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August 18, 2016

ADDENDUM # 2

LOI# 7550787

Title: Medicaid Managed Care Services

Bid Closing Date & Time: September 12, 2016 at 10:00 AM (Eastern Time)

Notice to Vendors:

ATTACHED ARE VENDOR QUESTIONS WITH STATE RESPONSES. NO FURTHER QUESTIONS WILL BE ANSWERED.

David J. Francis
Interdepartmental Project Manager

Interested parties should monitor this website, on a regular basis, for any additional information that may be posted.

Vendor Questions for LOI #7550787 Medicaid Managed Care Services

Question 1: Can you please tell me if there is any "Letter of Intent to Propose" required for the RI Medicaid Managed Care Services, LOI #7550787 in advance of the full document due September 12, 2016?

Answer to question 1: **No, there is not a requirement for an intent to propose letter.**

Question 2: Could you please help me with the following questions: Whether companies from Outside USA can apply for this?
(Like, from India or Canada)

Answer to question 2: **Federal Final Rule §438.602(i) states that an MCO which is contracted with the State cannot be located outside the USA. MCOs may however have off-shore operations. Licensing and in-state requirements outlined in the bid are not negotiable.**

Question 3: Could you please help me with the following questions: Whether we need to come over there for meetings?

Answer to question 3: **Successful bidders will be required to meet in-person with the EOHHS on a regular basis**

Question 4: Could you please help me with the following questions: Can we perform the tasks (related to RFP) outside USA? (like, from India or Canada)

Answer to question 4: **Federal Final Rule §438.602(i) states that an MCO which is contracted with the State cannot be located outside the USA. MCOs may however have off-shore operations. Licensing and in-state requirements outlined in the bid are not negotiable.**

Question 5: Could you please help me with the following questions: Can we submit the proposals via email?????

Answer to question 5: **No, proposals must be submitted per the instructions detailed in the LOI.**

Question 6: Will EOHHS hold an open enrollment period in 2017 or 2018? During which months will EOHHS hold open enrollment? Will the open enrollment process run

through Bridges? Please describe the role of the DHS Field Office Staff in the open enrollment process?

Answer to question 6: **Yes, EOHHS will hold an open enrollment in 2017. Open enrollment activities will run through all the EOHHS Medicaid systems. DHS field staff are responsible for Medicaid eligibility.**

Question 7: Will EOHHS mail letters to beneficiaries as part of the open enrollment process? How many days will beneficiaries have to select a health plan? What happens if beneficiaries do not respond?

Answer to question 7: **Yes, EOHHS will mail letters to beneficiaries. Beneficiaries will have 30 days to respond. Beneficiaries will remain in current MCO (if successful in bid) if no response is provided.**

Question 8: Please share in more detail the default assignment methodology. EOHHS proposes to assign based on quality metrics, how will this account for new bidders without demonstrated quality under the contract?

Answer to question 8: **Auto-assignment methodology will be shared with successful bidders.**

Question 9: Will the default assignment methodology take into consideration previous health plan enrollment of the head of household or family members? Will the methodology assign members to a plan they or their family members have been previously enrolled in?

Answer to question 9: **Both questions above are considered in the auto-assignment methods.**

Question 10: **RI Transformation Program**
Section 2.4.3 (pg. 21) Please explain how the LTSS priority relates to the procurement given that most of the spending for these services is in populations outside the procurement. Please provide examples of the expectations that EOHHS has for the managed care program regarding LTSS

Answer to question 10: **EOHHS expects collaboration and coordination with the successful MCOs as it relates to populations both covered in this bid and those managed by EOHHS directly. This includes the development and progression of Accountable Entities, including a**

clear demonstration of the MCOs ability to engage effectively with accountable entities.

Question 11: **Emergency Medical Services**
Section 3.2.4.2 (pg. 31, 32) Bidder agrees to make services available within (5) business days for treatment of a non-emergent, non-urgent mental health or substance use condition." However the table on the top of page 32 states "within 10 business days." Which time frame is correct?

Answer to question 11: **Within 10 business days is the correct time frame.**

Question 12: **Enrollment of Newborns**
Section 3.2.3.1 Please describe the bidders responsibility regarding presumptive eligibility for newborns. Under this procurement, will EOHHS continue to require the health plans to cover services pending the newborns enrollment? How long will EOHHS require presumptive eligibility coverage?

Answer to question 12: **Yes, please refer to the model contract Section 2.05.02.01 for requirements.**

Question 13: **Care Coordination and Care Management**
Section 3.2.6.1 (pg. 35) The LOI states the HRA must be completed within 90 days of the member's enrollment with the bidder. Does the HRA requirement only apply to Children with Special Health Care needs, Children in Substitute Care, Rhody Health Partners and Medicaid Expansion?

Answer to question 13: **The HRA requirement applies to all members enrolled in the MCO.**

Question 14: **Section 3.2.6.1 (pg. 34)** EOHHS identifies members being released from correctional facilities as a priority population. How soon prior to release will beneficiaries be enrolled in the health plan and notified by EOHHS of a member's release from a correctional facility?

