Questions and Responses
RFP 12-15 Community HealthChoices Services for all Zones Commonwealth-Wide

	RFP Section	Question	Answer
1		A constituent is concerned about the recently released RFP for Community HealthChoices regarding the credentialing requirements in the RFP: Service Coordinator Supervisors must be an RN or a PA licensed social worker or PA licensed mental health professional with at least three years of relevant experience except that Service Coordinator Supervisors hired prior to the Start Date who have a Master's degree, but not a license, 1) must obtain a license within their first year of this Agreement and 2) must have the qualifications and standards proposed by the CHC-MCOs and approved by the Department.	These requirements have been changed. Refer to the revised Appendix A, Draft Agreement Section V.K. provided as an attachment to Addendum 5.
	RFP Section	Question	Answer
2		Will the InterRAI tool be required for the CNA? When will a version be released for plan review?	Yes, the inter*RAI* tool will be required for the clinical needs assessment. The tool will be available in mid-summer of 2016.
	RFP Section	Question	Answer
3		As individuals move from plan to plan, will the Department facilitate the exchange of CNAs and service plans?	The software that will be used to support the inter*RAI* tool will also support the CHC-MCOs' and Department's efforts in exchanging service plan information. When the tool and software are available, the Department will provide additional guidance.
	RFP Section	Question	Answer
4		Will the Department transmit member service plan history and utilization as members are assigned?	No, the information in the inter*RAI* tool will be transferrable to the plans.
	RFP Section	Question	Answer
5		Please confirm the HEDIS rates should be submitted as an attachment and the attachment will not be counted towards the page limits for the section. Is it correct that offerors participating in HealthChoices who also operate as a Commercial PA HMO should submit both Health Choices and Commercial HMO HEDIS data? In what format should the HEDIS rates be submitted?	The HEDIS rates can be provided as an attachment and do not count towards the page limits. Yes, both HEDIS data must be submitted. The HEDIS rates should be submitted in an Excel spreadsheet.
	RFP Section	Question	Answer
6		Appendix A Draft Agreement - page 35: Please clarify which HCBS are to be available 24/7.	As noted in Section V.2 of the Appendix A Draft Agreement, all services listed in Exhibit EE are to be made available on a 24/7 basis if that is what is determined necessary by the

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			Participant's approved Person Centered Service Plan.
	RFP Section	Question	Answer
7		For continuity purposes, we intend to have the same service coordinator who administers the comprehensive needs assessment and creates the individualized service plan serve as the participants' service coordinator. The participant will be offered and will always have the choice to change their service coordinator. Does DHS consider this to be sufficient participant choice?	Yes.
	RFP Section	Question	Answer
8		To better enable the coordination of services, will DHS use Medicare encounter data to verify and notify CHC-MCOs of a participants' Original Medicare or Medicare Advantage coverage if it is not through the CHC-MCO?	If DHS is aware of Medicare coverage for a CHC Participant, regardless of the source, DHS will share this information with the CHC-MCOs to support service coordination.
	RFP Section	Question	Answer
9		Will CHC-MCOs receive the NFCE determination notification at the time of enrollment from the LCD assessment entity, or from the IEE?	The IEE and the CAO will inform the CHC-MCOs of the Participant's eligibility determination.
	RFP Section	Question	Answer
10		Will DHS provide historical data to assist CHC-MCOs in forecasting and planning?	DHS will make available some data to support Participant service planning and has provided historical data summaries to support forecasting and planning.
	RFP Section	Question	Answer
11		Does the conflict of interest provision contained in the draft agreement at Exhibit E(1), Section O prohibit an CHC-MCO that is owned and operated by a large healthcare organization from entering into a network provider contract with an LTSS service entity that is also owned and operated by the same large healthcare organization? In this scenario, would be MCO be both the care manager and the care provider, thus interfering with its ability to perform under the contract free of conflict?	These types of potential conflicts will be reviewed on a case-by-case basis.
	RFP Section	Question	Answer

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12	General	Can you please provide a summary of historical fee schedule changes for all major service categories?	Historical fee schedule changes for OLTL's home and community-based waiver services can be found at the following link: http://www.dhs.pa.gov/provider/longtermcareprov/#.VvGkgK32aHs Historical rates for nursing facilities can be found at: http://www.dhs.pa.gov/provider/longtermcarecasemixinformation/rates/index.htm#.VvGeQ632ZkQ Historical fee schedule rates can be viewed on the on-line MA fee schedule at the following link: http://www.dhs.pa.gov/publications/forproviders/schedules/mafeeschedules/index.htm#.VvGigE32a70
	RFP Section	Question	Answer
13	General	Please explain the methodology that is used in creating the HCBS fee schedule. Will the Department continue to maintain and update the HCBS fee schedule?	Please refer to the public notice at http://www.pabulletin.com/secure/data/vol42/42-23/1058.html for a summary of the rate methodology used in developing OLTL's home and community-based services fee schedule. The Department currently plans to maintain and update the HCBS Fee Schedule for regions not covered by Community HealthChoices until the program is fully implemented.
	RFP Section	Question	Answer
14	General	If Participants have spend down obligations: Is the CHC-MCO is responsible for collecting spend down? If so, what are the protocols to follow if a Participant does not pay their spend down? If the CHC-MCO is responsible for collecting spend down, can they delegate that responsibility to NF providers? To HCBS providers? What methods may a Participant use to pay their spend down (e.g., mail in a check, submit it to a provider, etc.)? How does this vary from historical	If a Participant is over resource, he or she is paying private pay. CHC MCOs and their participating nursing facility providers will be responsible for the collection of private pay and Participant spend down. Home and Community based spend down is currently

		collection?	not available. The protocols for the non-payment and notification of non-payment to the Department will be developed during the Readiness Review process.
	RFP Section	Question	Answer
15	General	Please provide the most recent Medicaid Fee Schedule applicable to all CHC providers (Physician, Hospital, Ancillary, LTSS, and HCBS)	The most recent Medicaid HCBS fee schedule can be found at the following link: http://www.dhs.pa.gov/cs/groups/webcontent/documents/bulletin_admin/p_033877.pdf The current nursing facility rates can be found at the following link: http://www.dhs.pa.gov/provider/longtermcarecasemixinformation/rates/index.htm#.VvGeQ632ZkQ The MA outpatient fee schedule can be viewed at the following link: http://www.dhs.pa.gov/publications/forproviders/schedules/mafeeschedules/index.htm#.VvGigE32a70 Inpatient acute hospitals are paid via APR-DRG rates, and other inpatient hospital types (psych, rehab) via per diem rates and are not shown on a fee schedule.
	RFP Section	Question	Answer
16	General	Do we need DHS approval on all written communication to providers? For example, Cover Letters, Post Cards, Flyers, Faxes	Yes, if requested by the Department.
	RFP Section	Question	Answer

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17	General	Are there any restrictions on how the CHC-MCO reimburses its providers such as capitation models, less than 100% FFS models, etc.?	Generally, DHS will not imposed restrictions on how the CHC-MCOs reimburse their providers. Exceptions with some providers will exist and are noted in the Draft Agreement. Examples include FQHCs and RHCs.
	RFP Section	Question	Answer
18	General	If a case arises where CHC-MCO is looking to contract a PHO type provider, where the PHO is also a competitor, is there any fair pricing guidelines in the RFP for use of the same network? Example: If ABC PHO submits a bid for the RFP and their own reimbursement model reflects 90% of FS, is 90% the max that the ABC PHO can negotiate for the Offeror's use of the same network?	Currently, there are no fair pricing guidelines in the RFP; however, the Department may establish guidelines during negotiations.
	RFP Section	Question	Answer
19	Appendix A Draft Agreement,§ II Definitions - Provider Agreement, Page 26	As currently written, the Draft Agreement categorizes providers of long-term services and supports (LTSS) as Providers. However, many of the requirements applicable to Providers in the Draft Agreement are not appropriate for providers of non-healthcare LTSS. By way of example only, providers of home adaption LTSS should not be subject to the requirements applicable to healthcare providers. In addition, because Financial Management (FMS) Services and Non-Emergency Medical Transportation (NEMT) are listed on Exhibit EE(1), Covered Services List, the Draft Agreement also appears to categorize these service providers as Providers when contracted directly with the health plan. In our experience with working with LTSS, (A) providers of FMS and NEMT, when contracted directly with the health plan, should be characterized as subcontractors based on the nature of the services they provide, (B) healthcare providers of LTSS, such as home health, should be treated in the same way as providers of traditional healthcare services, (C) non-healthcare providers of LTSS, such as providers of home adaptation and home delivered meals, should be in a separate category apart from both subcontractors and healthcare providers and (D) providers of self-directed services should not be required to sign a contract with the health plan. We believe the best way to accomplish this is to have a separate state-approved template for non-healthcare providers of non-healthcare LTSS and exempt providers of self-directed services from the contracting requirements.	The Pennsylvania MA program does not differentiate its LTSS providers as non-healthcare and otherwise. The Offeror may, however, submit, in its proposal for consideration, a framework that enhances its contractual relationship with its provider network.

		With this background, and to enable CHC-MCOs to begin contracting their LTSS networks as soon as possible in anticipation of an award, would the Commonwealth consider the following revisions to the Draft Agreement? (1) Add a definition of "Non-Healthcare LTSS Provider" to identify non-healthcare providers of LTSS, such as providers of home adaptations, home delivered meals, job coaching, vehicle modifications, pest eradication and personal emergency response systems. (2) In the definition of Provider, replace "LTSS provider" with "LTSS provider (other than a Non-Healthcare LTSS Provider)." (3) In the definition of Subcontract, replace the last sentence with "This definition includes contracts with providers of Financial Management Services and Non-Emergency Medical Transportation, when contracted directly with the CHC-MCO, but excludes contracts with salaried employees, utilities, Providers and Non-Healthcare LTSS Providers." (4) Exempt providers of self-directed services from contracting requirements. (5) Add an Exhibit DD(1) containing the Department's requirements applicable to contracts with Non-Healthcare LTSS Providers.	
	RFP Section	Question	Answer
20	Appendix A Draft Agreement; § V.A.17., Page 43	Please provide additional details about The Services My Way model, including 1) the ability of the member to roll over unused funds, 2) any requirements of the member to develop a plan for roll over funds, and 3) what happens to any funds unused by the member.	Participants in the Service My Way model may save unused funds to purchase goods and services within the current state fiscal year that will assist them in meeting their needs and goals. Participants must obtain prior approval of the savings plan from the service coordinator. All funds in "savings" must be used by the end of each state fiscal year. After the end of the state fiscal year, the funds are no longer available to the participant.
	RFP Section	Question	Answer
21	Appendix A Draft Agreement; §	Participant Self-Directed Services: Please describe the current process of translating Participant Self-Directed Services into encounters. Will these services	Encounter data must be submitted for all services listed in Exhibit EE, Covered Services

	V.A.17., Page 43	count toward encounter acceptance targets for CHC-MCOs?	regardless of whether the Participant is receiving their services in the Participant Self-Directed Services model. All encounters will count towards encounter acceptance targets.
	RFP Section	Question	Answer
22	Appendix A Draft Agreement; § V.A.17., Page 43	Participant Self-Directed Services: For what other costs will CHC-MCOs be responsible? For example other states require background checks, Workers Compensation, etc. Are all of these costs covered by FMS?	The Department has modified the Draft Agreement to more accurately reflect the CHC-MCOs' responsibilities for FMS services. Specifically, the CHC-MCOs will be responsible to pay the FMS provider: 1) Reimbursement for payments the FMS provider makes on behalf of the Participant-employer for workers' wages and vendor goods and services, 2) A per-member per-month fee to perform tasks outlined in the FMS service description, and 3) A one-time start-up fee for new Participants, paid once in a lifetime per Participant. The cost of background checks and Workers Compensation is included in the payments listed above. See the FMS Service description in the MCO Draft Agreement for additional information.
	RFP Section	Question	Answer
23	Appendix A Draft Agreement; § V.A.17., Page 43	Participant Self-Directed Services: Please provide information on the administrative costs of FMS. Will CHC-MCO or the Department be responsible for this cost going forward?	FMS costs will be built into CHC-MCO capitated rates and the CHC-MCO will be responsible for this cost.
	RFP Section	Question	Answer

24	Appendix A Draft Agreement; § V - B(2a) Time Frames for Notice of Decisions; Exhibit G, §-B(3) Guidelines for Review, Page 47; H-6 and 7	Section V(B)(2)(a) of the Draft Agreement states CHC-MCO is required to notify Participant of the decision for a Prior Authorization Request "within two (2) business days of receiving the request, unless additional information is needed." However, in Section B(3)(a) of Exhibit G, Prior authorization Guidelines for Participating Managed Care Organizations in the CHC program, Section B.3 Administrative Requirements, the CHC-MCO's Prior Authorization policies "must demonstrate that the time frames are consistent with the following required maximum time frames: Immediate-Inpatient Place of Service Review for emergency and urgent admissions; 24 hours for all drugs and items or services which must be provided on an urgent basis; 48 hours (following receipt of required documentation) for Home Health services; 21 days for all other services." These requirements conflict - please clarify the required PA response requirements. Also, per NCQA the timeframe for a response related to an inpatient admission (urgent concurrent) is 24 hours. Please confirm "immediate" for inpatient admissions means within 24 hours as consistent with NCQA guidelines.	Unless a shorter timeframe is provided in Exhibit G, selected Offerors must comply with the timeframes for prior authorization in Section V(B)(2) of the Draft Agreement. The Department will revise Exhibit G in the final Agreement.
	RFP Section	Question	Answer
25	Appendix A Draft Agreement; § V.C., Page 48	How will rate setting Actuaries reflect the Continuity of Care requirements in rate setting assumptions?	Consideration is being given to the impact these requirements may have on the MCOs. Additional information will be provided to selected offerors during the rate negotiation process.
	RFP Section	Question	Answer
26	Appendix A Draft Agreement; § V-O(4) Limited English Proficiency Requirements, Page 62	Please provide a list of the predominant languages under which the CHC-MCOs will be required to translate documents.	The Department will provide a list of predominant languages to the selected Offerors. This list of predominant languages may change.
	RFP Section	Question	Answer
27	Appendix A Draft Agreement; § V-O(11a) Monthly File, Page 64	Please explain how the state will provide membership eligibility coverage spans via the daily, weekly, and monthly files?	Prospective Offerors can access this information via the link below once they are granted access. To request access, each person needing access to the information for each prospective offeror will need to read

			Management Directive 205.34 Commonwealth of Pennsylvania Information Technology Acceptable Use Policy and print, complete, and sign Enclosure 3 to Management Directive 205.34. The Management Directive may be accessed at http://www.portal.state.pa.us/portal/server.pt/gateway/PTARGS_0_2_785_711_0_43/http%3B/pubcontent.state.pa.us/publishedcontent/publish/global/files/management_directives/management___administrative_support/205_34.pdf The Offeror will need to scan and email the signed documents to Kelly McCarty at kemccarty@pa.gov. Each prospective Offeror should submit the list of names and signed documents in one email. https://www.humanservices.state.pa.us/omap_rfp/
	RFP Section	Question	Answer
28	Appendix A Draft Agreement; § V-P. Participant Services, Page 70	Section V(P)(1) of the Draft Agreement, which addresses Participant Services generally, states that the CHC-MCO's Participant services functions must operate at a minimum of 9am-5pm, Monday through Friday plus one evening per week (5pm to 8pm) and one weekend per month "to address non-emergency problems encountered by Participants." This general section also states that the CHC-MCO must have "arrangements to receive, identify and resolve in a timely manner Emergency Participant Issues on a twenty-four (24) hour, seven (7) day-a-week basis." Section V(P)(2) requires that the CHC-MCO "maintain and staff a twenty-four (24) hour, seven (7) day-a-week toll-free dedicated hotline to respond to Participants' inquiries, issues and problems regarding services". Please confirm that Section V(P)(2) is a more detailed discussion of the requirement that the CHC-MCO have arrangements 24/7 to address Emergency Participant issues, and that CHC-MCO's general customer service may keep hours in compliance with the non-emergency call requirements of Section V(P)(1).	Confirmed.

