Questions and Responses

HC Expansion RFP #06-15

October 20, 2015 Pre-Proposal Questions

No.	RFP or Agreement Section	Question	Response
General Proposal Formatting			
1.	RFP Part IV. Emergency Preparedness	Please confirm whether DHS expects offerors to submit with their proposal responses to the direct questions included in Section IV.(A)	This material should be included as part of the Work Statement Part II-5 clearly labeled as "Section IV-3 A. Emergency Preparedness.
2.	RFP Part II Requirements	Please explain how page limits will work if responses are broken out by zone.	The page limit restrictions separately apply to each zone. For example, if an offeror is submitting a proposal for the SE and SW Zones and a question allows 3 pages, the offeror may submit a 3 page response for SE and a 3 page response for SW—if necessary.
3.	Pre-Proposal Conference	Can we get a list of all vendors present with their phone numbers and email addresses	DHS is posting as an addendum to the RFP the documents from the Pre-proposal conference, including the sign-in sheet which captures the information in DHS's possession.
4.	Pre-Proposal Conference	Will a list of attendees be published? Will it include contact information?	See response to question No. 3.
5.	Part II Proposal Requirement	Given the page limitations for response and best practices in Graphic Design, we recommend that	Since 9 pt is common for tables in numerous graphics programs, 9pt may be used for tables and other appropriate graphical depictions.

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	s	the minimum font size for text within graphics and tables be 9 point font. Please confirm that this is acceptable	
6.	Part IV Work Statement—Emergency Preparedness	Please indicate where to include this information in the overall proposal submittal as indicated in the proposal requirements on page 15.	See response to question No. 1.
SDB and CPP			
7.	Part II-8. Small Diverse Business Submittal	Do current SDB contracts expire automatically when the new HC'c contract begins on 1/1/17 despite whether all previous commitments have or have not been met? Stated differently, are current MCOs excused from prior SDB commitments once the new HealthChoices agreement commences in 2017?	This answer is not required for an Offeror to submit a proposal.
8.	Contractor Partnership Program	What did Faith Ellis mean when she said that in the Contractor Partnership Program we negotiate the number of employees.	The proposals are reviewed to determine if they meet DHS goals. Following selection for negotiation, DHS will work with the selected MCOs to refine and clarify the CPP expectations regarding the HealthChoices Agreements.
Financial / Rates			

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9.	Appendix B:Financial Data, Admin & Profit Load	Would the Department provide the anticipated funding for administrative costs and profit for CY 2016 by zone?	The DHS does not currently have this information available.
10.	Appendix A & B: Timing of MCO Payments	Please explain the rationale for the timing of April-June CAP payments. Please reiterate the timing of payments again.	This delay was approved in the 2014-15 Commonwealth Budget and is expected to continue. The Agreement reflects this action
11.	Appendix B Rates	Can DHS make rating details for the rates currently in place in all zones available? Their details are typically part of the state actuary's rate/data book, actuarial certification and/or rate approval document submitted to CMS for approval.	DHS will not provide this data.
12.	Appendix B	Has the State's actuary calculated the level of provider reimbursement, relative to the State Fee Schedule, underlying rates?	In the rates data book, no. When the actuary develops rates, provider pricing is not reduced to FFS. Provider pricing is increased to FFS for inpatient hospital.
13.	Appendix B	Were any adjustments made in the development of the current rates to remove any variance between claims paid and 100% of the fee schedule?	See response to question No. 12.
14.	Appendix B	What is the impact of APR payments	**APR Percentage of Average September-December**

<table>
<tr><th>No.</th><th>RFP or Agreement Section</th><th>Question</th><th>Response</th></tr>
<tr><td></td><td></td><td>in the Sep-Dec 15 rates shown in Appendix B?</td><td>2015 Rates