Answer to question 14: **EOHHS will review operational processes regarding individuals being released from corrections with successful bidders.**

Question 15: **Electronic Visit Verification (EVV)**
Section 3.2.11.3.1 (pg.44) Please provides additional specifications of the health plan requirements associated with EVV. Will the bidder be required to contract with the state approved vendor? Please share the timeframe for implementation of the EVV requirement.

Answer to question 15: **Additional specifications, including implementation timeframes will be provided to successful bidders. Successful bidders will be required to contract with the State appointed vendor.**

Question 16: **Operational Readiness**
Section 4.3.6 (pg. 49-50) Please describe the role of the State Purchasing Agent in deferring the contract start date?

Answer to question 16: **The State Purchasing Agent has sole discretion in the final contract start date.**

Question 17: **Operational Readiness**
Section 4.3.6 (pg. 49-50) Please describe the minimum requirements that need to be in place for EOHHS to determine the readiness of a new entrant?

Answer to question 17: **Bidders should refer to 42 CFR 438.66. Detailed readiness documents will be shared with successful bidders.**

Question 18: **Operational Readiness**
Section 4.3.6 (pg. 49-50) Will EOHHS allow new entrants time beyond April 1, 2017 to meet full compliance?

Answer to question 18: **No**

Question 19: **Operational Readiness**
Section 4.3.6 (pg. 49-50) Will EOHHS require a stand-alone accreditation for the RI plan? Will new entrants be allowed additional time to achieve NCQA accreditation?

Answer to question 19: **Yes, stand-alone accreditation is required. Please refer to model contract Section 2.02**

Question 20: **Operational Readiness**

Section 4.3.6 (pg. 49-50) Does the state have an enrollment threshold before the NCQA accreditation requirement is required? For example, if a health plan has fewer than 10,000 enrollees will accreditation still be required?

Answer to question 20: **Please see response to question 19**

Question 21: **References**
Section 4.4.5 (pg. 52) Do bidders already contracted with EOHHS for Medicaid Managed Care Services need to provide references? Is this requirement only for new entrants?

Answer to question 21: **Yes, all bidders must submit references.**

Question 22: **Habilitative Benefit**
Section 4.8.5.2.4 (pg. 71) Is the Intellectual and Developmental Disabilities (IDD) population the only individuals eligible for the Habilitative benefit?

Answer to question 22: **Eligibility for the Habilitative benefit is described in the RI 1115 Waiver Standard Terms and Conditions, please refer to the procurement library for further information.**

Question 23: **Habilitative Benefit**
Section 4.8.5.2.4 (pg. 71) Are these services formerly covered through the DD waiver program? Is the full scope of services underneath the residential component of the DD waiver program?

Answer to question 23: **The State does not have a DD Waiver, the Habilitative benefit is described in the RI 1115 Waiver Standard Terms and Conditions, please refer to the procurement library for further information.**

Question 24: **Habilitative Benefit**
Section 4.8.5.2.4 (pg. 71) Please explain the communication of this change to the IDD providers? The movement of the benefit in-plan is a significant disruption to the IDD provider community, how has this change been communicated?

Answer to question 24: **Communications regarding this procurement and/or its contents to a provider network will not occur until an award is made and operational/readiness meetings and contracts are awarded to successful bidders.**

Question 25: **Habilitative Benefit**

Section 4.8.5.2.4 (pg. 71) Please provide the authorization criteria, payment codes and current provider list and provider rates associated with this benefit. Does the authorization criteria continue to exist with RI Department of Behavioral Healthcare, Development Disabilities and Hospitals Agency (BHDDH)?

Answer to question 25: **Bidders should describe their plan for how they will approach authorization for these services. Operational details will be shared and reviewed with successful bidders.**

Question 26: **Habilitative Benefit**

Section 4.8.5.2.4 (pg. 71) Is the administration of patient share a component of this benefit?

Answer to question 26: **Operational details will be shared and reviewed with successful bidders.**

Question 27: **Habilitative Benefit**

Section 4.8.5.2.4 (pg. 71) Please explain the role of RI Department of Behavioral Healthcare, Development Disabilities and Hospitals Agency in the oversight of the in-plan Habilitative benefit?

Answer to question 27: **Oversight of the Medicaid Managed Care Contracts will be conducted by EOHHS and/or its designees, including other State agencies.**

Question 28: **Habilitative Benefit**

Section 4.8.5.2.4 (pg. 71) How does the Department of Justice consent decree interact with the day Habilitative service?

Answer to question 28: **Successful bidders will be provided with information necessary with respect to the Department of Justice decree as EOHHS/BHDDH determines necessary and appropriate.**

Question 29: **CAHPs**

4.12.3 (pg. 81) Must health plans conduct both CAHPS Adult and CAHPS Child? Does the reference to CAHPS Child include both the CAHPS Child General Population and the CAHPS Child with Chronic Conditions surveys?

Answer to question 29: **Yes. The Child General Population Survey is required.**

Question 30: **Data Books- Please** provide the completion factor adjustments applied to the base data for each Medicaid managed care program.