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	RFP Section	Question	Answer
29	Appendix A Draft Agreement; § V.X.4.p. and Appendix A Draft Agreement; § VII.F., Pages 88 and 122	It appears there are situations where the Department can collect Overpayments and TPL directly (where amounts do not go to the MCO). How will the Department ensure these amounts are not included as reductions to the base data that the Actuaries use for rate setting?	Overpayment and TPL/COB amounts for tasks that are the responsibility of the CHC-MCO will be netted out of the base data used for the CHC capitation rate development process, whereas collections/recoveries made by the Commonwealth will not.
	RFP Section	Question	Answer
30	Appendix A Draft Agreement; § V.BB., Pages 98	How will rate setting Actuaries reflect the below network requirements in rate setting assumptions? "The CHC-MCO must enroll in its Network all willing and qualified LTSS Providers that provide HCBS through the OLTL waivers in effect prior to Start Date and through all NF in the zone... This requirement will remain in effect for LTSS Providers for 180 days after the Start Date. Following the 180 day period, the CHC-MCO may adjust its Provider Network in accordance with the Network access and adequacy standards outlined in this agreement."	These network requirements are being reviewed as part of the rate development process. Additional information will be provided to selected offerors during the rate negotiation process.
	RFP Section	Question	Answer
31	Appendix A Draft Agreement; § VII.B.1.a.ii., Page 112	Please clarify if Capitation Payments will be prorated based on the number of days a Participant is eligible in a given month. For example: will the Capitation Payment vary for a Participant enrolled from the 1st to the 30th vs. a Participant enrolled from the 5th to the 30th?	The Capitation Payments will be prorated based on the number of days a Participant is enrolled in CHC in a given month.
	RFP Section	Question	Answer
32	Appendix A Draft Agreement; § E.7., Page 120	Please clarify the Financial Responsibility for Dual Eligible Participants statement "The CHC-MCO must pay Medicare deductibles and coinsurance amounts relating to any Medicare-covered service for Dual Eligible Participants not to exceed the contracted CHC-MCO rate". Will the CHC-MCO allowed amount be taken into account? See examples below: Example 1: Medicare allowed amount $100 Medicare paid amount $80 CHC-MCO allowed amount for same service $90	Participants, including Dual Eligibles may not be balance billed for these services. If the CHC-MCO allowed amount means the same thing as contracted CHC-MCO rate, the answer is YES. For example, 1,the CHC-MCO liability is $10 (less any Medicaid copay applied by the CHC-MCO)

		Would payment be $10 (to bring Medicare paid amount up to CHC-MCO allowed amount) or $20 (participant's Medicare liability) Example 2: Medicare allowed amount $100 Medicare paid amount $0 (participant has not met deductible) CHC-MCO allowed amount for same service $90 Would payment be $90 (to bring Medicare paid amount up to CHC-MCO allowed amount) or $100 (participant's Medicare liability) If logic varies from either of these examples please explain reimbursement logic. If the answers vary by provider type and/or service type (e.g., Institutional vs. Professional, IP vs. NF), please describe. Please explain how reimbursement works currently.	For example 2, the CHC-MCO liability is $90 (less any Medicaid copay applied by the CHC-MCO) The logic, and answers, do not vary.
	RFP Section	Question	Answer
33	Appendix A Draft Agreement; § VII-F(2e) Post Payment Recoveries, Page 123	The 9 month and 6 month recovery period is for TPL only recoveries (commercial insurance) or is this related to any recovery reason (retro-terminations, fee schedule overpayments, etc.)?	The recovery period referenced in the cited section is for health-related TPL only recoveries.
	RFP Section	Question	Answer
34	Appendix A Draft Agreement; § VII-F(2e) Post Payment Recoveries, Page 123	What are the look-back restrictions for non-FWA overpayment recoveries such as retro-terminated members and manual calculation errors?	There are currently no look back restrictions for non-FWA overpayment recoveries; however, the Department may consider this option in negotiations.
	RFP Section	Question	Answer
35	Appendix A Draft Agreement; § VII-F(2e) Post Payment Recoveries, Page 123	What are the notification requirements for non-FWA overpayment recoveries such as retro-terminated members, COB/TPL (commercial coverage primary to Medicaid), and manual calculation errors?	There are currently no notification requirements for non-FWA overpayments; however, the Department may consider this option in negotiations.
	RFP Section	Question	Answer
36	Appendix A Draft Agreement; § IX.B (Disclosure of	This states that the "CHC-MCO must disclose to the Department information on ownership and control, business transactions, and persons convicted of crimes in accordance with 42 C.F.R. Part 455, Subpart B." That regulation states that such	Yes, the disclosure must be made at the time of proposal submission in accordance with 42 C.F.R §455.104 relating to Disclosure by

	Interests), Page 133	disclosures should be made at the time of proposal. Please confirm that this disclosure need not be submitted with the RFP. If it does have to be provided, please indicate whether the Department has a form it wishes Offerors to use and please confirm it would be given confidential treatment since the required disclosure includes Social Security Numbers and dates of birth.	Medicaid providers and fiscal agents: Information on ownership and control. The Department does not have a form for reporting this information. Offeror should designate the information that it considers to be confidential in accordance with RFP Part I, Section I-19. Offerors should also provide an electronic copy of its proposal with the information redacted as provided in RFP Part I, Sections I-12 and I-19.
	RFP Section	Question	Answer
37	Appendix A Draft Agreement; Appendix 3b.II.A	What is the intended time frame that the first Base Capitation Rates will remain in effect?	The initial capitation rates for the Southwest Zone will be effective January 1, 2017 through December 31, 2017..
	RFP Section	Question	Answer
38	Appendix A Draft Agreement; Appendix 3c	Please share any preliminary information on the Risk Corridor (including methodology and implementation date) if available.	DHS anticipates implementing a risk corridor during the first year of CHC in a given zone (e.g., January 1, 2017 through December 31, 2017 for the Southwest zone). Additional information will be provided at a later time.
	RFP Section	Question	Answer
39	Appendix A Draft Agreement; Appendix 3e	If Participants have spend down obligations: How will spend down be accounted for in Rate Setting? Will base claims include the gross cost (FFS/CHC-MCO cost plus spend down)? How will the Actuaries ensure they have fully captured all spend down?	The historical data summaries reflect data that is net of the Participant's share of cost. The MCOs will be responsible for collecting the Participant's share of cost. Therefore, the capitation rates will reflect a reduction for the overall average spend down amount.
	RFP Section	Question	Answer
40	Appendix A Draft Agreement; Appendix 3e	If Participants have spend down obligations, and the base claims in rate setting include gross cost (FFS/CHC-MCO cost plus spend down), and the CHC-MCO is responsible for collecting spend down how will rates be adjusted to account for this Participant share of cost? Will overall rates be reduced with an average spend	Refer to the response to Q.39.

		down assumption or will rates be adjusted on a Participant-specific level?	
	RFP Section	Question	Answer
41	Appendix A Draft Agreement; Appendix 3e	Please describe how any and all expenses not paid through the FFS claim system were/will be included in the rate setting base claims. For example: non-medical transportation, pest control, community transition services, career assessment, etc. What steps were taken to ensure that all expenses for covered services were included in the base claims?	The data summaries reflect costs for all CHC covered services that were provided during FY 12/13 and FY 13/14, including non-medical transportation and community transition services. As outlined on page 5 of the Mercer historical data summaries, any differences between historical service offerings and prospective service offerings will be considered during the capitation rate development process. Additional information on rate development will be shared as part of the rate negotiation process.
	RFP Section	Question	Answer
42	Appendix A Draft Agreement; Appendix 3g	Please share any preliminary information on the Individual Stop Loss Re-Insurance or any other risk sharing/risk pools (including methodology and implementation date) if available.	DHS may implement a high-cost risk pool in the second year of CHC in each zone (e.g., January 1, 2018 through December 31, 2018 for the Southwest zone). Additional information will be provided at a later time.
	RFP Section	Question	Answer
43	Appendix A Draft Agreement; Appendix 4	Will the Department continue to set NF rates with the same methodology that has been used in the past? If not, please explain how the rate methodology will change. In addition, please provide the current NF fee schedule.	This question is not relevant to submitting a proposal to this RFP. The link to NF rates is provided in response to Q.15.
	RFP Section	Question	Answer
44	Appendix A Draft Agreement; Appendix 4	Will CHC-MCOs be responsible for supplemental payments to Nursing Facilities or will the Department continue to make those payments?	DHS will include a dedicated PMPM amount in CHC-MCO capitation payments as defined in Appendix 4 to ensure access to care in private and county nursing facilities for CHC Participants. The CHC-MCO must use all the

			dedicated funding to reimburse private and county nursing facilities in a manner agreed upon between the CHC-MCO and the private and county nursing facilities.
	RFP Section	Question	Answer
45	Appendix A Draft Agreement; Appendix 4	Please describe any other supplemental payments to providers that will become the responsibility of the CHC-MCOs.	Other than the Appendix 4 payments, the Department currently does not anticipate any other supplemental payments to providers.
	RFP Section	Question	Answer
46	Appendix A Draft Agreement; Exhibit J- Medical Assistance Transportation Program, Page L-1	Please clarify the MATP benefit if a Medical Assistance eligible recipient has a medical service paid by Medicare and is provided by a Non-Medicaid service provider.	MATP is available to Medical Assistance eligible Participants whose medical service is paid by Medicare as long as the medical service is performed by a Medical Assistance service provider and all other eligibility requirements are met. For Medicare and Medicaid-services, the service must be provided by a Medical Assistance service provider to be eligible for the benefit.
	RFP Section		Answer
47	Appendix A Draft Agreement; Exhibit J- Medical Assistance Transportation Program, Page L-1	Please provide more information around the MATP agencies that are referenced in this section (quoted below). What the agencies are, how many agencies there are, etc. Are CHC-MCOs permitted to use alternative agencies to provide transportation services? "MATP agencies have been instructed to contact the CHC-MCO for verification that a Medical Assistance Participant's services request is for transportation to a Medical Assistance compensable service. The Department strongly encourages the CHC-MCO to jointly undertake activities with MATP agencies such as sharing Provider Network information, developing informational brochures, and establishing procedures which enhance transportation services for Participants."	MATP Information may be found through the following link: http://matp.pa.gov/. CHC-MCOs may use alternative agencies for Non-Medical Transportation.
	RFP Section	Question	Answer

48	Appendix A Draft Agreement; Exhibit K(1) Quality Management and Utilization Management Program Requirements, Standard IX- F(2), Page K(1)-24	Standard IX (F)(1) of Exhibit K(1) states that the CHC-MCO "must ensure that Prior Authorization and Concurrent review decisions . . . That result in a denial may only be made by a licensed physician". Does this include those administrative determinations that do not involve medical necessity but are based in benefit coverage guidelines and made by supervisor/managers? Please clarify.	DHS is not certain what is meant by "benefit coverage guidelines." Section II of the Draft Agreement defines concurrent review as a review for Medical Necessity and accordingly requires that any denial be made by a licensed physician. The definitions of Prior Authorization and Prior Authorized Services include both incorporate concepts of Covered Services and Medical Necessity and also would require that denials be made by a licensed physician.
	RFP Section	Question	Answer
49	Appendix A Draft Agreement; Exhibit M Coordination with BH-MCOS, Page M-	Does the Commonwealth or County Behavioral Health Authorities host a database of behavioral health care utilization data or plans of care that can be used to assist in the coordination and collaboration of CHC and behavioral health services?	A statewide data base regarding utilization or plans of care is not currently available.
	RFP Section	Question	Answer
50	Appendix A Draft Agreement; Exhibit Q	The state mentions a reapplication monthly file, how should the MCO handle this membership once received? Are they renewal members?	The reapplication file is a file that the CHC-MCO will use to identify Participants in need of a Medicaid reapplication. CHC-MCOs may use this information to reach out to Participants and remind them of their upcoming reapplication due dates at the CAO. HealthChoices plans have used this to try to reduce the number of no-shows to the CAO reapplication appointments and thus reduce breaks in MCO coverage.
	RFP Section	Question	Answer
51	Appendix A Draft Agreement; Exhibit BB Provider Network Composition/Service Access, Page 308	1.a PCPs: Please confirm that PA DHS considers the following provider specialties to be PCPs: Family Practice, Internal Medicine, General Practice, Geriatric Medicine, and OB/GYN.	All such provider specialties may serve as primary care physicians.
	RFP Section	Question	Answer

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52	Appendix A Draft Agreement; Exhibit BB Provider Network Composition/Service Access, Page 307 - 310	Exhibit BB: Provider Network Composition/Service Area discusses travel time for Urban and Rural counties. Is there a County List for Urban and Rural county classifications?	The attached link from the Center for Rural Pennsylvania shows population density by county: http://www.rural.palegislature.us/rural_urban.html The map in the attached link, from the 2010 census, shows the urban vs. rural designation: http://www.rural.palegislature.us/ruralcounties.html
	RFP Section	Question	Answer
53	Appendix A Draft Agreement; Exhibit BB- Provider Network Composition/Service Access, Page BB-1	Please clarify what the passing threshold rate is for Geo Access requirements (travel time). For Example: 95% passing threshold for PCP, Provider Specialists, Hospitals etc. Language within the Draft Agreement only discusses Travel Time; it makes no mention of passing access threshold.	Department of Health regulations do not contain specific language that references a "passing threshold rate", or a "passing access threshold". As it relates to access, 28 Pa.Code § 9.679(d) requires that: "a plan shall provide for at least 90% of its enrollees in each county in its service area, access to covered services that are within 20 miles or 30 minutes travel from an enrollee's residence or work in a county designated as a metropolitan statistical area (MSA) by the Federal Census Bureau, and within 45 mile or 60 minutes travel from an enrollee's residence or work in any other county". If the Plan cannot meet this requirement they will need to report this, explain why and also how they intend to provide access to covered service through an alternate means.
	RFP Section	Question	Answer
54	Appendix A Draft Agreement; Exhibit CC -§ 1.i: Outpatient Drug	Please confirm that the continuity of care period for pharmacy services is 60 days consistent with the general timeframes of the sources noted in this sections.	The Continuity of Care requirements for pharmacy services are defined in the MA Bulletins. The links are provided below.

	(Pharmacy) Services, Page CC-2		http://www.dhs.pa.gov/publications/bulletinsearch/bulletinselected/index.htm?bn=99-03-13&o=N&po=OMAP&id=09/01/2003#.VurMOpjrvGg
	RFP Section	Question	Answer
55	Appendix A Draft Agreement; Exhibit EE(2) - Adult Daily Living	This section mentions: "Providers may bill for one (1) day when Basic or Enhanced Adult Daily Living services are provided for four (4) or more hours in a day. Providers must bill for a half day when Basic or Enhanced services are provided for fewer than four (4) hours in a day." Please clarify if this billing procedure is currently followed. Please clarify if this billing procedure is not currently followed, how this will be captured in the rate setting process.	This section describes the billing procedure that is currently followed, and will therefore be reflected in the base data used for rate development. Adult Daily Living services are captured in the rate setting process according to the current billing procedure.
	RFP Section	Question	Answer
56	Appendix A Draft Agreement; Exhibit EE(2)-Covered Services	How are non-standard services currently paid? For example: pest control, community transition services, career assessment, etc. Traditionally these providers may not have submitted a standard health claim and may be invoicing the Department instead. Please describe the current process of translating these services into encounters. Will these services count toward encounter acceptance targets for CHC-MCOs?	Providers currently submit claims through the PROMISe™ system for OLTL waiver services. In CHC, all providers, including those of non-standard services will be enrolled in the MA program and assigned specialties based on the services requested. OLTL will provide CHC-MCOs a list of approved providers. CHC-MCOs will be responsible for communicating their payment process with providers. CHC-MCOs will be required to submit the services as encounters through PROMISe™.
	RFP Section	Question	Answer
57	Appendix D, Page 1 of Appendix D	Offerors are required to complete an Appendix D "for each state where the Offeror has contracted with a state agency to provide managed care and managed long-term services and supports (MLTSS) since January 2012. Please confirm that an Offeror need not complete Appendix D with respect to a state with which it has only executed a MIPPA agreement related to its D-SNP plans in that state.	Offerors need not complete Appendix D for a state where it only has a MIPPA agreement related to its D-SNP plans.

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	RFP Section	Question	Answer
58	Appendix D, Page 1 of Appendix D	Offerors are asked to "document that both entities are under the control of the same corporate family." What type of documentation is anticipated? Would a copy of Exhibit 21.1 to the most recent Annual Report on Form 10-K filed by the Offeror's parent be sufficient? IS the Offeror required to submit copies of the documentation with its proposal or is the requirement simply that it be able to document common control?	The entity relationship should be evident and documented in the financial reports submitted with the proposal.
	RFP Section	Question	Answer
59	Appendix J	Item 7 requests a "Narrative on any pending lawsuits or investigations involving Offeror or any affiliate". A full response to such a broad question is likely to be less useful to the Department's evaluation than a more narrow question might be. For example, any large managed care organization has a steady flow of minor lawsuits involving disputes with providers, members and employees. In order to provide the Department with the most relevant information, could Offerors narrow their responses to lawsuits (a) likely involving liability over $2 million and/or (b) involving allegations (regardless of amount) that the Offeror (or its affiliate) violated its contract with a government customer (by not providing benefits, etc.)?	Offerors may narrow their responses to those pending lawsuits or investigations that (a) are likely to involve liability of over $2 million; (b) involve allegations regardless of amount that the Offeror or its Affiliates violated an agreement or contract with a governmental entity; and/or (c) would significantly affect the Offeror's ability to provide services as required by this RFP.
	RFP Section	Question	Answer
60	Appendix J	Item 8 requests "Information which identifies any parent corporation ownerships and relationship status." Please confirm that a corporate organizational chart showing the parent and its various direct and indirect subsidiaries would satisfy this request.	Yes, a corporate organizational chart will satisfy the requirement.
	RFP Section	Question	Answer
61	Appendix J	Item 9 requests "Information on intermediary subsidiary which holds Offeror's stock (indirect only)." Please confirm that identification of the intermediary entities is sufficient to respond to this question. If not, what additional information is requested?	Yes.
	RFP Section	Question	Answer
62	c_222677 Community HealthChoices Data Summaries (databook dated 2/18/16)	The databook mentions (see quote below) that some data is from the managed care program. Please describe which populations and services were provided through managed care. Please also provide magnitude in relation to total dataset. "The data encompass Acute Medical services (historically provided through either the fee-for-service (FFS) program or the HealthChoices (HC) Physical Health (PH)	The population consists of Non-dual eligible Participants who were enrolled in the Attendant Care, Independence, OBRA or CommCare waivers during the historical data summary period who received their acute medical services through the HC PH

	http://dhs.pa.gov/cs/groups/webcontent/documents/document/c_222677.pdf, Page 2 of 18	managed care program)."	managed care program. To capture these costs, managed care encounter data was included. The encounter data represents roughly 5.5% of the total statewide service costs across all population groups.
	RFP Section	Question	Answer
63	c_222677 Community HealthChoices Data Summaries (databook dated 2/18/16) http://dhs.pa.gov/cs/groups/webcontent/documents/document/c_222677.pdf, Page 7 of 18	Please explain how the "Member Months" lines were calculated. How were partial month eligibility spans counted: as a full month or a partial month?	Participants with partial month eligibility spans were only counted as a partial member month in order to align eligibility with their partial month of costs.
	RFP Section	Question	Answer
64	c_222677 Community HealthChoices Data Summaries (databook dated 2/18/16) http://dhs.pa.gov/cs/groups/webcontent/documents/document/c_222677.pdf, Page 7 of 18	Please comment whether the "Nursing Facility" line includes Participant liability (spend down). The Nursing Facility line appears to be low when compared a monthly cost calculated with the average NF per diem rates. Please comment whether any "HCBS Waiver Services" include Participant liability (spend down) in the expense shown.	Refer to responses to Q.14 and Q.39.
	RFP Section	Question	Answer
65	c_222677 Community HealthChoices Data Summaries (databook dated 2/18/16) http://dhs.pa.gov/c	The databook located at this URL: http://dhs.pa.gov/cs/groups/webcontent/documents/document/c_222677.pdf Has missing data points. For example: page 7 of 18, the value in row "Nursing Facility", Column "Dually Eligible Individuals Residing in a Nursing Facility" "Ages 60+" is missing all digits except cents. Please provide a corrected version.	An issue arose when the summary was posted, making it illegible. The issue has since been fixed. We apologize for any inconvenience.

	s/groups/webcontent/documents/document/c_222677.pdf, Page 7 of 18		
	RFP Section	Question	Answer
66	c_222677 Community HealthChoices Data Summaries (databook dated 2/18/16) http://dhs.pa.gov/cs/groups/webcontent/documents/document/c_222677.pdf, Page 7 of 18	Please provide the "Member Months" for FY15, FY16, FY17, and calendar year 2017 projections. Please provide at same level of population detail as provided in the Community HealthChoices Data Summaries file (dated 2/18/16). Please split out the NE and NW zones from each other if possible.	DHS does not plan to provide additional data at this time.
	RFP Section	Question	Answer
67	c_222677 Community HealthChoices Data Summaries (databook dated 2/18/16) http://dhs.pa.gov/cs/groups/webcontent/documents/document/c_222677.pdf, Page 7 of 18	Please provide counts (by fiscal year) of membership adds and terminations. Please provide for FY13, FY14, FY15, FY16, and FY17. Please provide at same level of population detail as provided in the Community HealthChoices Data Summaries file (dated 2/18/16).	DHS does not plan to provide additional data at this time.
	RFP Section	Question	Answer
68	c_222677 Community HealthChoices Data Summaries (databook dated 2/18/16) http://dhs.pa.gov/cs/groups/webcontent	Please provide the "Member Months" for the NW and NE zones split out from each other for FY13 and FY14. Please provide at same level of population detail as provided in the Community HealthChoices Data Summaries file (dated 2/18/16).	DHS does not plan to provide additional data at this time.