In reply to a submitted question

<table>
<tr><th>Zone</th><th>TANF/MAGI</th><th>SSI/BCC</th><th>Newly Eligible</th></tr>
<tr><td>Southwest</td><td>3.5%</td><td>4.0%</td><td>10.1%</td></tr>
<tr><td>Southeast</td><td>5.6%</td><td>6.2%</td><td>8.6%</td></tr>
<tr><td>Lehigh Capital</td><td>3.4%</td><td>3.7%</td><td>6.9%</td></tr>
<tr><td>New East</td><td>0.9%</td><td>1.0%</td><td>1.8%</td></tr>
<tr><td>New West</td><td>0.9%</td><td>1.0%</td><td>1.7%</td></tr>
</table></td></tr>
<tr><td>15.</td><td>Appendix B</td><td>Please describe the anticipated rate cell structure to be in place in 2017. I am specifically interested in how premium associated with the Healthy Beginnings Program will be reflected in this rate structure.</td><td>DHS no longer has Healthy Beginnings categories in Medical Assistance. While the categories no longer exist, there are expectations for MCOs according to the Healthy Beginnings Plus Program. See the DRAFT Agreement (Appendix A of the RFP), Section V.A.#16.(b).</td></tr>
<tr><td>16.</td><td>Appendix B</td><td>How are Healthy Beginnings members reflected in the average premium values contained in Appendix B.</td><td>See response to question No. 15.
Below is the current rate structure.

List of Rating Groups</td></tr>
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			TANF-MAGI < 2 Months **TANF-MAGI 2-11.999 Months** **TANF-MAGI Ages 1-20** **TANF-MAGI Ages 21+** **SSI-HH-Other Disabled** **Breast and Cervical Cancer** **Newly Eligible Women Ages 19 and 20** **Newly Eligible Women Ages 21 to 34** **Newly Eligible Women Ages 35 to 44** **Newly Eligible Women Ages 45 to 54** **Newly Eligible Women Ages 55 to 64** **Newly Eligible Men Ages 19 and 20** **Newly Eligible Men Ages 21 to 34** **Newly Eligible Men Ages 35 to 44** **Newly Eligible Men Ages 45 to 54** **Newly Eligible Men Ages 55 to 64**

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			Maternity Care
Quality Initiatives / Incentives			
17.	Section II-5 Care Management Questions	Please define "Community-based Cooperative Care Teams"	Community-based cooperative care teams' activity can involve care coordination by licensed and non-licensed team members. Examples of licensed providers include but are not limited to: physicians, dentists, dental hygienists, public health dental hygienists, physician's assistants, Certified Registered Nurse Practitioners (CRNPs), nurse midwives, RNs, LPNs, MSWs, dieticians, psychologists, and pharmacists. Examples of non-licensed team members include but are not limited to: medical assistants/technicians, community health workers, doulas, paramedics/EMTs, faith-based ministries, and peer specialists. This list of examples is not fully inclusive.
18.	Healthy Beginnings Plus II-5.Work Statement Questionnaire: Care Management Question 6 pg. 23	Please clarify which components of the Health Beginnings Plus Program are being referred to here. The use of and screening qualified providers? Or ensuring benefits outlined in the HBP Program are met including assigning care coordinators?	According to the Medical Assistance (MA) – Healthy Beginnings Plus Program, 55 Pa. Code § 1140.41(11)(15)(16) and (20) Participation requirements. 11. The qualified Provider shall provide by its own staff or through a subcontractor, or be able to provide the following services at the same time and in proximity to the obstetrical services: (i.) Nutrition counseling by a nutritionist or a registered dietitian to clients with obstetrical high-risk conditions. See the Manual for provider qualifications. (ii). Genetic risk assessment, information and referral by the obstetrical services provider as described in the Manual. (iii). Outpatient and inpatient obstetrical services to clients with

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			medical or obstetrical high-risk conditions (iv). Psychosocial counseling services by a social worker, a professional who performs these services under the supervision of the social worker, or by an individual who has the experience and competence to perform these services as assured, whose qualifications shall be submitted, by the qualified provider and approved by the Department for clients with psychosocial high-risk conditions, including substance abuse assessment and referral as described in the Manual. (v). Tobacco smoking cessation counseling by the obstetrical provider or care coordinator. 15. The qualified provider shall provide, when necessary, the following services either onsite or in the local community provided by the qualified provider's own staff or through a subcontractor that is a provider of these programs as described in the Manual: (i). Prepared childbirth classes (ii). Parenting education program 16. The qualified provider shall provide, when necessary, the following community/home-based services and support services provided by the qualified provider's staff or through a subcontractor: (i). Outreach services for enrollment of eligible women, including casefinding/recruitment from other agencies, and follow-up for missed appointments, home assessment and patient education. (ii). Home health services by nurses and home health aides for