Answer to question 30:

Rates are based on FY13-FY15 data, with claims from the State's encounter and, where applicable, its fee-for-service claims system. Because the State transitioned to a new 837-compliant Encounter system in FY14, the State has elected to fully reconcile its claims data against the health plan's own claims data to ensure accuracy of its data. The data run was completed in November 2016.

The following table outlines the aggregate completion factors used across the rating packages. Please note that actual completion factors differ by provider type and for each product by distribution of claims by provider type.

	SFY13	SFY14	SFY15
Non-SOBRA	1.0000	0.9996	0.9842
SOBRA	1.0000	0.9993	0.9779

Backup (from EOHHS' Rate Setting materials):

II. Completion/IBNR

Values	SFY11	SFY12	SFY13	SFY14	SFY15
PdAmount	$1,715,318,150	$1,733,331,736	$1,741,707,924	$1,920,054,699	$2,110,989,529
Pd@100%	$1,715,318,150	$1,733,331,736	$1,741,707,924	$1,920,781,552	$2,144,807,050
CompRatio	1.0000	1.0000	1.0000	0.9996	0.9842

III. Sobra

Row Labels	SFY11	SFY12	SFY13	SFY14	SFY15
Sobra	$49,069,671	$49,331,040	$47,358,936	$47,488,184	$48,536,464
NonSobra	$1,666,248,479	$1,684,000,696	$1,694,348,988	$1,873,293,368	$2,096,270,586
Total	**$1,715,318,150**	**$1,733,331,736**	**$1,741,707,924**	**$1,920,781,552**	**$2,144,807,050**

Findings: Sobra will be filtered out from this point forward since MC Maternity expense is inherent in the data.

Question 31: **Data Books-** Will the state consider an amendment to this agreement allowing for a rebasing of capitation payment rates for Rate Periods 2 and 3 (effective 2/1/2017 – 6/30/2017 and 7/1/2017 – 6/30/2018, respectively) that is based, in part, upon

the Plan's actual experience during each previous rate period and/or expected trends that are different than historical experience for the upcoming period?

Answer to question 31:

EOHHS has provided actuarially certified rates through June 30, 2018 to allow for greater certainty for potential bidders.

Absent explicit legislatively mandated and actuarially quantifiable initiatives (either new savings or new programs), the provided rates should be considered as the binding rates for the two rating periods (2/1/2017-6/30/2017 and 7/1/2017-6/30/2018)

However, the State reserves the right to adjust the rates based on emerging trends that pose significant upward or downward pressures on price or utilization that is not reflected in the base experience and historical trends utilized (i.e. FY15 data)

Question 32: **Data Books-** Over the next 5 years, will the health plan be provided the opportunity to propose different risk arrangements or is this initial contract period the only opportunity?

Answer to question 32:

Yes, a health plan could propose to change a future amendment to a contract to reflect a different risk share arrangement.

Question 33: **Data Books-** As new services / initiatives are implemented over the length of this agreement, will there be an amendment to adjust the capitation payment rates to account for these services/ initiatives?

Answer to question 33:

Yes. The rates are certified to actuarially sufficient to reflect the scope of benefits and population served. As new services/initiatives are implemented the rates will be correspondingly adjusted if and as necessary.

Question 34: **Data Books-** Does EOHHS plan on implementing acuity-based risk adjusted payments during the 5 year contract period?

Answer to question 34:

The State's capitated payments are risk adjusted to gender and age and/or broad population groups. At this time the State does not have plans to implement acuity-based capitation at the individual or subgroup level.

If the health plans' risk profile significantly deviate from each other, the State reserves the right to consider acuity-based risk adjusted payments for subsequent rating periods.

However, please note that with respect to Accountable Entity's shared savings the State may recognize approved acuity based payments by the health plan to its providers (and those retained by the health plan) as an allowable health expenditure.

Question 35: **Data Books-** Are benefit costs specific to the Habilitative services for IDD members included in the capitation rates? This is a new benefit. If so please provide detail.

Answer to question 35: **Yes. Please see Appendix A for PMPM impact of "Habilitative Services" for the two rating periods.**

Question 36: **Data Books-** Please confirm that the provider incentive program can be awarded to both providers that have existing Accountable Entity (AE) contracts and for those providers that are seeking to become a certified AE.

Answer to question 36: **The provider incentive program is intended to support providers that are intending to become or are already a certified AE, including those not yet certified. The State must approve any provider incentive payment arrangement with priority given to those still developing the capabilities to become a certified AE.**

Question 37: **Data Books -** Please clarify that AE incentives for the contract beginning 2/1/17 and ending 6/30/17 are allowable as a risk share medical expense but AE incentives for the contract beginning 7/1/17 and ending 6/30/18 are outside the risk share calculation and are treated as Health System Transformation Payments.

Answer to question 37:

The provider and AE incentives are outside of the risk share calculation for both rating periods. Neither Provider Incentive Program payments nor Health System Transformation Program payments are included in the capitated payments nor are an allowable medical expenditure (for purposes of risk share).