	/documents/document/c_222677.pdf, Page 7 of 18		
	RFP Section	Question	Answer
69	RFP Part I; § I-4, Page 4	Data link provided on page 11 of 52 of RFP states that "Current participants of DHS Office of Long Term Living waiver programs who are 18 to 21 years old" will be included in CHC. This population is not listed in the RFP. Please confirm this population is NOT included in CHC. Link: http://dhs.pa.gov/citizens/communityhealthchoices/chchistoricaldatasummary/index.htm#.Vr9_SK3ruHt	CHC does not include current participants in DHS OLTL waiver programs who are 18 to 21 years old. The information on the link has been corrected.
	RFP Section	Question	Answer
70	RFP Part I; § I-4, Page 4	The total population provided on page 11 of 52 in the chart is 420,614 for FY15 (if you sum all population categories together). However, the Mercer file "Community HealthChoices Data Summaries" (dated 2/18/16) has very different enrollment counts. The Mercer file has Member Months of 3,807,533 for FY13 and 3,896,486 for FY14 (if you sum all population categories). This translates to average membership of 317,294 for FY13 and 324,707 for FY14 (if you divide by 12 months). Please explain why the population counts provided in the RFP are so much higher than the ones provided by Mercer. What was the average enrollment for the CHC program in FY15?	The counts in the RFP are counts of Participants regardless of how long they were in any particular group. This will give MCOs the number of actual people who would "walk through the door" during a typical year. The eligible counts on page 11 cannot be summed because a Participant may have moved between population groups during the year and would be counted in multiple groups. The historical annual average length of eligibility for the Participants in the Mercer data summaries was less than 12 months, so dividing the member months by 12 will not provide an accurate count of eligibles. Dividing member months by 12 does provide an average count of enrollees during a given month within the illustrated fiscal year.
	RFP Section	Question	Answer
71	RFP § I-13 Small Diverse Business Information, Page 8	The Small Diverse Business (SDB) Certification Program has certain gross annual revenue requirements for SDBs (>$7M for Design companies, >$20M for Sales & Svc, and >$25M for IT Svcs & Svc Businesses). If Offeror had, for example, $5M in business for a Design SDB, and that Design SDB already had $6M in gross revenue from other clients, then would Offeror's $5M then disqualify that Design SDB	The Gross revenue is averaged over a three year period of time. According to your example, $5M plus $6M will equal $11M divided by 3 years would be less than the threshold amount of $7M for Design

		from being a SDB?	companies.
	RFP Section	Question	Answer
72	RFP § I-13 Small Diverse Business Information, Page 8	If Offeror finds several SDBs that can provide the same service but elects to divide up the work/spend between the several SDBs so as not to have them exceed their gross revenue caps but each portion was less than 50% of the spend, would that deemed as acceptable by the Department and/or BDISBO during the evaluation?	Please understand that each commitment is specific to the SDB, and the Offeror can have as many SDBs in its commitment as it chooses. In reference to the 50% rule, to receive credit for an SDB commitment, the SDB subcontractor must perform at least fifty percent (50%) of the work subcontracted to the SDB.
	RFP Section	Question	Answer
73	RFP Part II, Work Statement Questionnaire, Page 22	Question 15 at the bottom of page 22 asks the Offeror to describe its approach to "prioritizing HCBS". Could the Department provide additional clarification regarding the phrase "prioritizing HCBS"? Does this mean the Offeror's approach to helping Participants stay in the community as long as possible?	Prioritizing HCBS does mean to support the provision of services in the Community.
	RFP Section	Question	Answer
74	RFP § II-6(B)(3), Financial Condition, Page 32	What types of "documentation" about Offeror's available lines of credit is the Department requesting?	A description of the available lines of credit is adequate. At a minimum, the description should include the type of credit, lending institution, applied collateral and available amount. The Department may request further documentation if it determines it is necessary.
	RFP Section	Question	Answer
75	RFP § II-6(F), Financial Condition, Page 33	Would the Department accept or consider an alternative to the SAP-basis equity requirement in II-6(F) (e.g., a parental guaranty or a bid bond) in lieu of the Offeror meeting the "Three (3) Part Test" prior to submission of the proposal? In our experience, only minimum capitalization (i.e., $1-2M) is necessary at the time of licensure and full capitalization funding (i.e., the Three (3) Part Test) is not required until commencement of operations. Requiring full capitalization before the proposal is even submitted may unnecessarily restrict the use of those funds for an excessive period of time prior to operations. We fully acknowledge the requirements in RFP § II-6(G) stating that the Offeror must meet the "Three (3)	No.

		Part Test" by the last day of the second quarter prior to the zone program implementation date, and believe this to be a more typical deadline for funding.	
	RFP Section	Question	Answer
76	RFP § II-6(I), Financial Condition, 34	Please confirm that the only subcontracts that must be submitted as appendices to the RFP are those with subcontractors in which Offeror has a financial interest.	Yes for proposal submittal.
	RFP Section	Question	Answer
77	RFP § II-7, Objections and Additions to Standard Contract Terms and Conditions, Page 34	Please confirm that the only objections to the terms in Appendix A Draft Agreement that the Offeror needs to include in Tab 8 are objections to Exhibits D and E(1) of Appendix A. Further, with respect to additional terms, please confirm that Offeror need only specify those additional terms it proposes to add to Exhibits D and E(1) of Appendix A.	Confirmed for both comments.
	RFP Section	Question	Answer
78	RFP § II-8(A), Small Diverse Business Submittal, Page 34	Please clarify the meaning of "subcontracting" for purposes of the Small Diverse Business Submittal. Under RFP § II-4(D), a subcontractor is a person or entity "employed in lieu of staff to help staff and implement the obligations under the Agreement" and provides claims processing as an example. Likewise, the definition of subcontract in the Draft Agreement (Appendix A) is an agreement with a person or entity "to perform part or all of the CHC-MCO's responsibilities under this agreement. Exempt from this definition are salaried employees, utility agreements and Provider Agreements." However, the term "subcontractor" as used in § II-8(A) seems broader since it expressly includes "purchasing supplies and/or services through a purchase agreement", which would not be subcontracting under the other definitions. Please confirm that for its Small Diverse Business Submittal, Offeror may list SDBs that supply / support its business but that do not perform Offeror's contractual obligations on its behalf.	The Department encourages all Offerors to make significant commitments to use SDBs as subcontractors to perform a service or suppliers to provide materials under the scope of the agreement. For purposes of an Offeror's SDB commitment only, subcontractors are as described in RFP Part II, Section II-8(A) and (B).
	RFP Section	Question	Answer
79	RFP § II-10 Contractor Partnership	The request for a narrative for the Contractor Partnership Program indicates that statements A-E "pertain to the hiring of individuals that are receiving TANF cash assistance". Please confirm that statements A and B should actually include totals	Statements A and B are referring to all hires not just TANF specific hires.

	Program, Page 36	(total anticipated employees in the zone and number of management and non-management employees). If these are in fact supposed to include only TANF cash assistance recipients, then how do statements A and B differ from statement C (the number of TANF cash assistance consumers to be hired)?	
	RFP Section	Question	Answer
80	RFP § II-10 Contractor Partnership Program, Page 36	Does the Offeror get "credit" if its subcontractors hire TANF cash assistance consumers?	Offerors may propose Subcontractors as part of its CPP commitment. While Small Diverse Businesses may volunteer to assist Offerors in its CPP commitments, Offerors cannot require these SDBs to hire qualified TANF recipients as a stipulation to partnership for purposes of a SDB commitment. While developing hiring numbers and plans, Offerors should look both company and subcontractor-wide for the full duration of the agreement while establishing potential openings to be filled.
	RFP Section	Question	Answer
81	RFP Page 30, Provider network Composition and Network management, 1. Bullet #3	Please clarify whether service coordination providers are included in the reference to "any current willing and qualified HCBS, nursing facility, and LTSS providers that are enrolled MA providers at the time of implementation", given that service coordination is described as an administrative function of the MCO.	Yes, they are included in the reference. During the Continuity of Care period following transition, Service Coordinators are considered providers.
	RFP Section	Question	Answer
82	RFP Page 30, Provider network Composition and Network management, 1. Bullet #3	Please describe the difference between HCBS provider and LTSS provider.	LTSS encompasses all services provided. HCBS is a subset of LTSS.
	RFP Section	Question	Answer

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83	RFP Page 30, Provider network Composition and Network management, 1. Bullet #6	Please clarify whether the MCO must provide a choice of service coordination Network providers for Participants given that service coordination is described as an administrative function of the MCO.	After the continuity of care period which is the later of 180 days or until a comprehensive needs assessment has been completed and a PCSP has been developed and implemented, service coordination is an administrative function and not a network function. Participants, however, must have the opportunity to change service coordinators.
	RFP Section	Question	Answer
84	RFP Page 30, RFP Page 30: Provider network Composition and Network management, 1. Bullet #6	Please clarify whether the MCO must provide a choice of service coordination Network providers for Participants during the 180 day continuity of care period.	The COC period covers the service coordination agency. If the Participant wants to change agencies, the COC period no longer applies. The MCO would then be responsible for service coordination. If the Participant wants to stay with the service coordination agency during the COC Period but change service coordinators then that would be between the Participant and the service coordination agency.
	RFP Section	Question	Answer
85	RFP Page 30, RFP Page 30: Provider network Composition and Network management, 1. Bullet #6	Please clarify whether the MCO must provide a choice of service coordination Network providers for Participants after the 180 day continuity of care period.	No. See response to Q.83.
	RFP Section	Question	Answer
86	RFP Page 30, Provider network Composition and Network management, 1. Bullet #6	Please clarify the Department's expectations regarding participant choice of service coordinator after the 180 day continuity of care period.	See response to Q. 83 and Q. 85.
	RFP Section	Question	Answer

87	Draft Requirements page 18, Encounter	Is service coordination considered a covered healthcare service provided to a CHC-MCO participant?	During the continuity of care period, which is the later of 180 days or until a comprehensive needs assessment has been completed and a PCSP has been developed and implemented, service coordination is considered to be a service. After the continuity of care period, it is considered an administrative function of the MCO Plan.
	RFP Section	Question	Answer
88	Draft Requirements page 22, Network	Are service coordination entities considered to be Providers who are providing Covered Services to Participants?	During the continuity of care period as referenced in Q.87, service coordination entities are considered to be providers. After the continuity of care period, service coordination is considered an administrative function of the MCO Plan.
	RFP Section	Question	Answer
89	Draft Requirements page 22, Network	Are service coordination entities considered to be Providers who are providing Covered Services to Participants during the 180 day continuity of care period?	See response to Q. 88.
	RFP Section	Question	Answer
90	Draft Requirements page 22, Network	Are service coordination entities considered to be Providers who are providing Covered Services to Participants after the 180 day continuity of care period?	See response to Q. 88.
	RFP Section	Question	Answer
91	Draft Requirements page 22, Network Provider	Is a service coordination entity considered a Healthcare Provider, necessitating a written Provider Agreement and credentialing by a CHC-MCO?	See response to Q. 88. During the COC period, a service coordination entity is considered to be a provider which may necessitate a written provider agreement and credentialing as determined by the MCO.
	RFP Section	Question	Answer

92	Draft Requirements page 22, Network Provider	Is a service coordination entity considered a Healthcare Provider, necessitating a written Provider Agreement and credentialing by a CHC-MCO during the 180 day continuity of care period?	See responses to Q. 88 and Q. 91.
	RFP Section	Question	Answer
93	Draft Requirements page 22, Network Provider	Is a service coordination entity considered a Healthcare Provider, necessitating a written Provider Agreement and credentialing by a CHC-MCO after the 180 day continuity of care period?	After the continuity of care period, service coordination is an administrative function of the plan.
	RFP Section	Question	Answer
94	Draft Requirements page 23, Non-participating Provider	Does the 180 day continuity of care period extend to LTSS providers who elect to not participate in the CHC-MCO's Network?	No, this requirement is for any willing provider.
	RFP Section	Question	Answer
95	Draft Requirements page 24, Out-of-Network Provider	Does the 180 day continuity of care period extend to LTSS providers who have not been credentialed by and do not have a signed Provider Agreement with the CHC-MCO?	During the continuity of care period, the OLTL credentialing is valid but a provider agreement may still be necessary for the MCO and any willing provider.
	RFP Section	Question	Answer
96	Draft Requirements page 49, Continuity of Care, 2. Waiver Participants	Is service coordination considered a service during the 180 day continuity of care period or until a comprehensive needs assessment has been completed and a PCSP has been developed and implemented, whichever date is later?	Yes, the continuity of care period extends to whichever date is later.
	RFP Section	Question	Answer
97	Draft Requirements page 49, Continuity of Care, 2. Waiver Participants	Does the Department require encounter data for service coordination during the 180 day continuity of care period or until a comprehensive needs assessment has been completed and a PCSP has been developed and implemented, whichever date is later?	Yes, we do need encounter data for Service Coordination during the COC period.
	RFP Section	Question	Answer

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98	Draft Requirements page 49, D. Choice of Provider	Are service coordinators considered "Providers within the CHC-MCO Network"?	See responses to Q. 88.
	RFP Section	Question	Answer
99	Draft Requirements page 49, D. Choice of Provider: -	Are service coordinators considered "Providers within the CHC-MCO Network" after the continuity of care period?	See responses to Q. 93.
	RFP Section	Question	Answer
100	Draft Requirements page 49, D. Choice of Provider	Please clarify the Department's expectations for service coordinators who are subcontractors of the MCO regarding "The CHC-MCO may not attempt to steer participants to Affiliates who are Providers or interfere with the participants' choice of Network Providers".	Since service coordination is an administrative function of the MCO, this provision does not apply.
	RFP Section	Question	Answer
101	Draft Requirements page 49, D. Choice of Provider	Please clarify the Department's expectations for service coordinators who are employees of the MCO regarding "The CHC-MCO may not attempt to steer participants to Affiliates who are Providers or interfere with the participants' choice of Network Providers".	See response to Q. 100.
	RFP Section	Question	Answer
102	Draft Requirements page 56, J. Service Coordination	Does the 180 day continuity of care period extend to Service Coordinators who do not meet the CHC-MCO qualifications?	Yes, the OLTL credentialing during the COC period applies.
	RFP Section	Question	Answer
103	Draft Requirements page 56, K. Service Coordinator and Service Coordinator Supervisor requirements	Please clarify the stated requirements in bullet #2 regarding "within their first year of this Agreement".	Refer to the revised Appendix A, Draft agreement Section V.K provided with Addendum 5 in regards to revised service coordinator supervisor standards.
	RFP Section	Question	Answer

104	Draft Requirements page 57, L Nursing Home Transition	Please describe "appropriately qualified staff".	This is for the Offeror to define in its proposal.
	RFP Section	Question	Answer
105	Draft Requirements page 66, New Participant Orientation, bullet #14	Please clarify what is meant by "Service Coordination Unit and how to contact it directly, if necessary".	The Department is requiring that selected Offerors address this element as part of its new Participant orientation policies and procedures or its written plan or program. Offerors will have to define how it will orient new Participants to the Service Coordination Unit.
	RFP Section	Question	Answer
106	Draft Requirements page 67, Provider Directory	Does the department expect that the CHC-MCO will list Service Coordinators in the Provider Directory?	The provider directory must include all providers in the network. Since service coordination is an administrative function of the Plan after the COC period, this is not a requirement.
	RFP Section	Question	Answer
107	Draft Requirements page 74. T. Provider Dispute Resolution Process	Are Service Coordinators included in the CHC-MCO Provider Dispute Resolution Process?	Since service coordination is an administrative function of the Plan after the COC period, this is not a requirement.
	RFP Section	Question	Answer
108	Draft Requirements page 74, T. Provider Dispute Resolution Process	Will Service Coordinators have Provider Agreements?	Since service coordination is an administrative function of the Plan after the COC period, this is not a requirement. Also see response to Q. 91.
	RFP Section	Question	Answer
109	Draft Requirements page 76, V. Executive Management –	Should the final sentence read "These full time positions must be solely dedicated to the Pennsylvania's Community HealthChoices programs"?	This requirement has been modified in Appendix A Draft Agreement in Addendum 5 to the RFP. The position that may be shared is the Chief Financial Officer.

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	RFP Section	Question	Answer
110	Draft Requirements page 82, X. Administration, 2. Contracts and Subcontracts, d.	Are Service Coordinators who are not employees of the CHC-MCO subject to the provisions contained in Exhibit V, Required Contract terms for Administrative Subcontractors?	Yes.
	RFP Section	Question	Answer
111	Draft Requirements page 94, Z. Selection and Assignment of Service Coordinators, bullet #1	Regarding choice of Service Coordinator, will the Department issue access and adequacy requirements for the administrative function of service coordination?	The Department may establish adequacy requirements for these administrative functions; however, Offerors should propose their own service levels for administrative functions.
	RFP Section	Question	Answer
112	Draft Requirements page 95, Z. Selection and Assignment of Service Coordinators, bullet #5	What "Network" is referenced here regarding Service Coordination termination?	Network in this case means MCO.
	RFP Section	Question	Answer
113	II-5. Work Statement Questionnaire - Management Information Systems, Question No. 18	Please provide clarification/specificity regarding the "outcome measures" DHS expects offerors to communicate with Network and Out-of-Network providers as stated in Question 18 of the MIS section of the Work Statement Questionnaire.	An outcome measure is data about health states, i.e., states occurring within the body of a patient. This data could be by Participant or aggregate.
	RFP Section	Question	Answer
114	Agreement, page 37 and Exhibit M	The RFP identifies that the CHC-MCO is responsible for the BH services included in the 1915(c) waiver and also includes Exhibit M "Coordination with BH-MCOs". Will DHS provide specific guidance to ensure consistency in how this is managed? Is the state requiring all behavioral health services start with the CHC-MCO and then get referred on to a BH-MCO?	Yes, DHS will provide specific guidance to ensure consistency in how this is managed to selected Offerors. Behavioral health services will be managed by the Behavioral Health MCOs.

