPS rates.

107. Q. How will the premium payment be issued and communicated to the issuer?

A. Payment will be made via ACH transaction. In the event bank account information has not been set up in the system, a paper check will be issued. An 820 Capitation File (monthly) and 36 month summary file will provide each Health Plan with payment data.

108. Q. Is the Healthy PA program considered a government program (like Health Choices) for the purposes of the meeting the 80% threshold for exemption from the ACA tax?

A. Please consult with a tax specialist or attorney for this determination.

109. Q. What percentage of Medicaid FFS reimbursement is Mercer assuming for provider reimbursement in their capitation rate development, and does is differ between Medical and Rx benefits?

A. Based on available information, DPW's actuary targeted a mid-point between Medicaid and commercial pricing when developing the draft potential 2015 HPA rates. DPW wants to increase access and provider capacity in this program and to lay the groundwork for a seamless transition by members to employer sponsored or exchange market coverage. The question has less significance with pharmacy benefits.