The State will directly reimburse the health plan outside of its capitation for any EOHHS-approved incentive payments, to the limits ascribed in the data books.

The incentive payments are distinct from any payments made to a provider or retained by the health plan in accordance with a state-approved shared savings program between an AE and the health. These State-approved shared savings payments are recognized as an allowable medical expenditure.

Question 38: **Data Books-** Are benefit costs specific to the Health Home OTP services for IDD members included in the capitation rates? This is a new benefit. If so, please provide detail.

Answer to question 38:

Yes. Please see Appendix A for PMPM impact of "OTP Health Home" for the two rating periods, and for additional information.

Question 39: **Letter of Intent**
Is there a formal "Letter of Intent to Propose" required to DOA or EOHHS in advance of the full document due September 12, 2016 or is the Letter of Transmittal – LOI Section 4.1 the only letter of intent required for this procurement when we submit the full LOI response?

Answer to question 39: **No, there is not a requirement for an intent to propose letter.**

Question 40: **LOI Formatting Section 4.5** – Numbering on page 53 is out of sync. What numbers should we use in our response?

Answer to question 40:

4.5.2 Alternative Payment Methodologies and Accountable Entities
4.5.2.1 Contracting Arrangements with EOHHS Certified Accountable Entities
4.5.2.2 Description of Contracting Status for any other Alternative Payment Methodologies

4.5.2.3 Submission of Completed Alternative Payment Methodology Reporting Template
4.5.3 Rhode Island Medicaid Health System Transformation Program
4.5.3.1 Primary Care Practice Transformation

Question 41: **LOI Formatting Section 7 –** Please confirm font type and size, margins and line spacing for LOI response.

Answer to question 41: **Time New Roman, 12 point font, standard default margins and line spacing.**

Question 42: **LOI Formatting Attachment 1** – Section 4.5.1-4.5.7 – Header appears to be missing with maximum points and page count. What are the correct points and page counts for this section?

Answer to question 42:
Maximum Points = 20
Number of Pages = 25

Question 43: **Provider Directory-** Should the Plan submit its Provider Directory in the same flash drive as the copy of the LOI or should the Plan submit the Provider Directory information on a separate flash drive?

Answer to question 43: **A separate flash drive.**

Question 44: **Contract Questions:**
Attachment M – Performance Goal Program
Pgs. 286-295 - The 95th percentile benchmark was recently introduced by NCQA and is not used with any other performance program, including NCQA Accreditation and NCQA Ratings. Will EOHHS consider a transition period prior to implementing the new benchmarks to allow dissemination by the health plan to providers and adoption as an industry norm?

Answer to question 44: **EOHHS may consider a transition period prior to implementing the new benchmark on a measure by measure basis.**

Question 45: Contract, 2.05.02.03, Enrollment of Uninsured Children up to 18 above 250% FPL, Page 44, and
LOI, 1.16, Introduction,
Page 9

Section 2.05.02.03 of the Model Contract states:

"Contractor agrees to make coverage available to uninsured children under eighteen years of age with income above 250 percent of the Federal poverty level, at a monthly premium rate (payable by the family) not to exceed the full community rated non-group premium for the defined benefit package, as described later in this chapter."

And 1.16 in the LOI, states:
"In order to perform the contemplated services related to the Rhode Island Health Benefits Exchange (HealthSource RI) , the vendor hereby certifies that it is an "eligible entity," as defined by 45 C.F.R. § 155.110, in order to carry out one or more of the responsibilities of a health insurance exchange. The vendor agrees to indemnify and hold the State of Rhode Island harmless for all expenses that are deemed to be unallowable by the Federal government because it is determined that the vendor is not an "eligible entity," as defined by 45 C.F.R. § 155.110."

Will EOHHS please confirm the MCO is not required to offer a commercial product on the Rhode Island Health Benefits Exchange and is eligible to bid on this procurement as a licensed health maintenance organization by the State of Rhode Island?

Answer to question 45: **The bidder is not required to offer a commercial product on the RI Exchange.**

Question 46: Attachment 3,
Rate Setting Process Will EOHHS please provide the capitation rates for the period 7/1/2016 through 1/31/2017 for each population (e.g., RIte Care, CSHCN, etc.)?

Answer to question 46: **Yes. Upon execution of pending contract amendments with the Health Plans the rates for 7/1/2016 through 1/31/2017 will be made publicly available through EOHHS' website.**

Question 47: Attachment 3,
Rate Setting Process For the proposed capitation rates, will EOHHS please provide a breakdown of the membership by rating category (e.g., total number of Males 15-44) by population (e.g., RIte Care, CSHCN, etc.)?

Answer to question 47:

The data books include a forecast of the average monthly enrollment in each of the rating periods. However, enrollment may be impacted by trends in the state's economy, open enrollment for the State's health exchange, and functionality of the State's integrated eligibility system.
EOHHS resets its two-year fiscal year forecast twice annually for its testimony in the Caseload Estimating Conference (in November and May).
For trending purposes, the following table reflects enrollment in RIte Care, CSHCN, Substitute Care, Rhody Health Partners, and Expansion by the rating

groups for each month in Fiscal Year 2015, the base year used for setting rates for this procurement.