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	RFP Section	Question	Answer
115	Agreement, page 96 and Exhibits W, DD	Please confirm the requirement for a "needs screening" has been removed as a responsibility of the CHC-MCO. "Needs screening" is mentioned in Exhibits W, DD and on page 96 (Provider Education).	The needs screening is not a requirement. However, plans may use needs screening as appropriate to evaluate a Participant's health state.
	RFP Section	Question	Answer
116	Agreement, page 353	For participants whose family member(s) are currently receiving payment to provide Personal Assistance Services, will the name and contact information of the family member(s) be provided to the CHC-MCO?	Yes.
	RFP Section	Question	Answer
117		If a participant has both Medicaid and Medicare coverage (duals) and they select a CHC-MCO, will Medicare be the primary insurance and CHC-MCO be their Medicaid coverage? Could a participant carry three separate insurers?	Yes. Yes, but Medicaid is payer of last resort.
	RFP Section	Question	Answer
118	Agreement – Exhibit GG, MIPAA Agreement Requirements	Is DHS requiring the CHC-MCO to have a MIPAA contract to encourage Medicare-Medicaid enrollees in LTSS to obtain their Medicare benefits from a companion D-SNP?	No, DHS is requiring selected Offerors to have a companion D-SNP to provide Dual Eligible Participants with a coordinated experience if they choose to enroll in both the CHC-MCO and its companion D-SNP.
	RFP Section	Question	Answer
119	Question No. 15 of the Provider Network Composition and Network Management section of the Work Statement Questionnaire	Please provide clarification/greater specificity regarding the meaning of the phrase "related or affiliated with your MCO" in Question No. 15 of the Provider Network Composition and Network Management section of the Work Statement Questionnaire. Is "affiliated" intended to mean contracted as a par provider? Does "related or affiliated" have another intended meaning, such as a business partner, owner, etc.?	See Section II Definition of the Appendix A, Draft Agreement. Affiliation can be any affiliation, including but not limited to, par providers, business partner, or owners.
	RFP Section	Question	Answer

120	Page 36	"The CHC-MCO is permitted and encouraged to offer LTSS to Participants who are not yet NFCE. These services will not be reimbursed by the Dept." Are there any requirements surrounding this?	These services are provided at the discretion of the Plans.
	RFP Section	Question	Answer
121	Page 41	"The CHC-MCO must provide all NFCE Participants with non-medical transportation". Are there any requirements surrounding this?	Please reference Appendix A, Draft Agreement, Exhibit EE for the definition of non-medical transportation and also service definition that will be made available in the 1915c waiver application to be published in May, 2016.
	RFP Section	Question	Answer
122	Page 43	"Although not responsible for FMS, the CHC-MCO must establish relationships and cooperate with all of the Commonwealth-procured FMS entitles in order that necessary FMS services can be provided to Participants." The State will contract with FMS? How many and who? Will there be any type of agreement between the FMS and the CHC-MCO?	Please note that the Department has modified Section V.A. 17 of the Draft Agreement to more accurately reflect the CHC-MCOs' responsibilities for FMS. Yes, the Department will have agreements with FMS entities. Details on this procurement will be provided to CHC-MCOs at a later date. FEAs and CHC-MCOs will have to establish an agreement supporting payment arrangements.
	RFP Section	Question	Answer
123	Page 49	Service Coordination…"Continuity of Care Period includes Service Coordination Entities that runs from the Participant's effective date of Enrollment for 180 days or until a comprehensive needs assessment has been completed and a PCSP has been developed and implemented, whichever date is later". Should the 'or' be an 'and'? Is it 180 days AND a comprehensive needs assessment and PCSP? If 'or', and the Comprehensive Needs Assessment indicates the Participant does not need the amount/scope/duration of services the Participant is receiving, can the CHC-MCO begin to reduce services, or must the CHC-MCO continue current level of services for at least 180 days?	In response to the first two questions, the statement is correct as written with the word 'or'. The CHC-MCO must work with the service coordination agency covering the service plan during the COC period to determine service level needs.
	RFP Section	Question	Answer

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124	Page 50	"The CHC-MCO" must provide Participants with choice of Providers within its Network, including Service Coordinators." Does 'Service Coordinators' refer to Service Coordinator Entities, or actual Service Coordinators with the CHC-MCO? Typically Service Coordinators are assigned based on location to member, specialty, and caseload; however, the member can request a new Service Coordinator at any time.	After the COC period, it relates to the actual service coordinators. The Participant must have the opportunity to change service coordinators.
	RFP Section	Question	Answer
125	Page 51	"For Participants with existing PCSPs in place at the time of Enrollment, the Comprehensive Needs Assessment must be completed within 180 days of their effective date of Enrollment, except that Participants who are due for a level of care redetermination prior to the 180th day following this date must have a comprehensive needs assessment completed within five (5) business days of the level of care redetermination." If the Service Coordination Entity is coordinating care for 180 days after Enrollment, are they responsible for members that need a level of care redetermination prior to 180 days? Does the Service Coordination Entity complete the level of care redetermination and the comprehensive needs assessment?	Minimally, the MCO is responsible for collecting the data for level of care redetermination from the date of enrollment. The MCO would also be responsible to do the comprehensive needs assessment during the 180 days period.
	RFP Section	Question	Answer
126	Page 52	"The Department will designate a tool to be used for comprehensive needs assessments and reassessments." When will the CHC-MCOs receive the tool?	Refer to the response to Q.2.
	RFP Section	Question	Answer
127	Page 59	"A Participant has the right to change his or her CHC-MCO plans at any time." For continuity of care, would the Department consider a 45 day change window after enrollment with a CHC-MCO, and then an annual change period?	No, Participants may change CHC-MCO plans at any time.
	RFP Section	Question	Answer
128	Page 64	"The CHC-MCO must report to the appropriate CAO using the CAO notification form any changes in the status of families or individual Participants…" Where may the CAO Notification Form and CAO contacting information, be found?	The Department will provide the information to the selected Offerors.
	RFP Section	Question	Answer

129	Page 69	"The CHC-MCO may not request disenrollment of a Participant for any reason." Would the Department consider disenrollment requests for things such as: 1) The member and/or family is putting themselves and others at risk; 2) The member can no longer be safely cared for at home and refuses to transition to a Nursing Facility; 3) Member exceeds Cost Neutrality for HCBS and refuses to transition to a Nursing Facility; 4) Member only wants to be in the Participant-Direction program, but is not able to be his/her own Employer of Record, and has no one to serve as a Representative, and refuses formal contract providers for LTSS; 5) Member refuses to pay Patient Liability	No, the program will not allow disenrollment of a Participant by a CHC-MCO for any reason.
	RFP Section	Question	Answer
130	Page 94	"The CHC-MCO must offer the Participant a choice of Service Coordinators from amongst those employed by or under contract with the CHC-MCO." If the Service Coordinator is the one responsible for conducting the Comprehensive Needs Assessment visit, how is it that the member receives a choice in selecting their Service Coordinator? Wouldn't a Service Coordinator have to be assigned prior to the visit with the member?	Participants must have the opportunity to change service coordinators at any time. A service coordinator will have to be assigned, however, before the initial visit.
	RFP Section	Question	Answer
131	Overall Agreement	There are several references to documents that will be supplied on the CHC-MCO Intranet. When will CHC-MCOs get access to the CHC-MCO Intranet?	Access will be provided to selected Offerors.
	RFP Section	Question	Answer
132	Page 125	Reporting Requirements Section - Will there be specific reporting templates the CHC-MCO must use? If so, where will they be located, and when we the CHC-MCOs receive the templates?	The Department may provide templates as well as file layouts for reporting requirements. They will be located on the intranet and we will provide access to selected Offerors.
	RFP Section	Question	Answer
133	Exhibit K(3)	Critical Incident Reporting and Management - What is the timeframe for reporting Critical Incidents? What are the appropriate agencies (with their contact information) that must receive the report? Is there a specific Critical Incident reporting form that needs to be utilized?	Critical incidents are required to be reported within 48 hours. All incidents need to be reported to OLTL, the Service Coordinator, law enforcement, fire department and any

			other authorities as needed. Allegations of abuse, neglect and exploitation need to be reported to APS or OAPSA (for Participants 60 and over). The MCO will be required to comply with all of the requirements of the bulletin on Critical Incident Management issued on 4/16/15 – Number 05-15-02,51-15-02,54-15-02,55-15-02,59-15-02 located at: http://www.dhs.pa.gov/cs/groups/webcontent/documents/bulletin_admin/c_171054.pdf
	RFP Section	Question	Answer
134	Exhibit P	CHC-MCO Participant Coverage - Rule: G-5 - States the BH-MCO and FFS are both responsible for the residential/treatment costs. Who is responsible for the residential/treatment costs in this instance?	If the Participant is in a CHC-MCO, the BH-MCO is responsible for the cost of residential treatment. If the person is in FFS, FFS is responsible.
	RFP Section	Question	Answer
135	Exhibit P	CHC-MCO Participant Coverage - Are there other Rules that may be missing? For Example: F-2, F-5, F-6, G-1, G-2, G-3?	Rules were removed that do not apply to Participants served by CHC.
	RFP Section	Question	Answer
136	Exhibit Q	Data Support for CHC-MCOs - "The Department will make available to each CHC-MCO access to the Department's CIS database. This database provides eligibility history, demographic information, and TPL information to support the CHC-MCO in meeting their obligations." There is no mention of LTSS members having a Patient Liability amount for which they would be responsible. Will LTSS members, either receiving HCBS or NF services, be responsible for paying Patient Liability?	The CHC-MCOs and their network nursing facilities will be responsible for collecting patient pay amounts for Nursing Facility Services. If any Participant has a patient pay amount for HCBS, the CHC-MCO will be responsible for collecting it.
	RFP Section	Question	Answer

137	Exhibit T	"The CHC-MCO must notify the Participant when the CHC-MCO fails to decide a first level Complaint or first level Grievance within the time frames specified in this agreement, using the required template." What is the specific template that needs to be used?	All reporting templates will be available on the CHC-MCO intranet site. Templates will be made available to selected offerors.
	RFP Section	Question	Answer
138	Exhibit T	"The CHC-MCO must notify the Participant when it denies payment after a service has been delivered because the CHC-MCO determined that the service was not Medically Necessary, using the required template." What is the specific template that needs to be used?	All reporting templates will be available on the CHC-MCO intranet site. Templates will be made available to selected offerors.
	RFP Section	Question	Answer
139	Exhibit T	"The CHC-MCO must send a written notice to the first level Complaint decision, using the required template, to the Participant." What is the specific template that needs to be used?	All reporting templates will be available on the CHC-MCO intranet site. Templates will be made available to selected offerors.
	RFP Section	Question	Answer
140	Exhibit EE(2)	Covered Services - LTSS - Will the Department provide specific HCPCS (including Modifiers, if applicable) or Revenue Codes to the CHC-MCOs?	All HCPCS and relevant revenue codes will be provided to the selected Offerors for encounter submission.
	RFP Section	Question	Answer
141	Exhibit EE(2)	Covered Services - LTSS - Will the Department provide current Provider Information (contact information, services provided, service area, etc.) to the CHC-MCOs early on so the CHC-MCOs can start developing the network?	Yes, the information will be provided to selected Offerors during the readiness review process.
	RFP Section	Question	Answer
142	Exhibit EE(2)	Covered Services - LTSS - Employment Skills Development - "Employment Skills Development includes transportation as an integral component of the service, for example, transportation to a volunteer of training activity. Add limitations…" What are the limitations referenced here?	Refer to the revised Appendix A, Draft Agreement provided with Addendum 5 to the RFP.
	RFP Section	Question	Answer
143	Overall Agreement	What specific Service Coordination forms will the Department require the CHC-MCOs to use? When will the CHC-MCOs have access to all of the prescriptive forms?	Information on forms, and the forms themselves, will be made available during the readiness review process.

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	RFP Section	Question	Answer
144	I. General Information, Eligible Population, Page 4	It appears that there may be incorrect values in the Mercer Community HealthChoices Historical Data Summaries dated February 18, 2016 with values truncated or incorrect in Dually Eligible Individuals Residing in a Nursing Facility, Nursing Facilities LOC and Dually Eligible Individuals Enrolled in a HCBS Waiver, Personal Assistance LOC. The amounts that currently in the report do not produce the report's totals.	Refer to the response to Q.65.
	RFP Section	Question	Answer
145	I. General Information, Eligible Population, Page 4	The membership in the Mercer Community HealthChoices Historical Data Summaries dated February 18, 2016 differs from what is on this Page. This appears to be due to the CHC Population data is based upon unduplicated annual counts versus member month in the Mercer tables. Please confirm if that is the case (one report is an annual count versus other member months) or if there are populations considered for MLTSS which are not included in the Mercer document. Please provide average monthly membership estimates for the initial contract period.	See response to Q. 70. The RFP contains counts of CHC eligible individuals, whereas the Mercer data summary contains a count of the member months associated with the eligible individuals. The Mercer document contains all populations eligible for CHC. Regarding the last question, DHS does not plan to provide additional data at this time.
	RFP Section	Question	Answer
146	I. General Information, Type of Agreement/Rates, Page 5	This section references that historical data information has been provided including service utilization information; however, the Mercer Community HealthChoices Historical Data Summaries dated February 18, 2016 are only PMPM's. Please provide for the following by level of care and by population grouping for each of the two historical year periods: • Unduplicated recipient counts • Unit costs. Also, please provide what types of units are used within the datebook for the different categories of service? (days, episodes, procedures etc.) • Utilization • Program changes and other adjustments (including supplemental payments, completion factors and TPL adjustments) • Count of claims adjudicated	Regarding the requests for unduplicated recipient counts, unit costs, utilization, and count of claims adjudicated, DHS does not plan to provide additional data at this time. Program change and other rate adjustment information will be shared with selected offerors during the rate negotiation process.
	RFP Section	Question	Answer

147	I. General Information, Type of Agreement/Rates, Page 5	The relevant RFP text reads, in part: "The historical data summary provides a detailed summary of the enrolled population including demographic information, service utilization information, and geographic information. This information can be found on the Department's website at the following link…" We are unable to find the utilization data that is referred to on this Page – can the Department provide via a direct reference link or addendum?	We are considering claims data (on the Mercer document and LIFE report) to be "utilization." We apologize for any confusion.
	RFP Section	Question	Answer
148	I. General Information, Type of Agreement/Rates, Page 5	The Mercer Community HealthChoices Historical Data Summaries dated February 18, 2016 narrative is clear to point out that it does not include program changes and other necessary adjustments, and that the population groupings will differ from CHC rating group structure and that, therefore, no direct comparison can be made between the summaries and the capitation rates. ASOP 41 Actuarial Communications requires that another actuary be able to reproduce the results of a project with the information provided in the report. Specifically it says "In the actuarial report, the actuary should state the actuarial findings, and identify the methods, procedures, assumptions, and data used by the actuary with sufficient clarity that another actuary qualified in the same practice area could make an objective appraisal of the reasonableness of the actuary's work as presented in the actuarial report." ASOP 49 requires adherence to ASOP 41. In compliance with these ASOPs, please provide the additional information needed to crosswalk between the data, the assumptions and the final rates including the spreadsheets showing the calculations.	The Mercer Historical Data Summaries were developed to provide Offerors with information on historical costs for the CHC eligible population. Information on adjustments used to develop capitation rates will be shared with selected offerors during the rate negotiation process.
	RFP Section	Question	Answer
149	I. General Information, Type of Agreement/Rates, Page 5	Please confirm that the rates for each of the individual capitation rate cells are being certified as actuarially sound.	Rate cells will be certified as actuarially sound.
	RFP Section	Question	Answer
150	I. General Information, Type of Agreement/Rates, Page 5	Rates are to be based upon a negotiation within actuarially sound rate ranges. Will Mercer be providing their rate ranges by rate cell? If so, when?	Capitation rates by rate cell will be shared with selected Offerors during the rate negotiation process.
	RFP Section	Question	Answer

151	I. General Information, Type of Agreement/Rates, Page 5	What is the process for rate negotiation?	The Department will meet with each selected Offeror for questions regarding the agreement and rates.
	RFP Section	Question	Answer
152	I. General Information, Type of Agreement/Rates, Page 5	Please list the assumptions (in addition to managed care efficiency assumptions) that are varied to develop the range of actuarially sound rates. For example, is the administrative assumption different at the high versus low end of the rate range as well as by population cohort?	Capitation rate development information will be shared with selected Offerors during the rate negotiation process.
	RFP Section	Question	Answer
153	I. General Information, Type of Agreement/Rates, Page 5	Is there a required Medical Loss Ratio?	This is to be determined during negotiations.
	RFP Section	Question	Answer
154	I. General Information, Type of Agreement/Rates, Page 5	"The Department will pay…using a schedule of PMPM capitation rates and may make other types of payments, as provided by the Agreement." What is meant by "other types of payments"?	The Department may provide for additional payments to selected Offerors in its agreement such as those payments described in Appendix A, Draft Agreement, Appendix 4.
	RFP Section	Question	Answer
155	I. General Information, Type of Agreement/Rates, Page 5	Has the Department considered using a typical CDPS or other risk adjuster for the Acute portion of the capitation payment? Has the Department considered a risk adjuster for LTC like New York uses (i.e. UAS scores)? Will the Department consider either of these risk score methodologies? Longer term, does the Department feel that risk adjustment is appropriate for this population?	DHS will consider risk adjustment after the initial year of CHC implementation. Specifics around the model that will be utilized and how it relates to this population will be considered at that time.
	RFP Section	Question	Answer
156	I. General Information, Type of Agreement/Rates, Page 5	Please provide a description of what is intended by each of the following: • Risk corridor • High-cost risk pool • Pay for performance incentive How will these items be funded? How are they defined? How will plans be paid from these funds?	Additional information on each of these will be shared at a later time.
	RFP Section	Question	Answer

157	II-5 Participant Service Coordination and Care Management, Page 21, Question 1	How many individuals are currently self-directing in each of the waivers, by Self Directed model and by CHC geographic zone?	Additional historical data will be provided to Selected Offerors.
	RFP Section	Question	Answer
158	II-5 Participant Service Coordination and Care Management, Page 21, Question 1	It appears that the state will continue to contract with FMS providers for individuals self-directing through CHC. Will the state be responsible for remitting payment to the FMS for the administrative services and will the CHC-MCO be responsible for remitting payment to cover payments to workers/agencies for self-directed services?	See response to Q. 22 and Q. 122. The MCOs will be responsible for all payments to the FEAs.
	RFP Section	Question	Answer
159	II-5 Participant Service Coordination and Care Management, Page 21, Question 5	Could you please confirm that "cognitive impairment" in this context refers to dementia and traumatic brain injury and not other types of cognitive impairment? If not, please specify the other types of impairments?	This refers to all types of cognitive impairment.
	RFP Section	Question	Answer
160	II-5. Participant Service Coordination and Care Management Service Integration, Page 24, Question 7	Please confirm that the D-SNP model of care is excluded from the 15-Page limit.	Yes, it is excluded from the 15-page limit and should be provided as an appendix.
	RFP Section	Question	Answer
161	II-5. Service Integration, Page 245, Question 7	Please confirm that Department requests a description of the MLTSS model of care (MOC) with an explanation of the alignment with the attached D-SNP MOC, not an actual MLTSS MOC. If an MLTSS MOC is required, please confirm that it is excluded from the 15-page limit.	An actual MLTSS Model of Care is required and may be submitted as an appendix outside of the 15-page limit.
	RFP Section	Question	Answer
162	Part III B, Pages 38-39	Are there instances in which an arrangement between a small diverse business (SDB) and a subcontractor, affiliate, or parent organization of the Offeror, whereby the services or products offered by the SDB are directly related to the products and or services required by the Community HealthChoices Program, count toward the Offeror's total SDB commitments? If so, can the Department	Please understand in order to receive credit toward an Offeror's SDB commitment, the SDB scope of work must be directly related to the agreement's specific scope of work.