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			pregnant women and newborn infants. (iii). Personal care services as previously approved by the Department 20. Because there will be clients who need drug and alcohol treatment services, qualified providers shall either develop a formal documented coordination system or a formal agreement between the local single county authority or licensed providers in the provider's service area responsible for drug and alcohol services, including drug and alcohol inpatient detoxification, drug and alcohol outpatient counseling and, if services exist, for drug and alcohol residential rehabilitation and drug and alcohol partial hospitalization services. The referenced components of the Health Beginnings Plus Program are ensuring the benefits outlined in the HBP program are met including assigning Care Coordinators, not the use of and screening qualifying providers.
19.	Section II-5 Care Coordination Question #1	Please define "Delivery systems"	"Delivery system" examples can be reviewed at Section V. D. of the HealthChoices DRAFT Agreement (Appendix A of the RFP).
Evaluation Criteria			
20.	III-4 Technical Evaluation Criteria	How will proposals that include multiple zones be evaluated/scored? If an MCO can be approved for one zone and not	DHS will separately evaluate the proposal for each Zone and score each zone separately. For all offerors, whether selected for negotiations or not, DHS will separately score the Technical Submittal for each zone.

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		another will the technical response be scored individually by zone or in aggregate?	
21.	Section II-10 Contractor Partnership	Please explain how the CPP submission impacts an Offeror's score.	Following selection for negotiation, DHS will work with the selected MCOs to refine and clarify the CPP expectations regarding the HealthChoices Agreements. CPP is not a scored technical element of the RFP, but is a requirement for most DHS contracts and agreements.
22.	Section II-5/Provider Network Composition Question #7	The Proposal asks for data related to the HER Meaningful Use Program. How does the Department anticipate that MCOs will obtain this information and will MCOs be penalized for providing incomplete information or estimated figures since there is no repository or official source of this info and MCOs may need to poll their provider network under a tight response timeframe.	Both MA and Medicare providers that participate in the MU program are publicly identified via internet links attached below. Offerors can use those provider lists to generate a response. The reason DHS included Medicare is that many of our high volume internal medicine physicians who see complex Medicaid adults decided to pursue the Medicare MU program instead of the Medicaid MU program. https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/DataAndReports.html Scroll about ¾ way down the page to the heading: **Recipients of Medicare EHR Incentive Program Payments.** Under this heading are several reports that will provide the listings for the providers and hospitals who received Medicare EHR Incentive payments. The reports are downloaded as Excel files that you will be able to sort by state/city/provider name, etc. For the Medicaid EHR Incentive payments, DHS has an interactive map on the main page of our website at www.pamahealthit.org **NOTE**: it is best to use Internet Explorer when viewing the map. When

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			you click on the map, it will open up a window with options. If you want to see the provider and/or hospital names who have received Medicaid EHR Incentive payments, choose the tab that says 'Locations' and then select the appropriate options and choose 'Display Locations'
			Pharmacy
23.	RFP 06-15/HealthChoices DRAFT Agreement	Will the Pharmacy claims for Behavioral Health be excluded with the behavioral health carve-out; or will the MCOs still manage those pharmacy claims.	The HealthChoices Physical Health/Behavioral Health processes have not changed. HealthChoices Physical Health MCOs are responsible for behavioral health pharmacy coverage/claims.
24.	RFP 06-15; Appendix A RFP (Agreement Exhibit BBB)	Page 444 letter (e), re: 340 B Could you please clarify i— Specifically, will covered entities continue to be able to purchase through 340 B drugs for HealthChoices covered individuals	Covered entities can continue to purchase drugs under 340B. The section referenced clarifies how the Department will handle encounters to comply with Federal requirements and avoid duplicate discounts on 340B drugs.
25.	In Question 8, Section II-5 Pharmacy	"Describe how you will meet the requirement that all data required by the Department for all outpatient drugs paid for by the MCO are submitted timely, completely and accurately to the Department." Please clarify the definition of "outpatient drugs" in the question.	Reference the DRAFT Agreement (Appendix A of the RFP), Part II Definitions, Covered Outpatient Drug.

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Managed Care Operations / Delivery / Standard Terms and Agreement			
26.	Draft Agreement (Appendix A of RFP). Section VII.E.#5 and Exhibits AAA.	We understand that language in the Appendix A indicating that an MCO must contract with a sufficient number of FQHC has been corrected/updated to "all" FQHC/RHCs willing to contract at the PPS rate. Correct?	The DRAFT Agreement (Appendix A) at Section VII.E. correctly indicates the provision that MCOs must contract with any RHC/FQHC that agrees to accept the PPS rate and case management processes. Exhibits AAA are accessibility/access exhibits and contain the older language. They will be amended to parallel the Agreement body language and issued as Addendums.