Fiscal Year 2015:														
Product	**Pay Level**	**Jul-14**	**Aug-14**	**Sep-14**	**Oct-14**	**Nov-14**	**Dec-14**	**Jan-15**	**Feb-15**	**Mar-15**	**Apr-15**	**May-15**	**Jun-15**	**FY Average**
RIte Care Core	MF < 1	5,851	5,918	5,837	5,886	5,838	5,849	6,024	6,068	5,919	5,890	5,895	6,025	5,917
	MF 1-5	25,447	25,600	25,073	24,971	24,620	24,187	24,914	24,788	25,337	25,593	25,342	25,804	25,140
	MF 6-14	41,113	41,416	40,699	40,751	40,051	39,497	40,618	40,422	41,195	41,555	41,106	41,559	40,832
	M 15-44	16,365	16,521	16,163	16,336	16,146	16,110	16,626	16,622	16,653	16,770	16,656	16,785	16,479
	F 15-44	37,978	38,351	37,771	38,119	37,695	37,482	38,633	38,619	38,848	39,232	38,809	39,325	38,405
	MF 45+	7,698	7,764	7,660	7,749	7,753	7,896	8,070	8,109	8,042	8,117	8,101	8,197	7,930
	EFP Only	752	680	527	417	335	234	234	191	183	180	158	200	341
RIte Care CSHCN	Substitute Care	2,113	2,132	2,144	2,159	2,185	2,144	2,155	2,160	2,196	2,207	2,207	2,213	2,168
	SSI < 15	3,469	3,472	3,478	3,520	3,515	3,501	3,554	3,566	3,552	3,517	3,500	3,459	3,509
	SSI 15-20	1,854	1,873	1,862	1,867	1,879	1,878	1,884	1,880	1,862	1,854	1,858	1,888	1,870
	Katie Beckett	94	95	94	90	85	85	90	94	94	93	93	94	92
	Adoption Subsidy	1,430	1,428	1,447	1,473	1,478	1,474	1,510	1,509	1,539	1,547	1,536	1,535	1,492
Expansion	F 19-24	4,977	5,186	4,965	5,313	5,470	5,644	5,775	5,989	6,140	6,155	6,219	6,350	5,682
	F 25-29	2,835	2,977	2,798	3,045	3,174	3,296	3,404	3,585	3,729	3,750	3,772	3,872	3,353
	F 30-39	2,581	2,697	2,588	2,774	2,860	2,983	3,044	3,121	3,206	3,189	3,220	3,277	2,962
	F 40-49	3,924	3,986	3,771	3,999	4,101	4,202	4,192	4,310	4,394	4,403	4,423	4,484	4,182
	F 50-64	8,612	8,843	8,484	9,094	9,350	9,743	9,847	10,210	10,333	10,396	10,369	10,525	9,651
	M 19-24	5,297	5,494	5,307	5,618	5,757	5,936	6,115	6,381	6,633	6,707	6,754	6,911	6,076
	M 25-29	4,115	4,320	4,188	4,484	4,682	4,863	5,027	5,279	5,511	5,586	5,677	5,767	4,958
	M 30-39	5,067	5,329	5,239	5,622	5,811	6,057	6,171	6,467	6,699	6,830	6,936	7,095	6,110
	M 40-49	4,653	4,826	4,710	4,947	5,074	5,286	5,351	5,539	5,690	5,739	5,776	5,867	5,288
	M 50-64	6,628	6,851	6,712	7,184	7,447	7,725	7,902	8,192	8,324	8,453	8,479	8,692	7,716
Rhody Health Partners	SSI 21-44	3,949	3,997	3,962	3,913	3,881	3,869	3,821	3,944	3,965	3,966	3,951	3,920	3,928
	SSI 45+	6,946	7,007	6,924	6,824	6,791	6,750	6,612	7,021	6,990	6,942	7,000	6,982	6,899
	SPMI	2,196	2,219	2,210	2,200	2,198	2,192	2,164	2,254	2,293	2,301	2,317	2,331	2,240
	ID/DD	834	838	841	839	842	837	835	862	855	859	861	864	847

Question 48: 4.4.4, Health Plan Financial Viability, Claims Reinsurance Coverage- Is EOHHS willing to accept a bidder with reinsurance coverage with a self-insured restricted reserve fund instead of a third-party reinsurer?

Answer to question 48: **Yes, EOHHS is willing to accept a bidder with reinsurance coverage with a self-insured restricted reserve fund. Such reinsurance coverage arrangements must meet or exceed the effectiveness and application of the reinsurance provisions outlined in the contract and must be approved by the State.**

Question 49: 4.6.2, Processes for New Member Orientation,
Page 56. The LOI asks the bidder to submit its proposed Member Handbook with the response. If a plan submits its current Member Handbook from another market, will the plan receive full credit for this requirement in the proposal scoring?

Answer to question 49: **A new bidder can submit a member handbook from another market.**

Question 50: Managed Care Reporting Calendar and Template (Item 20). The Template tab includes a sample report for RIte Care Quarterly Informal Complaints. Will EOHHS please provide the templates for the other 32 reports?