		provide more details and/ or examples of these instances?	
	RFP Section	Question	Answer
163	Exhibit A, Appendix A, Draft Agreement, Page 160	When does the Department plan to release Agreement Exhibit A, Managed Long Term Services and Supports Regulatory Compliance Guidelines?	Refer to the revised Appendix A, Draft Agreement provided with Addendum 5 to the RFP.
	RFP Section	Question	Answer
164	Section VII. Financial Requirements, Item E.3.b, Appendix A, Draft Agreement, Page 118	Please confirm this wording is accurate: "Services were rendered under the terms of the Provider A."	"A" should be "Agreement"
	RFP Section	Question	Answer
165	Exhibit K(1) Quality Management and Utilization Management Requirements, Item A, Appendix A, Draft Agreement, Page 202	Can the Department confirm that the "written program description, work plan, evaluation and policies/procedures that meet requirements outlined in the agreement" are expected from the CHC-MCO after award?	Yes, they are expected after agreement award.
	RFP Section	Question	Answer
166	Appendix A, Draft Agreement	Appendix A refers multiple times to a CHC Intranet site, and documents, such as "QM and UM reporting requirements" (Item 7, Page 106), and payment denial letters (Item 18, Page U-4/270) being housed on this site. Will the Department be making the CHC Intranet site available for bidders to view these requirements and documents, or can the Department provide the requirements and documents referenced in Appendix A to bidders via the procurement website?	Information on and access to the intranet site will be made available to selected Offerors.
	RFP Section	Question	Answer
167	Exhibit EE(2) Covered Services, subsection Financial Management	Please describe how the Department reimburses F/EAs for Participant- directed services and if there are any special payment arrangements the Department has that MCO's need to consider.	See response to Q. 22, Q. 23 and Q. 122. The Fiscal/Employer Agent (F/EA) currently submits claims through the PROMISe™ system for Participant directed services. In

	Services, Appendix A, Draft Agreement, Pages 345-346		CHC, costs for participant directed services will be included in the capitation rate paid to CHC MCOs.
	RFP Section	Question	Answer
168		Could DHS please clarify what is meant by "subscribers" of the CHC-MCO?	Subscriber refers to Participant.
	RFP Section	Question	Answer
169	Tab 6 Work Statement and Work Statement Questionnaire, Service Integration, Question 4	How will NFCE consumers be determined, and by whom? Please clarify as this information affects how Offerors address aspects of this program where coordination is required.	Level of Care will be determined by a conflict free entity. Individuals newly presenting will be referred to the IEE who will arrange for a Level of Care determination. For annual redeterminations, MCOs will collect Level of Care information and forward documentation to the conflict free entity for the final determination.
	RFP Section	Question	Answer
170	Tab 6 Work Statement and Work Statement Questionnaire, QI & PM, Questions 2 & 11	Could DHS clarify the timing of the availability of prior year Medicaid data for care planning purposes? The ramp up time to address super-utilizers could be significantly shortened with access to this data.	Prior Medicaid data will be supplied to the selected CHC-MCOs prior to the implementation for each zone once necessary agreements including business associate agreements are fully executed.
	RFP Section	Question	Answer
172	Draft Agreement - Section IV: Applicable Laws & Regulations, 1. National Accreditation	Could DHS please clarify what its NCQA expectations are for a plan which already has accreditation for other products in Pennsylvania?	As noted in Section IV of the Draft Agreement, the CHC-MCO must be accredited by NCQA or by a national accreditation body and obtain accreditation within the accreditation body's specified timelines. The requirement applies to the CHC-MCO specifically.
	RFP Section	Question	Answer

173		Can MCOs use a subcontractor for non-medical transportation instead of MATP?	Yes, for non-medical transportation only. MATP cannot be used for non-medical transportation.
	RFP Section	Question	Answer
174		In the PS & CC section, question 24: Can you define what transitioning between service delivery systems references?	Transitioning plan for Fee for Service to managed care.
	RFP Section	Question	Answer
175		Under the service integration section of the RFP, please confirm that the model of care submission does not count against the 15 page limit in that section.	See response to Q. 160 and Q. 161..
	RFP Section	Question	Answer
176		Please confirm the following executive management positions can be shared between Community Health Choices and HealthChoices: Administrator, CFO, Medical Director, Pharmacy Director, CHC Program Manager, Director of QM and VM, and the IS Coordinator.	Only the CFO may be shared between the programs. See revised Section V.V. of Appendix A, Draft Agreement attached to Addendum 5 to the RFP.
	RFP Section	Question	Answer
177		Confirm whether the assessment tool(s) for level of care and for the comprehensive assessment are the same or different tools.	The level of care assessment and comprehensive needs assessment are two separate tools. The level of care assessment is being developed utilizing a subset of questions of the comprehensive needs assessment.
	RFP Section	Question	Answer
178		The total population provided on page 4 of the RFP in the chart is 420,614 for Fiscal Year 15 (if you sum all categories together). However, the Mercer file "Community HealthChoices Data Summaries" (dated 2/18/16) has very different enrollment counts. The Mercer file has Member Months of 3,807,533 for FY13 and 3,896,486 for FY14. (If you sum all population categories). This translates to average membership of 317,294 for FY13 and 324,707 for FY14 (if you divide by 12 months). Please explain why the population counts provided in the RFP are so much higher than the ones provided by Mercer. What was the average	Please refer to question 70.

		enrollment for the CHC program in FY15?	
	RFP Section	Question	Answer
179	Page 41 of 365 of Appendix A	Transportation: Please describe the current reimbursement process for transportation providers. For example: do the transportation providers invoice the Department directly, is there an intermediary who coordinates the payment, etc. If there is an intermediary please include scope and cost information.	Providers currently submit claims through the PROMISe™ system for non-medical transportation. For OLTL programs, Non-Medical Transportation is considered a vendor service and is reimbursed per one-way trip/per item. A vendor service means that the Department will pay a provider for the allowable cost of a vendor good or service when rendered to an enrolled waiver participant. A vendor good or service is an item that is not on the Medical Assistance (MA) fee schedule and is purchased by a Department-approved provider and rendered to an enrolled waiver participant. The payment may not exceed the amount for similar vendor goods or services charged to the general public. Non-Medical Transportation will count toward encounter acceptance targets for CHC MCOs.
	RFP Section	Question	Answer
180	Page 7 of 18 of "Community HealthChoices Data Summaries" (dated 2/18/16)	Please comment whether the "Nursing Facility" line includes participant liability (spend down). The Nursing Facility line appears to be low when compared to a monthly cost calculated with the average Nursing Facility per diem rates. Please comment whether any "HCBS Waiver Services" include Participant liability (spend down) in the expense shown.	Refer to the responses to Q.14 and Q.39.
	RFP Section	Question	
181		Why in the definition of Actuarial Soundness different that of ASOP #49?	The Actuarial Soundness definition has been updated to align with the definition in ASOP #49. See revised Section II of Appendix A, Draft Agreement attached to Addendum 5 to the RFP.

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	RFP Section	Question	
182		Does the state plan to fully reflect the impact of the ACA Health Insurer Fee in its capitation rates.	See Appendix 3a for a description of DHS's treatment of the ACA Health Insurer Fee. Consideration for this fee will be built into the capitation rates for CHC-MCOs who are subject to the fee. The amount included in the capitation rates will be an estimate and then the Department will perform a reconciliation for each CHC-MCO, once the actual fee amount has been provided to the CHC-MCO by the federal government.
	RFP Section	Question	
183		Will any additional FFS experience information be provided prior to the required submission date? We are specifically interested in understanding historical utilization and cost by population, zone, category of service, etc.	DHS does not plan to provide additional data at this time.
	RFP Section	Question	
184		Please describe what is meant by "efficiently and effectively operated Medicaid Managed Care program" as formed in multiple places in the Actuarial Sound Rate definition.	Refer to the response to Q.181 and revised definition of Actuarially Sound Rates .
	RFP Section	Question	
185		The RFP states that the Department may enter into additional agreements with qualified CHC-MCO's in the future. Can the Department please clarify this? Will the Department be allowed to contract with additional qualified CHC-MCO's outside of the RFP Process?	Any additional agreements will originate from a competitive procurement process.
	RFP Section	Question	
186		What are the expectations of the Commonwealth for CHC-MCO's to develop the LTSS direct Service Workforce?	The Department's expectation is that the CHC-MCOs develop and maintain a broad provider network to ensure access and choice of services.
	RFP Section	Question	

187		Please confirm that I-SNP should be included alongside D-SNP.	We are requiring D-SNP. An I-SNP is not required.
	RFP Section	Question	
188		Per DOL Ruling, will we be funded in capitation to pay O.T to Home Care Workers who work over 40 hours (i.e. a cod that covers their cost).	The DOL ruling requirements related to overtime and minimum wage requirements for home care workers are being considered during the rate development process. More information will be shared with selected offerors during rate negotiations.
	RFP Section	Question	
189		Is there a specific credentialing firm that the Commonwealth requires MCOs to use for HCBS provider enrollment. If not, will you need to approve our standard provider enrollment app?	No, the Commonwealth credentials all OLTL providers. The Commonwealth will work with the CHC-MCOs on all credentialing related materials.
	RFP Section	Question	
190		Is service coordination an administrative function or a medical expense?	See response to Q 87.
	RFP Section	Question	
191		Is it the intention of the Department to conduct a full readiness review for the SW Zone and a basic readiness review for the additional zones during the July-Nov 2016 timeframe?	A readiness review will be performed on all selected offerors for each zone and the time frame for the review will be determined once selections are made.
	RFP Section	Question	
192		Please expand on question 13—"Describe how you will help coordinate the administration of FMS for participants." This appears to be a service coordination function, rather than Provider Network oriented. Please address how this pertains to provider networks.	See responses to Q. 22, Q. 23 and Q. 122. The MCO will be responsible for coordination of payment for all FMS services to the FEA.
	RFP Section	Question	
193		Does the Commonwealth expect the bidding MCO's to leverage Electronic Visit Verification technology?	CHC-MCOs may utilize this tool but it is not a requirement.
	RFP Section	Question	

194		Is the SDB committing to staying verified under the correct guidelines? Ex. Under 100 employees for the duration of the contract?	DGS verified Small Diverse Businesses (SDBs) must be current, providing a valid certificate at the time of the submittal. SDBs must adhere to an annual recertification/verification process with BDISBO.
	RFP Section	Question	
195		In the Service Integration and Case Management Section, Question 5—"Describe how your plan will coordinate with each participant's Medicare Part D coverage, MCOs will be able to do so with covered entities in the state's programs. But will not have access to Part D claims Data for individuals who enroll in Medicare Advantage plans not under contract with the state, or for individuals in Medicare FFS. Has the state considered facilitating access to Medicare Part D claims data through a partnership with CMS to enable this form of coordination by its contracted CHC MCO's?	Medicare pharmacy data can be attained through the CMS data partner State Data Resource Center (SDRC). Information about SDRC can be found here: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/State-Data-Resource-Center.html
	RFP Section	Question	Answer
196	Appendix A Draft Agreement; § V-A(14), Page 41	Transportation: Please describe the current reimbursement process for transportation providers. For example: do the transportation providers invoice the Department directly, is there an intermediary who coordinates the payment, etc. If there is an intermediary please include scope and cost information. Please describe the current process of translating Transportation services into encounters. Will these services count toward encounter acceptance targets for CHC-MCOs?	See response to Q. 179.
	RFP Section	Question	Answer
197	Appendix A Draft Agreement; § V-A(17) Participant Self-Direct Services, Page 43	Participant Self-Directed Services: Based on the RFP and supporting information on the Commonwealth of Pennsylvania website it appears that in Services My Way Participants can choose a rate to pay their providers which leads to different payment rates by provider. How is this currently administered to allow for payment rates to providers that vary from one Participant to another?	Services My Way is treated no differently than Employer Authority. It is the FEAs' responsibility to ensure that wages and benefits do not exceed the established rate.
	RFP Section	Question	Answer
198	Appendix A Draft Agreement; § V-A(17) Participant Self-Direct Services,	Participant Self-Directed Services: Please describe how personal assistance workers currently notify FMS or the Department of hours worked. How are hours verified for payment? Are there any restrictions that apply to CHC-MCOs regarding the verification process of personal assistance worker hours? If there	Personal Assistance workers use paper time sheets or the FEA portal. It is the service coordinators' responsibility to verify hours worked and services delivered. The

	Page 43	are restrictions, please describe.	Department is not putting any restrictions on CHC-MCOs utilizing or developing a verification process.
	RFP Section	Question	Answer
199	Appendix A Draft Agreement, Exhibit D, Standard Terms and Conditions, Section 18-a(3), Termination for Cause	It appears that the sentence "The Department will set forth in the grounds for the termination in the notice and will...." is incomplete. Please provide the missing language.	This entire section will be revised to: The Commonwealth may terminate the Agreement for default under Paragraph 16, Default or other cause as specified in the Agreement or by law, by providing written notice of default to the CHC-MCO. Except as provided in Section X.A.2 of the Agreement, the Commonwealth will provide forty-five (45) days written notice setting forth the grounds for termination and provide the CHC-MCO with forty five (45) or such longer time as approved by the Commonwealth in which to implement a corrective action plan and cure the deficiency. If corrective action is not implemented to the satisfaction of the Commonwealth within the approved cure period, the termination shall be effective at the expiration of the approved cure period. If it is later determined that the Commonwealth erred in terminating the Agreement for cause, then, at the Commonwealth's discretion, the Agreement shall be deemed to have been terminated for convenience under the Subparagraph 18.a.
	RFP Section	Question	Answer
200	Appendix A Draft Agreement, Exhibit EE(1), 1-2	At the pre-proposal conference on March 16, 2016, Service Coordination was cited as an administrative expense. If that is the case, does that mean expenses paid for Service Coordination does not count towards Medical Loss Ratio (MLR) calculations? Also, if Service Coordination is performed by a Small Diverse Business (SDB), can	The Department may negotiate a Medical Loss Ratio during negotiations.

		those dollars be allocated towards the SDB percentage? We would like to understand these same questions for other defined benefits that are not traditional medical, for example, but not limited to: Career Assessment, Employment Skills Development, Home Adaptions, Job Coaching, Job Finding, Non-Medical Transportation, Pest Eradication, etc.	
	RFP Section	Question	Answer
201	Appendix A Draft Agreement, Exhibit EE(2) Covered Services, Long Term Services and Supports Definitions, 5	Please specify the limitations that were intended to be added, if any.	Additional limitations are in the revised Exhibit EE to the Draft Agreement (Appendix A) attached to Addendum 5. In the event that a conflict arises between the draft Agreement and the content of the CHC 1915b/c waivers approved by the Centers for Medicare & Medicaid Services, the 1915b/c waivers shall take precedence.
	RFP Section	Question	Answer
202	Appendix A Draft Agreement, Exhibit EE(2) Covered Services, Long Term Services and Supports Definitions, 8	Please confirm that the last word in the sentence should instead be “employer.”	Yes.
	RFP Section	Question	Answer
203	Appendix A Draft Agreement, Exhibit J Medical Assistance Transportation Program, L-1	Can MATP be used to transport a CHC member to services at a provider that participates with Medicare only?	No. See response to Q. 46.
	RFP Section	Question	Answer

204	Appendix A Draft Agreement, Standard VIII, K(1)-21	Is there an online database that can be used to verify the current Provider Agreement and an active PROMISe™ Provider ID issued by the Department?	There is not currently an online database that can be used to verify the current Provider Agreement and an active PROMISe™ Provider ID. In CHC, providers will be enrolled in the Medical Assistance (MA) program and assigned specialties based on the services requested. OLTL will provide CHC MCOs a list of approved providers.
	RFP Section	Question	Answer
205	Appendix A Draft Agreement, SECTION IV: APPLICABLE LAWS AND REGULATIONS, A Certification, Licensing and Accreditation, 31	When will the bidders receive the "streamlined credentialing process"?	This information will be provided during the Readiness Review process.
	RFP Section	Question	Answer
206	Appendix A Draft Agreement, SECTION V: PROGRAM REQUIREMENTS, A Covered Services 14 Transportation, 41-42	Is MATP the required provider of non-medical transportation to CHC covered services for NFCE participants or can the plan contract with other transportation providers for non-medical transportation?	No. MATP cannot be used for non-medical transportation. MATP is used expressly for medical transportation. Yes, the plan can contract with MA enrolled transportation providers for non-medical transportation.
	RFP Section	Question	Answer
207	Appendix A Draft Agreement, SECTION V: PROGRAM REQUIREMENTS, A Covered Services J Service Coordination, 56	Is Service Coordination an administrative function or a medical expense?	See response to Q. 87 and Q. 88.
	RFP Section	Question	Answer

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208	Eligible Population, Page 4	Please confirm whether the Community Well Duals population numbers include dual eligible Participants with Serious Mental Illness and/or dual eligible Participants with Intellectual/Developmental Disabilities? If it does not, please provide the diagnostic categories and/or other pertinent population descriptions for this eligibility category.	1. We did not use diagnosis codes to determine which CHC Population Group for an individual. 2. At a high level, to be considered part of the NFI Dual CHC Population Group: a. The recipient had to be in a specific list of MA categories provided by the Program Office. b. The recipient had to have Medicare A, B, C, D. c. The recipient could not be in a NCFE Facility or Waiver. d. The recipient could not be in a list of specific Excluded Facility Codes provided by the Program Office. 3. An individual could not be both a NFCE Dual/Non-Dual and a NFI Dual. Those CHC Population Groups were mutually exclusive.
	RFP Section	Question	Answer
209	Appendix A Draft Agreement, SECTION V: PROGRAM REQUIREMENTS, A. Covered Services X. Administration 5 Management Information Systems, 88-90	The section mentions that the credentialing requirements will be provided by the Department and listed in Exhibit K(1). When will the Department provide the additional credentialing requirements outside of Exhibit K(1)?	This will occur following the award of agreements during the readiness review process.
	RFP Section	Question	Answer

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210	Appendix A Draft Agreement, SECTION V: PROGRAM REQUIREMENTS, A. Covered Services Z. Selection and Assignment of Service Coordinators, 94	Would the Department consider a choice between two different employees of the CHC-MCO as meeting the requirement?	Participants must have choice of service coordinators. It is up to the CHC-MCO to provide that choice of qualified individuals.
	RFP Section	Question	Answer
211	Appendix A Draft Agreement, SECTION VII: FINANCIAL REQUIREMENTS, Table Of Contents, 5	Health Insurance Premium Payment Program is missing from the draft agreement but is listed in the Table of Contents. Please provide agreement language.	This reference was removed. Refer to Appendix A, Draft Agreement provided with Addendum 5.
	RFP Section	Question	Answer
212	Appendix A Draft Agreement, SECTION VIII: REPORTING REQUIREMENTS, E.3., 118	Please confirm that the last word was meant to be “Agreement.”	Yes. Refer to Appendix A, Draft Agreement provided with Addendum 5.
	RFP Section	Question	Answer
213	Appendix D Offeror's Managed Care and MLTSS Experience	Appendix D asks for managed care and MLTSS Experience since January 2012. At the top of page 3, however, it asks for contract duration dates for 2010-2011, 2011-2012, 2012-2013, and 2013-2014. Please confirm that these dates should be 2012-2013, 2013-2014, 2014-2015, and 2015-2016.	Refer to the revised Appendix D provided with Addendum 3.
	RFP Section	Question	Answer

214	Work Statement Questionnaire, PARTICIPANT SERVICE COORDINATION AND CARE MANAGEMENT, Page 22	Please provide additional clarification on distinguishing between initial authorizations and reauthorizations. Are you specifically looking for information regarding reduction or suspension of services?	The response to that question should address but not be limited to reduction in services.
	RFP Section	Question	Answer
215	Draft Agreement	"The Department will designate a tool to be used for comprehensive needs assessments and reassessments. The CHC-MCO is permitted to gather additional information not included in the designated tool to supplement but not supplant the Department-designated tool." We are asking the Commonwealth to clarify if the interRAI tool will be the designated tool for comprehensive needs assessment. This will facilitate CHC-MCO systems planning and decisions as to which additional questions may be included by the CHC-MCO in the assessment to inform the service planning process.	See response to Q. 2.
	RFP Section	Question	Answer
216	Requirement in November Draft Agreement that appears to have been removed from the March Agreement	The following requirement is not contained in the March Agreement. Does this indicate that the needs screening tool and 30 day requirement is no longer a requirement? The November RFP Draft agreement contained the following: Section E:Needs Screening page 40 Upon Enrollment, the CHC-MCO will conduct a needs screening using a tool approved by the Department to identify any unmet needs, healthcare needs requiring chronic condition or disease management, service gaps, or need for Service Coordination. Any Participant whose needs screening reflects unmet needs, service gaps, or a need for Service Coordination will be referred for a comprehensive needs assessment. The needs screening must be completed within the first 30 days of Enrollment, and may be conducted by phone, electronically, by mail, or in person.	The needs screening is an option, not a requirement, for the CHC-MCOs.
	RFP Section	Question	Answer
217	Agreement Section V Program Requirement, G. Person-Centered	The Care Management Plan has now been added as a one of 2 components of the holistic PCSP. The second component is the LTSS Service Plan. Is the state's preference to have both Plans combined onto one form or can the Plans be completed on two separate forms which are then combined into a holistic PCSP?	The Offerors may propose their approach.

	Service Plans (PCSP)		
	RFP Section	Question	Answer
218	Agreement, C. Continuity of Care	The statement, **whichever date is later**, seems to conflict with the statement, **or until**, in subsection 2. Waiver Participants. If the new comprehensive needs assessment and PCSP is completed prior to 180 days and indicates an increase or shifting of service hours from one benefit to another, i.e. meal no longer needed because participant will now attend a day program; does this statement indicate that a change cannot occur until the end of 180 days as that will always be the later date? Current language: 2. Waiver Participant- For a Participant who is receiving LTSS on the CHC-MCO Start Date through an HCBS Waiver program on his or her Effective Date of Enrollment, the CHC-MCO must provide a continuity of care period for continuation of services provided under all existing HCBS Waiver service plans through all existing service Providers, including Service Coordination Entities that runs from the Participant's effective date of Enrollment for 180 days **or until** a comprehensive needs assessment has been completed and a PCSP has been developed and implemented, **whichever date is later.**	See response to Q. 123.
	RFP Section	Question	Answer
219	Section V.K. - Service Coordinator & Service Coordinator Supervisor Requirements, page 57	The requirement in the first bullet states "Service Coordinators hired prior to the CHC zone Start Date must have the qualifications and standards proposed by the CHC-MCOs and approved by the Department." Are MCOs allowed to propose currently contracted AAA/CIL service coordinators to be "grandfathered" in to provide services?	Offerors should propose service coordinator standards and qualifications that they believe are appropriate to meet the requirements of the RFP.
	RFP Section	Question	Answer
220	Management Information Systems, Pages 28-29	Are the subcontractors referenced in questions 5 and 12 of the Management Information Systems (MIS) section only those organizations that share data with the CHC-MCOs?	No, it is meant for any organization responsible for data associated with CHC.
	RFP Section	Question	Answer

221		Does the PA Community HealthChoices Program require the CHC-MCO to deduct Patient Liability (Monthly SSI amount minus monthly personal allowance) from Nursing Facility claims prior to reimbursing Nursing Facilities? If so, is the patient liability provided via the Daily and/or Monthly 834?	Yes, and the Department will share the patient pay liability information with the CHC-MCOs.
	RFP Section	Question	Answer
222	Section V.R. - Participant Complaint, Grievance & DHS Fair Hearing Process, B. Complain Requirements, paragraph h., Page 272	In order to ensure maximum access, flexibility and convenience for participants, can the Department confirm that web/conference calls are permissible?	First level complaint review may be conducted in web and telephone conference sessions only at the option of the CHC-MCO Participants.
	RFP Section	Question	Answer
223	Work Statement Questionnaire, II-5. Provider Network Composition and Network Management	Question 13 states: "Describe how you will help coordinate the administration of Financial Management Services for Participants." Can the Department clarify the Financial Management Services Benefit described in the CHC Contract, specifically those services provided by the FMS Vendors contracted by the Commonwealth	See responses to Q. 22, Q. 23 and Q. 123. It is the responsibility of the CHC-MCOs to provide for all FMS services and all payments to FEAs.
	RFP Section	Question	Answer
224	Part II-4. Tab 5 - Personnel, D. Subcontracts, page 19	The Subcontracts sections asks Offerors to "Provide a description of each subcontractor that will be employed in lieu of staff to help staff and implement the obligations under the Agreement, excluding subcontracts with providers that are providing direct care services to Participants." Is DHS primarily looking for the subcontractors supporting major functional areas of the RFP? (E.g., In-Plan Services; Coordination of Care; Participant Services; Complaint, Incident Management, Grievance and Fair Hearings; Pharmacy; Provider Network; Provider Services; Service Access; Quality Management/Utilization Management (QM/UM); Claims Payment and Processing; and Encounter Data Reporting.)	No, all subcontractors with subcontracts as defined in Section II of the Draft Agreement must be provided.
	RFP Section	Question	Answer

225	Part II-5. Tab 6 - Work Statement and Work Statement Questionnaire: Provider Network Composition and Network Management, Question #3, page 31	Are dental providers considered specialists for the purposes of network composition time and distance requirements?	They will be generally viewed as a specialist in this program.
	RFP Section	Question	Answer
226	Appendix A - Draft Agreement, Appendix 3b Explanation of Capitation Payments, page 148	When will the Department provide a data book for all covered services along with the capitation rate development narrative/rationale for the First Year Base Capitation Rates?	DHS does not plan to provide additional data at this time.
	RFP Section	Question	Answer
227	Appendix A - Draft Agreement, Appendix 3b Explanation of Capitation Payments, page 148	Will the Department provide the CMS-approved actuarially sound capitation rate ranges or only a single capitation rate for each rate cell?	Refer to the response to Q.150.
	RFP Section	Question	Answer
228	Appendix A - Draft Agreement, Appendix 3c Risk Corridor, page 149	When will the Department release the mechanics and formulas for reimbursement/payment under the Risk Corridor arrangement?	Refer to the response to Q.38.
	RFP Section	Question	Answer

229	Addendum 2 CHC Historical Data Summary, "COMMUNITY HEALTHCHOICES HISTORICAL DATA SUMMARIES February 18, 2016" (Mercer Letter) Pages 7 through 18	Several of the cells in the pdf tables are unreadable. Can the Department please correct these cells and, if possible, provide the tables in Excel format? The columns in questions are for (1) Dually Eligible Individuals Residing in a Nursing Facility Ages 60+, (2) Dually Eligible Individuals Enrolled in a HCBS Waiver Ages 21-59 and (3) Dually Eligible Individuals Enrolled in a HCBS Waiver Ages 60+.	Refer to the response to Q.65.
	RFP Section	Question	Answer
230	Part II-5. Tab 6 - Work Statement and Work Statement Questionnaire: Quality Improvement and Performance Measures, Question #11 page 25	NCQA retired the Comprehensive Diabetes Care LDL Control <100 and modified the Cholesterol Management for patients with Cardiovascular Disease Conditions: LDL-C Controlled <100 due to systematic changes in clinical practice guidelines. The data is not available for the most recent year of HEDIS CY14. Should the Offeror submit HEDIS CY 2011, HEDIS CY 2012, HEDIS CY 2013 for this measure?	If HEDIS data is available for HEDIS CY 2011, HEDIS CY 2012, HEDIS CY 2013, it should be submitted even if it is inactive data.
	RFP Section	Question	Answer
231	Community HealthChoices RFP 12-15, Appendix A - Draft Agreement, Exhibit K(1), Standard IV. C , page K(1)-18	Missing word. "The CHC-MCO must have mechanisms and processes for aggregate trending of changes to s, and reporting aggregate data to the department." Please define "s".	This is “services”.
	RFP Section	Question	Answer
232	Part II-5. Tab 6 Work Statement and Work Statement Questionnaire: Pharmacy, Question #1, page 26	Will Medicare pharmacy data be provided to the Offeror for dual eligible participants?	See response to Q. 195.
	RFP Section	Question	Answer

233	Part II-5. Tab 6 Work Statement and Work Statement Questionnaire: Service Integration, Question #8, page 24	Will there be an indicator on the enrollment file for participants who are eligible for Veteran's health services?	The enrollment files do not contain an indicator for a person who is a veteran. Additionally, veterans placed in VA homes are not eligible for CHC.
	RFP Section	Question	Answer
234	Appendix A - Draft Agreement, Executive Management and Other Administrative Components, page 75-79 and Appendix F	Are the titles listed in the Draft Agreement for the same positions as those listed in Appendix F? Which titles should the Offeror use in the response? Draft Agreement: (1)"Information Systems Coordinator," (2)"Quality Management/ Quality Improvement Coordinator," and (3)"Director, Network Management." Appendix F: (1)"Chief Information Officer," (2)"Performance/Quality Improvement Coordinator," and (3) "Network Management Coordinator," respectively.	Please use (1)"Information Systems Coordinator," (2)"Quality Management/ Quality Improvement Coordinator," and (3)"Director, Network Management." Please be sure to differentiate between executive management and principal administrative positions.
	RFP Section	Question	Answer
235	Appendix A - Draft Agreement, Exhibit K(1) - Standard II.E and Standard II.F, pages K(1)-14	Is the “Senior Medical Director” noted in Exhibit K(1) Standard II-E. is the same as the “Medical Director” noted in Exhibit K(1), Standard II-F. ? If so, which title should the Offeror use in the response?	Senior Medical Director and Medical Director are the same person.
	RFP Section	Question	Answer
236	Appendix A - Draft Agreement, Section V.E Comprehensive Needs Assessments and Reassessments, page 50-52	In addition to the standardized state-determined tool for determining the Nursing Facility Clinically Eligible population, will there be a state-determined and mandated tool for comprehensive assessment and reassessments designed for needs identification and service planning? The CHC-MCOs will only have the ability to administer its own trigger assessments, if certain member needs warrant deeper assessment.	Yes, the Department is identifying both and the tool is being developed and will be provided in mid-summer of 2016.
	RFP Section	Question	Answer
237	Part I-4. Problem Statement, page 1	Will DHS apply for a CMS waiver to combine the existing Medicaid Home and Community Based Services waivers into a single waiver with one set of covered services for Community HealthChoices?	The question is not relevant to submitting a proposal to this RFP.
	RFP Section	Question	Answer

238	Appendix A - Draft Agreement, Section V.E Comprehensive Needs Assessments and Reassessments, page 50-52	Please confirm the State or its Agent will be responsible for the initial level of care (LOC) determination and the CHC-MCO will be responsible for the re-evaluation of LOC annually. Confirm that CHC-MCOs will conduct comprehensive assessments and reassessments. Confirm whether the assessment tool(s) for LOC and for the comprehensive assessment are the same or different tools.	The conflict free entity will complete the initial LOC determination. The CHC-MCO will collect the LOC redetermination data and will provide LOC data to the conflict free entity.
	RFP Section	Question	Answer
239	Section IV.A page 31 Applicable Laws and Regulations	Will the Department provide the Offeror with the credentialing requirements for the Community HealthChoices program?	Yes, we will provide the information to the selected Offeror during the readiness review process.
	RFP Section	Question	Answer
240	Part II-1. Tab 2 - Zone(s) of Operation	Will the Offeror have the flexibility to modify their zone selection(s) stated in the response at a future time prior to contract execution?	No.
	RFP Section	Question	Answer
241	Part II-5. Tab 6 - Work Statement and Work Statement Questionnaire: Provider Network Composition and Network Management	Will the Department share with the Offeror a list of dentists that are currently providing dental services in the Medical Assistance Fee For Service program to the current Medicaid MLTSS population?	A list of dentists currently providing services in the MA Fee-for-Service program will be provided to Selected Offerors.
	RFP Section	Question	Answer
242	Work Statement Questionnaire, II-5. Quality Improvement and Performance Measures, Question 11, Page 25	Question 11 in the Quality Improvement section provides three distinct scenarios - 1) Offerors currently participating in the HealthChoices Program, 2) Offerors who operate as a Commercial Pennsylvania HMO, and 3) Offerors who do not participate in the HealthChoices Program and who do not operate as a Commercial HMO in Pennsylvania must provide the three most recent years of HEDIS® performance measures for one Commercial HMO line of business they operate in another state. Since Community HealthChoices is not a commercial program and the Department is seeking CHC-MCOs experienced in MLTSS, please confirm that Offerors may submit the three most recent years of Medicaid HEDIS rates for the eight measures identified in the question.	The Department is not clear as to what information is to be confirmed. The Department is seeking HEDIS information in all three scenarios. If an Offeror participates in the HealthChoices program, it should submit HealthChoices HEDIS information. If an Offeor is not participating in HealthChoices but operates a commercial line of business in Pennsylvania, it should submit HEDIS information for that commercial line of business. If the Offeror does not participate in HealthChoices or

			operate a commercial HMO in Pennsylvania, it should submit HEDIS rates for a commercial line of business as defined in the RFP. As provided in response to Q.286, alternately, it may provide Medicaid HEDIS information for another state.
	RFP Section	Question	Answer
243	Draft Agreement Section V. C.2	During the 180 days of continuity when a CHC MCO is required to utilize the SCEs, are the SCEs considered delegates? If yes, will DHS require the standard delegation approval and oversight process? We recommend bypassing this process unless the CHC MCO intends to contract with them after the 180 days of continuity	Service coordinators are considered to be service providers during the COC period. The remaining questions are not relevant to the completion of the proposal.
	RFP Section	Question	Answer
244	RFP Service Integration Q7	Can Offeror submit pending Model of Care or does the Offeror have to submit the most recent approved Model of Care for their DSNP product? Our most recent approved MOC is dated 2014 and pending MOC will be most relevant to the CHC population at contract start date in 2017.	The 2014 model of care may be submitted as part of the proposal. In the absence of an existing, approved, model of care, the draft may also be submitted.
	RFP Section	Question	Answer
245	Draft Agreement Section V. A. 19. Settings for LTSS	The section states "NFCE Participants who are residing in Personal care Homes or Domicillary Care Homes as of the Start date will be permitted to remain in those settings while in CHC." Will those Participants be eligible to receive LTSS services in that setting?	Yes. The Participant will be able to receive LTSS services if the Participant is residing in a PCH or Dom Care Home at the start of CHC. The Domiciliary Care Homes portion of this requirement was deleted from Appendix A Draft Agreement.
	RFP Section	Question	Answer
246	Draft Agreement Section V. A. 19. Settings for LTSS	If a NFCE Participant resides in a Licensed Assisted Living Facility, is the CHC MCO responsible to provide LTSS services to that Participant?	CHC-MCO is responsible to provide all LTSS services on a participant's PCSP.
	RFP Section	Question	Answer

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247	Draft Agreement Exhibit Q	Will the enrollment file detail if the Participant is Nursing Facility Ineligible (NFI) or Nursing Facility Clinically Eligible (NFCE). IF NFCE, will the enrollment file detail if the Participant receives HBCS or resides in a Nursing facility? If HCBS, will the enrollment file detail if the Participant is participating in person directed services or Services My Way?	There will be codes and information on the enrollment file that will indicate if a participant is NFI, NFCE, receiving HCBS or in a nursing facility. The enrollment file will not indicate if a person is in person directed services or Services My Way.
	RFP Section	Question	Answer
248	Draft Agreement Exhibit EE(1)	Home Health services are included as Physical Health Services and as a LTSS benefit. It is duplicative. Should this benefit fall under LTSS or physical health service?	The benefit applies to both services.
	RFP Section	Question	Answer
249	Draft Agreement Section V.E. Comprehensive Needs Assessments and Reassessments	Please clarify if bullets 2, 3 & 5 are referencing NFCE or NFI populations. Is bullet 2 referring to NFCE population, specifically those without LTSS services who have a new immediate need? Bullet 1 & 4 are clear.	For bullets 2, 3 and 5, the individuals identified in the requirement are described without reference to their NFCE or NFI status.
	RFP Section	Question	Answer
250	Draft Agreement Section V.H. Care Management and Care Plans	The section states "The CHC-MCO must provide care management to all Participants." Please confirm that the intent is that care management services must be **available** to **all** Participants.	Yes. Refer to Appendix A, Draft Agreement provided with Addendum 5.
	RFP Section	Question	Answer
251	Draft Agreement Section V.H. Care Management and Care Plans	The section states "The CHC-MCO must assign to every Participant with a PCSP or care plan a Service Coordinator to implement and coordinate the services called for in the PCSP or care plan. If a member is NFI but has a care plan to address a chronic condition or unmet needs, can the CHC-MCO assign the Participant a Care Coordinator instead of a Service Coordinator?	Yes. Service Coordinators are primarily to coordinate LTSS.
	RFP Section	Question	Answer