Answer to question 50: **Successful bidders will receive the entire package of reporting templates and requirements upon award.**

Question 51: Attachment 1, Proposal Checklist Page 2. Will EOHHS please provide the suggested number of response pages for Section 4.5, Plan for Meeting Contract Goals for this Procurement and Special Initiatives Requirements?

Answer to question 51: **Please see response to question 42 above**

Question 52: Will EOHHS please confirm that the health plan is not required to send members 1099-HCs & 1095-A, 1095-B and 1095-C forms?

Answer to question 52: **Confirmed**

Question 53: 3.2.5
Provision of Covered Services/Benefits, Pages 32-33 and 4.8.2 Approach to cover Gender Dysphoria, Page 62 - In our experience, serving members with gender dysphoria involves an array of services, some of which might be considered non-covered benefits for the general population (e.g., hair removal). Will EOHHS please clarify the covered services and procedures for gender dysphoria?

Answer to question 53: **A comprehensive benefit package for the treatment of gender dysphoria will be provided to covered beneficiaries by the successful bidders. The bidder should describe and detail this coverage within federal guidelines and best practices nationally.**

Question 54: 4.16.1, Statement of Understanding (Plan for Serving Children in Substitute Care). We understand the complex physical and behavioral health care needs of children in substitute care, including the challenges from a developmental and care coordination perspective. Section 4.16.1 asks the Bidder to identify shortcomings in the existing system for children in substitute care. Will EOHHS please provide a description of the current system of care and services that exist today for these members so we can offer recommendations that add value?

Answer to question 54: **Children in substitute care will require a full continuum of medical, mental health and substance use disorders treatment. Please refer to Attachment O of the model contract.**

Offerors are also encouraged to review Section II. Purpose and Background of the recent DCYF LOI at http://www.purchasing.ri.gov/RIVIP/StateAgencyBids/7550411.pdf and the desired outcomes for this target population.

Question 55: 3.2.4.2, Days to Appt. for Non- Emergency, and 4.7.4.2, Plan for Meeting Service Accessibility Standards for Appt., Page 60. On page 31 of the LOI, under the bulleted item, "Days to Appointment for Non-Emergency Services," the opening paragraph states the Bidder "will make services for non-emergent mental health/substance use conditions available within five (5) business days" while the table on page 32 (repeated on page 60) indicates ten (10) business days. Will EOHHS please confirm the correct access standard?

Answer to question 55: **Please see answer to question 11 above**

Question 56: 4.7.5, Plan for Ensuring Access to Post-Stabilization Care, Page 61. Will EOHHS please confirm if the reference to 42 CFR 422.133(c) on page 61 is correct and not meant to be 42 CFR 422.113(c)?

Answer to question 56: **The correct citation is 42 CFR 422.113(c)**

Question 57: LOI, 4.8.4, Implementation of Requirements for EPDT, Page 63, and, Model Contract, 2.06.01.08, EPSDT, Page 60. The LOI requests that we describe how we will meet and measure performance in all areas of EPSDT including diagnosis and treatment. As described in the model contract, EPSDT includes, "all follow up diagnostic and treatment services deemed Medically Necessary to ameliorate or correct a problem discovered during an EPSDT screen." Will EOHHS please provide a description of the current performance measures?

Answer to question 57: **Please refer to the EPSDT periodicity schedule, Attachment D of the model contract and to the CMS-416 Annual Early & Periodic Screening, Diagnostic and Treatment Participation Report, which can be found at: *https://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/cms-416-instructions.pdf***

Question 58: Instruction and Notification to Offerors P. 8- Subcontractors may not all be identified at the time of proposal response. Is it EOHHS' intent that bidders may provide notification to EOHHS of additional subcontractors as such are identified?

Answer to question 58: **Subcontractors that are known to bidders at the time of proposal submission should be clearly identified. Additional subcontractors post award should be identified per the terms of the contract.**

Question 59: Instruction and Notification to Offerors P. 8- Section 38-2-2 (4)(B) Access to Public Records provides that trade secrets and commercial or financial information that is privileged and confidential are exceptions to Public Records. Can EOHHS advise whether redacting is permitted for a specific copy marked "Public" or is it appropriate for bidders to mark such trade secrets or commercial/financial privileged information with the legend that such pages are excepted from Public Records?"

Answer to question 59: **A redacted copy marked Public should be submitted with a bidder's submission. This redacted copy does not count towards the number of copies required. In addition, vendors should submit all highly confidential information (i.e. financial statements) – in a separately sealed envelope clearly marked. Please be mindful that the state is ultimate decision-maker as to what should or should not be disclosed.**

Question 60: Covered Population p. 12 -Section 2.2.2 Covered Population of the LOI lists the populations that plans are required to cover. Please share the State's vision for serving children in substitute care. Please define the benefits and scope of services for children in substitute care.