252	Draft Agreement Section V.Z. Selection and Assignment of Service Coordinators	The timeframes regarding selection of a service coordinator do not agree with the timeframes set forth in Section V.E. Section V.E. states that a comprehensive needs assessment must be completed by a Service Coordinator no later than 5 days from Enrollment for certain participants while Section V.Z. states that the CHC-MCO must make contact with the Participant within 7 days of the comprehensive needs assessment to provide information on options for selecting a Service Coordinator. Please clarify	The Draft Agreement has been modified to clarify that the CHC-MCO completes the comprehensive needs assessment within the time frames provision in V.Z of the Draft Agreement. The Service Coordinator must make contact with a Participant within 7 days of completion of the CNA.
	RFP Section	Question	Answer
253	Draft Exhibit EE(1)	Is a physician order required for non-medical LTSS Benefits?	Physician certification is required to establish NFCE; however, some LTSS services do require an additional physician order such as, but not limited to, home health services and DME.
	RFP Section	Question	Answer
254	Draft Agreement Exhibit EE(2)	Please clarify if FMS should be a covered or administrative service? It is listed as a covered service.	See responses to Q. 22, Q. 23 and Q. 123. While FMS is an administrative service, the CHC-MCOs will still have a billing and payment relationship with the FEAs.
	RFP Section	Question	Answer
255	Draft Agreement Exhibit Q	Will the 834 file provide Special Need indicator codes?	The 834 file does not provide a special need indicator code.
	RFP Section	Question	Answer
256	Draft Agreement Exhibit EE(2)	Financial Management Services. DHS stated that it will continue to directly contract with PPL for FMS. What is the responsibility of the CHC-MCO as it relates to FMS? Will the CHC-MCO only need to notify DHS of Participants who choose to exercise employer and/or budget authority?	See response to Q. 254. While FMS is an administrative service, the CHC-MCOs will still have a billing and payment relationship with the FEAs.
	RFP Section	Question	Answer
257	Draft Agreement 5A.19 Settings for LTSS	Will participants already in personal care or assisted living facilities be permitted to receive LTSS services from the CHC MCO?	Yes. All service settings must meet the requirements of the Federal HCBS regulations. Assisted living NFCE participants in need of LTSS may receive their services from the CHS-MCOs in an assisted living facility. Residential habilitation services are

			permitted to be provided in a Personal Care Home.
	RFP Section	Question	Answer
258	Draft Agreement BB Provider network	Will DHS be providing any guidance on provider payment rates?	Refer to the response to Q.17.
	RFP Section	Question	Answer
259	Draft Agreement 7C	When will DHS provide more detail on the development of capitation rates, reinsurance and risk corridor programs?	This information will be provided to selected offerors.
	RFP Section	Question	Answer
260	Draft Agreement Section V. A. 19. Settings for LTSS	Can an NFCE Participant transition to a Personal Care Home and remain enrolled in CHC?	Residential habilitation is an allowable service in a Personal Care Home. Otherwise, please refer to Draft Agreement Section V.A.19 Settings for LTSS for clarification regarding allowable service settings.
	RFP Section	Question	Answer
261	Draft Agreement Section V. AA.2. Provider Education	Does the MCO need to include participants, advocates and family members in designing the initial training and work plan prior to go-live?	Yes, the CHC-MCO must include participants, advocates and family members in designing the initial training and work plan prior to go-live.
	RFP Section	Question	Answer
262	Draft Agreement Exhibit EE(2) & Draft Agreement SECTION V: PROGRAM REQUIREMENTS A.Covered Services (19)	Please clarify if the CHC MCO be allowed to provide LTSS services to a CHC participant already in a Personal Care home or assisted living facility upon commencement of the program?	See response to Q. 257.
	RFP Section	Question	Answer

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263	Draft Agreement Exhibit EE(2)	Please confirm that only in-home respite is covered.	Refer to Appendix A, Draft Agreement, Exhibit EE(2), provided with Addendum 5, for the definition of Respite and its settings.
	RFP Section	Question	Answer
264	Draft Agreement Exhibit K(1).Standard 1, M.	How many days retroactive must the CHC-MCO accept a review?	The Department is unable to determine which standard is being referenced. For Standard I, M, no standard timeframe exists.
	RFP Section	Question	Answer
265	RFP Eligible Population section	The Community Well Duals population over 60 years of age in the Southeast zone is substantially higher than the group of people under 60 when compared to the numbers in other zones. Please confirm the numbers are correct.	Confirmed, the information is correct.
	RFP Section	Question	Answer
266	RFP M. Coordination of Services and Exhibit M	Obtaining consent can be a timely and administrative burden for the CHC-MCO, and also delays our ability to coordinate care. Would DHS consider streamlining the process for more efficient and effective data sharing? DHS could ask for universal consent at the time of enrollment, avoiding the need for time consuming and costly work by the plans on a case by case basis.	This question is not relevant to the submitting a proposal to the RFP.
	RFP Section	Question	Answer
267	Draft Agreement exhibit Q	Will the participant record provided by the department contain information about which DSNP the participant is enrolled in?	No, but other efforts will be made to share that information with the CHC-MCOs.
	RFP Section	Question	Answer
268	RFP II-5 Tab 6 - Work Statement and Work Statement Questionnaire	In Q15 of the Network section, please define "major service category".	Medical/surgical, pediatric/ neonatal, obstetric, psychiatric, LTSS and total.
	RFP Section	Question	Answer
269	Draft Agreement, Section V.BB.2 and Exhibit DD CHC-MCO Provider Agreements	What will the Department accept an LOA for purposes of the response to the RFP? I.e., Will an LOA stating that the parties will execute a final agreement with all required terms on or before January 1, 2017 suffice or will the LOA be required to include all of the mandated terms?	For proposal submission only, the Department will accept LOAs. The LOA should be dated prior to January 2017 and must include all mandated terms.

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	RFP Section	Question	Answer
270	Draft Agreement, Section V.BB.2 and Exhibit DD CHC-MCO Provider Agreements	Will the other Pennsylvania agency requirements (PID and PDOH) also apply to the provider and subcontract agreements? E.g., will the PID and PDOH requirements re provider agreements and IDS' agreements apply to LTSS-only agreements? If so, are we going to be required to have the PID and PDOH review and approve any templates limited to LTSS?	Yes, all applicable managed care law and regulations must be followed.
	RFP Section	Question	Answer
271	Draft Agreement, Section V.BB.2 and Exhibit DD CHC-MCO Provider Agreements	Will the Department of Human Services (the "Department") be providing templates with the required terms?	No, the Department will not be providing templates. It is up to the individual plans to decide the format subject to review and approval by the Department.
	RFP Section	Question	Answer
272	Draft Agreement, Section V.BB.2 and Exhibit DD CHC-MCO Provider Agreements	Are we allowed to amend existing Medicaid contracts to include LTSS?	Yes.
	RFP Section	Question	Answer
273	Draft Agreement, Section V.14. Program Requirements, Transportation	Will the MCOs be able to use a subcontractor for the non medical transportation instead of MATP since it's a requirement per the draft agreement?	Yes.
	RFP Section	Question	Answer

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274	RFP-II-5 Quality Improvement and Performance Measures Question 11	Bullet point 5 requests HEDIS rates for Breast Cancer Screening (Ages 42-69 years). The current age range for HEDIS is (Ages 50-74) Please clarify that the department is requesting the age range of 50-74.	Yes, that is the information the Department is requesting.
	RFP Section	Question	Answer
275	RFP -General Question	Will the Department provide a complete list of LTSS and other providers that the participants are currently using under the FFS system?	A list of participant providers will be provided to selected Offerors.
	RFP Section	Question	Answer
276	Appendix A Draft Agreement, Section IV: Applicable Laws and Regulations	Is there a specific application and/or standard credentialing form that the State will require MCOs to use for HCBS provider enrollment? If not, will the State need to approve our standard provider enrollment application?	The Department will provide guidance on credentialing during the readiness review process. All providers including HCBS providers need to be enrolled in the MA Program so all MCOs need to go through the a credentialing process approved by the Department.
	RFP Section	Question	Answer
277		Please confirm that I-SNP should be included alongside D-SNP.	We are requiring D-SNP. An I-SNP is not a requirement of the RFP.
	RFP Section	Question	Answer
278		We will have to contract with home care workers and other HCBS providers in order to manage this product. In the recent federal case Home Care Association of America, et al. v. David Weil, Administrator Wage & Hour Division, the U.S.Court of Appeals unanimously declared that the U.S. Department of Labor's proposed regulations guaranteeing overtime and minimum wage protection for certain classes of home health care workers are applicable to employees of third party agencies who provide companionship service and live-in care within a home. It is United's position that it will not employ any type of home care workers in the delivery of this product (rather they will be independent contractors like other care providers they contract with). Medicaid agencies in other states, however, have told managed care plans that have taken that same position that although you do not view them as your employees, you must still pay them overtime (for hours worked in excess of 40 hours per week). In some states, the agency	Direct care workers in the participant directed model of service delivery are employees of the participant and as such will continue to be covered by the Department of Labor's most recent ruling on overtime and minimum wage requirements. Billing modifiers will be used by the providers to cover overtime expenses and are part of the list of billing codes which will be given to plans selected. The cost of overtime will be figured into rates to be paid to workers. In addition, the agency provider type for PAS

		provided the managed care organizations and providers with a billing code/modifier to be used by providers to bill the overtime and have also built the overtime costs into the rates paid to the plans by the agencies. What is DHS's expectation of the plans on this topic and what if any written guidance will DHS be providing plans and providers alike? Will DHS be providing plans with money in their rates to cover the cost of the overtime if the plans are expected to pay overtime?	is a Home Care Agency. Department of Health has confirmed that direct care workers must be employees of home care agencies, they cannot be contractors. This information can be found in 28 Pa. Code §611.5.
	RFP Section	Question	Answer
279	V, A, 3, Page 35	Appendix A states, "The CHC-MCO must establish a program exception process, reviewed and approved by the Department, whereby a Provider or Participant may request coverage for items or services that are included in the Participant's benefit package but are not currently listed on the MA Program Fee Schedule. The CHC-MCO must also apply the program exception process to requests to exceed limits for items or services that are on the Fee Schedule if the limits are not based in statute or regulation. These requests are recognized by the Department as a Program Exception as described in 55 Pa. Code §1150.63." Please clarify whether those services included in the Participant's benefit package, but not listed on the MA Program Fee Schedule, are included in the CHC-MCO capitation rate?	To the extent program exceptions were approved and granted during the historical experience period, they will be considered during the capitation rate development process.
	RFP Section	Question	Answer
280	Exhibit B	Will premium withholds be part of the P4P MCO Incentives? Will the associated performance metrics be operations-based, HEDIS measures? Or both?	The P4P incentives have not been established and the metrics requirements are not established at this time.
	RFP Section	Question	Answer
281	Part 1 – I,5	Please confirm that risk adjustment will be based on an individual's health status/diagnosis/functional ability – similar to Medicare HCC Score?	Refer to the response to Q.155.
	RFP Section	Question	Answer
282	V, 0, 20, Page 69	How long will MCOs be liable for Service Coordination for members who involuntarily disenroll?	Involuntary disenrollment from CHC isn't an option of the program.
	RFP Section	Question	Answer

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283	2,f, Page 124	Incomplete sentence: f. Should the Department lose recovery rights to any Claim due to late or untimely filing of a Claim with the liable third party, and the untimeliness in filing that specific Claim is directly related to untimely submission of Encounter Data or additional records under special request, or inappropriate denial of Claims for accidents or emergency care in casualty related situations, *the Department may **(missing verb)** the amount of the unrecoverable Claim against the CHC-MCO.* Please provide the missing language.	The sentence should indicate "the Department may withhold the amount of the unrecoverable Claim from the CHC-MCO.
	RFP Section	Question	Answer
284	8. Outpatient Drug Pharmacy Services, Page 89	Please clarify whether the MA plan is to provide wrap coverage of Part D drugs or is coverage for full duals only for CMS excluded drugs or Part B cost-share?	The CHC-MCO must provide coverage of Part D excluded prescriptions and OTC medications and must cost share with Part B for full dual eligible MA beneficiaries.
	RFP Section	Question	Answer
285	A. V. O. 19 Participant Advisory Committee, Page 68	The agreement states*: "The CHC-MCO must include Participants who are representative of the population being served as well as family caregivers as members of the PAC….The PAC membership must be composed of at least 60% of Participants, with 25% of the total membership receiving LTSS."* Does the 60% include both Participants and family caregivers?	The 60% includes Participants only.
	RFP Section	Question	Answer
286	Part II, Question #11, Page 26	Regarding the sentence: *Offerors who do not participate in the HealthChoices Program and who do not operate as a Commercial HMO in Pennsylvania must provide the three most recent years of HEDIS® performance measures for a one Commercial HMO line of business they operate in another state"*: Please confirm that Offerors that do not manage commercial managed care contracts can provide HEDIS data for a Managed Medicaid contract. Medicaid HEDIS data could provide DHS with a more accurate picture of an Offeror's ability to successfully manage complex Medicaid and other public sector healthcare programs and populations.	Confirmed.
	RFP Section	Question	Answer
287	Appendix A, Exhibit J	Appendix A includes an Exhibit G and an Exhibit J – but no Exhibits H and I. Please clarify whether these exhibits are forthcoming.	No. These Exhibits are deleted.

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	RFP Section	Question	Answer
288	Appendix A, Exhibit EE(2)	Regarding the description of Nursing Facility Services and this sentence: *Nursing Facility Services include at least the items and services specified in 42 CFR 438.1(c)(8)(i). Nursing facility services are covered as defined in 55 PA Code 1187.51.* Question: we cannot find 42 CFR 438.1(c)(8)(i) in the Federal regulations. Please confirm that this is the correct citation, and could DHS provide the language of the requirement.	The correct citation is 42 C.F.R. Part 483.
	RFP Section	Question	Answer
289	Appendix A, Exhibit EE(1)	In the table titled "Community HealthChoices LTSS Benefits", the item: "Home Health Services (including" is truncated. Please provide the missing text to clarify this item.	Refer to the Appendix A, Draft Agreement, Exhibit EE(2), provided with Addendum 5, for the home health definition.
	RFP Section	Question	Answer
290	Appendix A, Exhibit EE(2)	Regarding the description of "Financial Management Services" and the sentence: *The initial start-up fee covers the lengthy process of enrolling Participants as a common law employ**ee***. Wouldn't Participants be an employ***er*** of the caregiver – and not an employee of the FMS contractor? We assume DHS means "employer" and not employee – are we correct in our assumption?	Refer to the response to Q.202.
	RFP Section	Question	Answer
291	Appendix A, Exhibit EE(2)	Regarding the description of "Employment Skills Development" and the sentence: "*Employment Skills Development includes transportation as an integral component of the service, for example, transportation to a volunteer or training activity. Add limitations…"* and there is nothing further. Please provide any additional text that is missing.	Refer to the response to Q. 142.
	RFP Section	Question	Answer

292	Appendix A, Exhibit C	There are a number of instances in the RFP (including Appendix A) where reference is made to "... the intranet supporting CHC." Several of these references also refer to documentation that seems to be important for Offerors to review. For example, there is this sentence in Appendix A, Exhibit C: *If the Provider that is being terminated from the Network is not a PCP or a hospital, the CHC-MCO, using the template notice titled C(3) Provider Termination Template for Specialist and FQHC Providers Who Are Not PCPs,* ***found on the intranet*** *supporting CHC ...* Our question: can DHS allow Offerors to access the "intranet supporting CHC" so that Offerors can respond with greater accuracy to RFP requirements? If access by Offerors is not possible, can DHS make documents referenced in the RFP as being on the "CHC intranet" available to Offerors (e.g. by posting on DHS' website)?	Prospective bidders can access the RFP HealthChoices site which is an exact mirror of our internal site via the link below once they are granted access. To request access, each person needing access to the information for each prospective offeror will need to read Management Directive 205.34 Commonwealth of Pennsylvania Information Technology Acceptable Use Policy and print, complete, and sign Enclosure 3 to Management Directive 205.34. The Management Directive may be accessed at http://www.portal.state.pa.us/portal/server.pt/gateway/PTARGS_0_2_785_711_0_43/http%3B/pubcontent.state.pa.us/publishedcontent/publish/global/files/management_directives/management___administrative_support/205_34.pdf The Offeror will need to scan and email the signed documents to Kelly McCarty at kemccarty@pa.gov. Each prospective Offeror should submit the list of names and signed documents in one email. https://www.humanservices.state.pa.us/omap_rfp/
	RFP Section	Question	Answer
293	Exhibit CC, Outpatient Drug (Pharmacy) Services, subsection 1	Several instances throughout this section refer to "covered pharmacies" when in context of the requirements it seems the Department meant to refer to "covered outpatient drugs." Is our interpretation of this correct?	Covered pharmacies and covered outpatient drugs are used interchangeably.
	RFP Section	Question	Answer
294	Exhibit CC, Outpatient Drug (Pharmacy) Services, subsection 4 (f)	The last sentence of subsection (e) seems to be repeated in subsection (f). Is this a duplication or did the State intend to make a further distinction in subsection (f)?	Refer to the revised Appendix A, Draft Agreement provided with Addendum 5.