Answer to question 60: **Children in Substitute Care are eligible for all the services and benefits outlined in the model contract. Please see response to question 54**

Question 61: Days to Appointment for Non-Emergency Services P.32 -Section 3.2.4.2 Access to Services – Service Accessibility Standards of the LOI references an access standard of five days and ten days as the access standard for routine mental health and substance use treatment. Please clarify which is the intended access standard.

Answer to question 61: **Please see answer to questions 11 above**

Question 62: In-Plan Benefits- Habilitative BH and SU Services- specifically called out for children with DD, provider network p. 241 -There are multiple references in the LOI and the Model Contract to the DD population (both adults and children). Please define

the population the State is referencing. Is this a direction change for the State? What are the case management expectations for the members with DD?

Please identify how in the rate build these new expenses are identified and handled? Is EOHHS planning to add any additional rates cells to identify these members (children with DD) beyond the current rate cells?

Answer to question 62:

EOHHS is striving to standardize comparable services across managed care populations.

With respect to Children:

Children on Supplemental Security Income are considered disabled and eligible for Medicaid. General information on disability criteria for children can be found here: https://www.ssa.gov/ssi/text-child-ussi.htm

Children not on SSI but living at home may also meet the disability criteria for Medicaid eligibility. Rhode Island's Katie Beckett program includes children under 19 with disabilities not on SSI. To be eligible for Medicaid coverage through Katie Beckett, a child must be:

- **under age 19, a Rhode Island resident;**
- **meet the income and resource requirements for Medicaid for persons with a disability;**
- **Qualify under the U.S. Social Security Administration's (SSA) definition of disability;**
- **Live at home; and**
- **Require a level of care at home that is typically provided in a hospital, nursing facility or an Intermediate Care Facility for Persons with Mental Retardation (ICF-MR)**

http://www.eohhs.ri.gov/Consumer/ConsumerInformation/Healthcare/PeoplewithSpecialNeedsandDisabilities/Children/KatieBeckettEligibility.aspx

With respect to Adults:

Adults eligible for Supplemental Security Income are automatically eligible for Medicaid. If the member does not have Medicare they automatically enrolled in Rhody Health Partners.

The Division of Developmental Disabilities within BHDDH is responsible for planning, providing and administering a community system of services and supports for adults with developmental disabilities such as group home services. These

members (again who do not have Medicare) are enrolled in Rhody Health Partners. The non-medical community system of services and supports for adults are not an in-plan benefit.

Question 63: Communities of Care p. 378-386- EOHHS made revisions to the Communities of Care program last year, removing several requirements which are now included in the new contract and LOI. Is the intention that the State is moving back to the original contract requirements?

Answer to question 63: **The Model Contract contains the revisions to the CoC program accepted by EOHHS in early 2015.**

Question 64: Identification for Enrollment in CoC p. 378 -Please clarify the required target population for the following statement in Attachment R of the Model Contract, "The target populations for CoC are the Contractor's enrollees who utilize the ER three (3) or two (2) or more inpatient stays in a twelve (12) month period."

Answer to question 64: **The above identifies the targeted population as of February 2015. The target populations for CoC are the Contractor's enrollees who utilize the ER three (3) or more times or have two (2) or more inpatient stays in a twelve (12) month period.**

Question 65: Covered Benefits p. 235 /Preventive Services P.401 -Regarding the Respite benefit; does this require EOHHS approval? Is this covered for adults as well as children?

Answer to question 65: **No, EOHHS is delegated this approval to successful bidders. Yes, this is covered for all populations.**

Question 66: Attachment A Covered Benefits -Home Care Services listed In Attachment A of the Model Contract , which is applicable to all members, would seem to indicate that LTSS services such as Personal Care Attendants and Private Duty Nursing are now covered services for RHP and ACA members. Please confirm.

Please identify how in the rate build these new expenses identified and handled?

Answer to question 66: **Please refer to Attachment A of the model contract, these services are not new benefits and should be delivered to members where such**

services are medically necessary and/or cost effective for treating a member's acute needs, post-acute needs or other disabilities. Additional dollars for personal care that had previously been made directly by BHDDH were added to the base and included in the aggregate trend applied in the rates. These dollars reflect a marginal increase in dollars allocated but not a new benefit.

Members who require long term care services and supports need to complete a long term care application with the State.

Question 67: APM P. 30-32 -AE P.114-117 Please explain how the 1% withhold for AE/APM contract requirements is handled in the rate build?

Answer to question 67: **The 1% AE/APM withhold is NOT reflected in the certified rates.**

Question 68: Rate Development p. 17,69, 122, 169, 215, 259, 301 and 340-
Could you please provide the detailed base medical development for the BH Services and CEDARR? Could you please provide the detailed development of the "CEDARR Services" program initiative savings?

Answer to question 68: **Please see Appendix A for PMPM impact of "IHH and Other BH Services" and "CEDARR services" for the two rating periods.**

Question 69: Rate Development p. 17,69, 122, 169, 215, 259, 301 and 340-
What is the "IHH and Other BH Services" separate Medical PMPMs and projected membership by rate cell for the rating periods of 2/01/17 – 6/30/17 & 7/01/17 – 6/30/18?