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	RFP Section	Question	Answer
295	Work Statement Questionnaire, Service Integration, Model of Care (Q. 7), Page 24	Please confirm you are requesting that the CHC-MCO attach the models of care for the CHC model and the D-SNP model of care. If a non-incumbent has not yet filed its Pennsylvania D-SNP application, would it be acceptable to submit our draft D-SNP MOC?	See response to Q. 244. A draft model of care will be submitted.
	RFP Section	Question	Answer
296	Section V: Program Requirements, A. Covered Services, 17. Participant Self-Directed Services, Page 43	Please clarify whether the Support Brokerage function will be assumed by the CHC-MCO Service Coordinator or the FMS vendor.	During the planned rollout of CHC, and beginning in January of 2017, the F/EA at that time, will be responsible to contract with an entity that can provide Support Broker services to participants in the participant directed model of PAS. The F/EA will be responsible to see that this function is completed. Support Broker Services will be defined as services designed to provide assistance as needed with employer-related functions and maintenance in order to support the participant's ability to self-direct their services.
	RFP Section	Question	Answer
297	Section V: Program Requirements, A. Covered Services, 17. Participant Self-Directed Services, Page 43	Please confirm that Participants will have access to both employer authority and individual budget authority options as described in "17. Participant Self-Directed Services" (participant direction of Personal Assistance Services and Respite through one of two models). Exhibit EE(1) describes the use of individual budget authority for participant direction community supports and participant direction goods and services.	Confirmed.
	RFP Section	Question	Answer
298	Section V: Program Requirements, A. Covered Services, 19. Settings for LTSS, Page 44	**If** the CHC-MCO is prohibited from providing LTSS services for NFCE Participants who live in Personal Care Homes or Domiciliary Care Homes, please confirm that the CHC-MCO will not be responsible for monitoring the health and welfare of NFCE Participants who remain in these settings.	Refer to the revised Appendix A Draft Agreement to the RFP published on 3/31/16 clarifying this provision.
	RFP Section	Question	Answer

299	Section V: Program Requirements, C. Continuity of Care, 5. Other Care or Service Plan Transition, Page 50	Please confirm the relationship between the OPTIONS program, ACT 150, and Community HealthChoices. If CHC-MCOs are required to coordinate services for Participants who are enrolled in either of these two programs, please confirm that both of these programs are the first payer. Please also confirm that CHC is the payer of last resort when CHC-MCOs are developing supplemental services for Participants who are otherwise not eligible for LTSS.	Both the Options program and the Act 150 program provide state-funded services. The state funded programs, Options and Act 150, are the primary payors because CHC is the payor of last resort. CHC is also the last payor following the payment of supplemental services.
	RFP Section	Question	Answer
300	Section V: Program Requirements, E. Comprehensive Needs Assessments and Reassessments, Page 52	Please confirm "level of supervision required" is level of supervision required to successfully implement activities of daily living and instrumental activities of daily living.	The definition for the level of supervision required may include, but may not be limited to, successfully implement activities of daily living and instrumental activities of daily living.
	RFP Section	Question	Answer
301	Section V: Program Requirements, E. Comprehensive Needs Assessments and Reassessments, Page 54	Please confirm that some LTSS provided to Participants will be to maintain independence or minimize functional decline, and in such cases, DHS recognizes that the "measurable outcomes to be achieved by the interventions" will not reflect an increase in independence or improved health outcomes.	Confirmed.
	RFP Section	Question	Answer
302	Section V: Program Requirements, J. Service Coordination, Page 56	Please confirm that the Service Coordinator is responsible for conducting an annual comprehensive re-assessment for participants (currently written as a clinical level of care assessment) and the external independent entity is responsible for clinical level of care assessments (now known as clinical eligibility determinations) prior to a Participant being deemed NFCE.	The service coordinator is responsible for conducting an annual reassessment for Participants and will also support data collection for the level of care re-assessments. The conflict free entity will be responsible for determination NFCE.
	RFP Section	Question	Answer
303	Section V, FF, Employment Support, Page 108	Please confirm that CHC-MCOs are required to "provide services that promote or lead to securing or maintaining competitive employment, including but not limited to job coaching and job finding, customized employment, Discovery, benefits counseling, and transportation" for Participants who are only NFCE. Please confirm that the CHC-MCO is only required to collect and publish employment related data for Participants who are NFCE. Please confirm that	The participants for these services must by NFCE. Yes. Yes. Yes.

		CHC-MCOs are required to coordinate OVR-related services for Participants who are NFCI and NFCE.	
	RFP Section	Question	Answer
304	Exhibit J, Medical Assistance Transportation Program	Please confirm that all non-medical (waiver service) transportation needed for services authorized in a Participant's Service Plan is to be provided through state funded Shared Ride transportation (first), MATP (second), and non-traditional supplemental services developed by the CHC-MCO and partners (third).	MATP is not eligible for non-medical transportation. Shared ride would be first and the non-Medical transportation provider would be second for these services.
	RFP Section	Question	Answer
305	Definitions, Page 24	The definition of Penalty Period is found on page 24, and states, "A Period of ineligibility for the payment of LTC services, including LTC Facility and HCBS, due to a transfer of assets for less than fair market value or excess home equity. Penalty Periods apply to LTC and HCBS." How will the CHC MCOs be notified if someone is in the "Penalty Period"? How long will a Participant be in the Penalty Period?	The CHC MCOs will be notified via the daily 834 benefit enrollment and maintenance file when a Participant is placed in a penalty period. The 834 file will include the penalty period start and end dates. The length of the penalty period will vary based on the dollar value of the transfer of assets for less than fair market value or the excess home equity.
	RFP Section	Question	Answer
306	V. A. 9.,Page 39	First paragraph states the MCO may not apply case management protocols when they would interfere with Emergency Services. Do they mean UM instead of CM?	Yes, it is UM.
	RFP Section	Question	Answer
307	Appendix 3f.	Please confirm the 5% withhold will be released/returned once an agreement is signed.	Confirmed, the 5% withhold will be released once an agreement is signed.
	RFP Section	Question	Answer
308	Exhibit A	Please clarify when Exhibit A will be provided to Offerors.	Refer to the revised Appendix A, Draft Agreement provided with Addendum 5.

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	RFP Section	Question	Answer
309	Exhibit K(1), Standard IV. C.	Some words appear to be missing. Would DHS please provide missing text.	Refer to the revised Appendix A, Draft Agreement provided with Addendum 5.
	RFP Section	Question	Answer
310	Exhibit K(4), CAHPS section	C. defines additional required questions to be added to the survey and provides instructions for D1-D5. Instructions for D6. appear to be missing. Could DHS please provide the missing language.	Refer to the revised Appendix A, Draft Agreement provided with Addendum 5.
	RFP Section	Question	Answer
311	Exhibit AA, A. second paragraph	For participants re-gaining eligibility after 6 months, please clarify the following terminology: "payment name and case payment name"?	Payment Name-the person in whose name benefits are issued. The two terms are used interchangeably.
	RFP Section	Question	Answer
312	Exhibit EE(1)	Community HealthChoices LTSS Benefits: the definition for Home Health Services appears to be missing words. Could DHS please provide the missing text.	The Department is unable to identify missing words in this section.
	RFP Section	Question	Answer
313	Prior draft—GGG (1)-(9)	This exhibit details performance measures that would be used to measure outcomes and results and generate reliable data on quality, effectiveness and the efficiency of the CHC-MCO. The only required measures are Medicaid HEDIS non-child, non-OB, non-BH questions. Given that the plan will only have usable acute care data for non-duals and the CHC-MCO's own D-SNP dual eligible Participants, the results of these measures will be based on small numbers and may not all be reportable. Please confirm that the omission of Exhibit GGG is intentional, or clarify when we can expect this missing exhibit.	Removal of exhibit GGG is intentional. Selected Offerors will receive reporting instructions and requirements thru the CHC-MCO intranet site at a later date.
	RFP Section	Question	Answer
314	MIS 18, Page 29	This RFP question speaks to communication of outcome measures to providers; however, it is not clear the Department is referring to plan-level or provider-level outcomes. Please clarify.	The Department is referring to both Plan level and Provider level outcomes.
	RFP Section	Question	Answer

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315	Calendar of Events	Will CHC-MCOs have the opportunity to ask specific rate and experience questions after the March 16th deadline to submit questions (e.g., after capitation rates are released by the Commonwealth)?	Selected Offerors will have the opportunity to ask specific rate and experience questions during the rate negotiation process.
	RFP Section	Question	Answer
316	Section I-4	Could DHS please clarify what proportion of the CHC-eligible population is eligible for LIFE? If available, please provide by sub-population and CHC Zone.	Anyone who lives in an area where a LIFE program operations, is NFCE, and is over 55 is eligible for LIFE.
	RFP Section	Question	Answer
317	Section I-4	Please confirm that enrollment in LIFE has historically been voluntary – prior to CHC – and provide the proportion of the eligible population that enrolled in the program (if applicable).	Confirmed the enrollment in LIFE historically has been voluntary. The proportion of the eligible population that has enrolled is approximately 6%.
	RFP Section	Question	Answer
318	Community HealthChoices Historical Data Summaries	Will CHC-MCOs be at risk to pay more or less than the payment received from the Commonwealth for any of the "Supplemental Payments for Nonpublic and County Nursing Facilities" listed on pages 5-6?	Selected Offerors must use **all** Access to Care supplemental payments received from the Department to increase payments to Nursing Facilities as provided in Appendix 4 of the Draft Agreement. Further information will be available during rate negotiations.
	RFP Section	Question	Answer
319	Section I-4	Can the Commonwealth provide the data book that will be used as the basis of capitation rates going forward? In particular, please provide historical base data – i.e., utilization and cost experience – by CHC Zone for expected CHC population, so that the CHC-MCOs have the ability to get comfortable with expected costs in future roll-out periods.	DHS does not plan to provide additional data at this time.
	RFP Section	Question	Answer
320	Section I-5	What risk adjustment models and/or methodologies are under consideration for future years?	Refer to the response to Q.155.
	RFP Section	Question	Answer
321	Section I-5	Please describe the potential Pay for Performance (P4P) mechanism(s), including the amount of withhold being considered (if applicable).	Refer to the response to Q.280.

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	RFP Section	Question	Answer
322	Appendix A – Draft Agreement; Appendix 3f	Please confirm there will be no 5% Withhold if a CHC-MCO has delivered a signed amendment on or before November 20th in any given year.	Confirmed.
	RFP Section	Question	Answer
323	Appendix A – Draft Agreement; Appendix 3f	Does the 5% Withhold apply if the MCO is engaged in discussions with the Commonwealth on the rate amendment on or after November 20th in any given year?	The Department reserves the right to withhold in this scenario.
	RFP Section	Question	Answer
324	Calendar of Events	Will there be a meeting with the Commonwealth and Mercer after the capitation rates are released? If a meeting is not currently contemplated, we request that a meeting be scheduled to provide bidders the opportunity to address any concerns	Please refer to question 315.
	RFP Section	Question	Answer
325	Section II: Definitions Actuarial Sound Rates, Page 13	Why is the definition for Actuarially Sound Rates different than the definition found in ASOP 49? ASOP 49 provides the definition of actuarial soundness that actuaries must follow in developing capitation rates	Refer to the response to Q.181.
	RFP Section	Question	Answer
326	Section II: Definitions Actuarial Sound Rates, Page 13	Please describe what is meant by "efficiently and effectively operated Medicaid Managed Care program" as found in the Actuarially Sound Rate definition for medical costs and administrative costs separately.	Refer to the response to Q.181 and Q. 184.
	RFP Section	Question	Answer
327	Section II: Definitions Actuarial Sound Rates, Page 13	What is considered an "efficiently and effectively operated Medicaid Managed Care program" as found in the Actuarially Sound Rate definition for medical costs in Year 1?	Refer to the response to Q.181 and Q 184.
	RFP Section	Question	Answer

328	Section II: Definitions Actuarial Sound Rates, Page 13	What is considered an "efficiently and effectively operated Medicaid Managed Care program" as found in the Actuarially Sound Rate definition for medical costs in Year 2?	Refer to the response to Q.181 and Q. 184.
	RFP Section	Question	Answer
329	Section II: Definitions Actuarial Sound Rates, Page 13	What is considered an "efficiently and effectively operated Medicaid Managed Care program" as found in the Actuarially Sound Rate definition in medical costs in Year 3?	Refer to the response to Q.181 and Q.184.
	RFP Section	Question	Answer
330	Section II: Definitions Actuarial Sound Rates, Page 13	Do administrative costs include an adjustment to fully reimburse for the Health Insurer Fee?	Refer to the response to Q.182.
	RFP Section	Question	Answer
331	Section II: Definitions Actuarial Sound Rates, Page 13	What is included in assessment costs?	The 'needs assessment' costs are the costs of the service coordinator activities to contact and meet with the participant to complete the assessment tool. The tool is required to be completed at least during the yearly re-evaluation, after certain 'trigger events' and upon request of the participant or family member in response to a change in need.
	RFP Section	Question	Answer
332	Section II: Definitions Actuarial Sound Rates, Page 13	What is considered an "efficiently and effectively operated Medicaid Managed Care program" as found in the Actuarially Sound Rate definition for administrative costs in Year 1?	Refer to the response to Q.181 and Q.184.
	RFP Section	Question	Answer
333	Section II: Definitions Actuarial Sound Rates, Page 13	What is considered an "efficiently and effectively operated Medicaid Managed Care program" as found in the Actuarially Sound Rate definition for administrative costs in Year 2?	Refer to the response to Q.181 and Q. 184.

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	RFP Section	Question	Answer
334	Section II: Definitions Actuarial Sound Rates, Page 13	What is considered an "efficiently and effectively operated Medicaid Managed Care program" as found in the Actuarially Sound Rate definition in administrative costs in Year 3?	Refer to the response to Q.181 and Q. 184.
	RFP Section	Question	Answer
335	Section V: Organ Transplants, Page 41	Please provide by SFYs (2012/2013 and 2013/2014), Zone, and rating group, the number and total incurred medical expense by transplant type.	This information will be available to the CHC-MCOs during rate negotiations.
	RFP Section	Question	Answer
336	Section VII: Retroactive Eligibility Period, Page 118	Please confirm that a CHC-MCO's liability excludes any expenses prior to the start date of each Zone. For example, Zone 1 is expected to start 1/1/17. Please confirm that any expense incurred prior to 1/1/17 is not the responsibility of the CHC-MCO.	The CHC-MCOs are not liable for services received by the participant prior to Start Date of a Zone.
	RFP Section	Question	Answer
337	Section VII: Retroactive Eligibility Period, Page 118	Please define the Effective Date. Is the effective date considered the date the member is assigned to a CHC-MCO? Is the effective date considered the date a member applies for eligibility?	The eligibility date for a CHC Participant will be the day financial eligibility is determined. The CHC enrollment date will be System Date +1 for LTSS Participants. For non-LTSS Participants, the dating rules will apply based on when they become eligible.
	RFP Section	Question	Answer
338	Section VII: Retroactive Eligibility Period, Page 118	Please provide by SFYs (2012/2013 and 2013/2014), Zone, and rating group, the number of member months and total incurred expenses that are considered to be from the retroactive period.	The requested information is not available at this time.
	RFP Section	Question	Answer
339	Community HealthChoices Historical Data Summaries, Page 5	Rating Groups: How will the rating groups be blended to develop the capitation rate? Will the blended rate be based on the Zone mix between Nursing Facility and HCBS?	The Nursing Facility and HCBS blended capitation rate will be based on the enrollment mix within the rating region. DHS is considering various risk mitigation techniques to address potential variation by MCO in NF/HCBS mix. Additional information will be provided to selected Offerors during

			rate negotiations.
	RFP Section	Question	Answer
340	Community HealthChoices Historical Data Summaries, Page 5	Will the blended capitation rate be based on each CHC-MCO mix between nursing facility and HCBS?	Refer to the response to Q.339.
	RFP Section	Question	Answer
341	Community HealthChoices Historical Data Summaries, Page 5	Please define temporary nursing facility individual.	The temporary nursing facility Participant reference applies to a waiver-enrolled Participant who has a short-term nursing facility stay and then returns to the community.
	RFP Section	Question	Answer
342	Community HealthChoices Historical Data Summaries, Page 5	If a member is considered HCBS and has a temporary stay in a nursing facility, will that member be considered HCBS while in the nursing facility? How will that impact the blended capitation?	For purposes of the Mercer historical data summaries, individuals were assigned to one of the population groups on a monthly basis using eligibility data as of the first of the month. If the individual's eligibility record showed both a nursing facility and waiver code as of the first of the month, then the individual's claims and membership were assigned to the NF population group for that month. Information related to the capitation rate blending approach will be provided to selected Offerors during rate negotiations.
	RFP Section	Question	Answer
343	Community HealthChoices Historical Data Summaries, Page 5	Will the blended rate paid to CHC-MCO be the same for the full year? How often will the blended rate be reset?	This information will be provided to Selected Offerors during rate negotiations.
	RFP Section	Question	Answer

344	Community HealthChoices Historical Data Summaries, Page 5	If a member moves from HCBS to Nursing Facility during the middle of the year, how does that affect the blended capitation rate?	Refer to the responses to Q.339 and Q.342.
	RFP Section	Question	Answer
345	Community HealthChoices Historical Data Summaries, Page 5	It states that when an HCBS member has a temporary Nursing Facility stay, the costs and membership data are moved to the applicable Nursing Facility group. If that member is considered HCBS for the full year in terms of the blended group rate, there will be a disconnect between the projected incurred medical and expense and the blended capitation. If the member in this situation will be considered HCBS for all 12 months, we request that the experience for the temporary Nursing Facility stay in the HCBS group.	Refer to the responses to Q.339 and Q.342.
	RFP Section	Question	Answer
346	Quality Improvement & Performance Measures Question #2	Is the state asking for health and HCBS quality and performance measures for all managed Medicaid lives or only for those in a LTSS plan? Does the state have any measurement time parameters?	The Department is asking for LTSS performance measures. The Department is in the process of developing a formal reporting structure, and it will be made available during the readiness review process.
	RFP Section	Question	Answer
347	I-5	Regarding annual renegotiation of capitation rates in each subsequent program year, please confirm that the Department intends to renegotiate rates individually with the CHC-MCOs.	Confirmed, the Department will renegotiate the rates with each CHC-MCO.
	RFP Section	Question	Answer
348	Appendix A, H.	This section states, "CHC-MCOs must provide care management to all Participants." Please confirm that the Department means that care management must be available to all Participants. A Participant could choose not to participate in the CHC-MCO's Care Management program or activities of care management.	Care management must be available and a Participant may choose not to participate.
	RFP Section	Question	Answer
349	Part 2, II-4, A	Please consider revising the requirement for resumes for all executive management positions to allow for resumes or job descriptions, similar to the HealthChoices RFP?	Resumes are needed for this requirement.
	RFP Section	Question	Answer

Questions and Responses
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350	Appendix A, I., Page 55	The Agreement states," The Department may review, question, and request revision to PCSPs. The CHC-MCO must provide the Department with weekly aggregate reports on PCSP changes in a format specified by the Department." Please clarify whether the Department is currently receiving this information on a weekly basis?	The Department owns the case management system used for relevant HCBS waivers. Therefore, this information is always available.
	RFP Section	Question	Answer
351	Draft Agreement	Under "Settings for LTSS" in the draft agreement, Personal Care Homes and Domiciliary Care Homes are prohibited settings. However, Assisting Living Residences (ALR) are not mentioned in the RFP or draft agreement. Will CHC-MCOs be permitted to offer Home and Community Based Services in ALRs?	Assisted Living Residences are an eligible setting for HCBS so long as they comply with federal regulations at 79 F.R. 2948 (January 16, 2014).