Answer to question 69:

Please see Appendix A for PMPM impact of "IHH and Other BH Services" for the two rating periods.
Certified rates assume stable membership in the Integrated Health Home population with approximately 10% of membership in Assertive Community Treatment.

Current membership by pay level is reflected in the following table:

Program	Product	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
Integrated Health Home	RIte Care/CSHCN	391	396	411	417	418	429	439
	RHP	1,762	1,796	1,803	1,808	1,780	1,788	1,807
	Expansion	908	929	940	941	928	947	954
Assertive Community Treatment	RIte Care	50	46	46	41	37	40	39
	RHP	279	291	286	288	300	294	297
	Expansion	120	135	135	120	108	99	100

Question 70: Rate Development P. 17,69, 122, 169, 215, 259, 301 and 340
Is the projected "Program Initiative Savings" for the "BH Services" for medical cost other than the actual "BH Services" medical cost? Could you please provide the detailed development of the estimated "BH Services" savings by rate cell, category of service, including units per 1,000, admits/patients per 1,000, membership and paid claims dollars? Do the projected savings include Physical and BH savings? Is the "BH Services" savings specific to the IHH?

Answer to question 70:

Savings targets reflect 6% in savings against the historical total care of cost for members receiving health home services at a Community Mental Health Center.

While the savings are allocated across pay levels based on the enrolled population's historical FFS utilization of the new behavioral health benefit, the savings are not anticipated to be achieved against a reduction in the new behavioral health dollars.

Question 71: Rate Development p. 17,69, 122,169, 215, 259, 301 and 340
Please indicate where the "OTP" medical cost is included in the rate development? Could you please provide the detailed development of the "OTP" medical cost by rate cell, category of service, including units per 1,000, admits/patients per 1,000, membership and paid claims dollars?

Answer to question 71:

Prior to July 1, 2016, the OTP health home benefit was covered as an out of plan benefit. The concurrent methadone treatment has historically been provided as an In Plan benefit for RIte Care members and Expansion members. It was included as an In Plan benefit for Rhody Health Partners beginning January 1, 2016.

Both the OTP Health Home payment and the methadone treatment payment are now covered as In Plan benefits.

Furthermore, as it relates to OTP health home, no savings were assumed against the OTP HH/Methadone treatment. However, as a result of differences in how the health plans and EOHHS FFS paid for methadone, EOHHS' rates assume a reduction in the payment for the OTP health home service from $87.52 to $53.50 per

week to offset the reality that the health plans have higher contracted rates for the methadone treatment than what the State has historically paid for this service. The State anticipates that the health plans continue to pay their contracted methadone rate of +/- $85 but pay the reduced OTP rate of $53.50 for a total cost of $138.50 per week.

Please see Appendix A for PMPM impact of "OTP Health Home" by product line.

Please see Appendix A for PMPM impact of "IHH and Other BH Services" and "CEDARR services" for the two rating periods.

Average monthly enrollment of distinct users of OTP health home services are:

Service Month	RIte Care	SubCare	CSHCN	Expansion	RHP
Dec-15	2,690	5	40	6,029	3,402
Nov-15	2,544	6	41	5,595	3,225
Oct-15	2,436	6	46	5,575	3,344
Sep-15	2,533	4	37	6,143	3,427
Aug-15	2,726	6	46	6,588	3,635
Jul-15	2,279	8	45	5,317	3,243
Jun-15	2,253	6	39	5,106	3,086
May-15	2,750	5	44	6,530	3,568
Apr-15	2,309	8	37	5,598	3,303
Mar-15	2,372	5	43	5,692	3,295
Feb-15	1,904	3	40	4,375	2,897
Jan-15	2,490	4	46	6,029	3,406
Dec-14	2,036	3	38	5,205	3,127
Nov-14	2,338	4	34	5,911	3,517
Oct-14	2,411	4	35	5,205	3,333
Sep-14	2,422	2	38	4,939	3,241
Aug-14	2,968	4	40	6,171	3,743
Jul-14	2,480	4	42	4,935	3,450
Jun-14	2,483	4	43	4,905	3,283
May-14	2,794	6	43	4,892	3,629
Apr-14	2,351	1	44	3,884	3,348
Mar-14	2,609	2	49	3,844	3,730
Feb-14	2,184	3	50	2,365	3,179
Jan-14	2,529	3	46	1,193	3,549

The rating assumes the participation in the OTP health home is stable and consistent with historical trends.

Question 72: P. 8 -Services will be contingent on the availability of funds.

What happens to the contract/award if there are insufficient funds?

Answer to question 72: **An award will not be made if funds are not available. Contract termination would follow process and requirements as outlined in the model contract.**

Question 73: P. 12 -Could you share details on the morbidity profiles of the Medicaid population in Rhode Island, e.g., ICD-10 codes?

Answer to question 73: **This data is not available at this time.**

Question 74: P. 12 -Successful bidders shall be required to cover: RIte Care, Rhody Health Partners and ACA eligible beneficiaries, with the exception of children in substitute care. All bidders shall include a proposal to serve children in substitute care in their submission.
Does winning the bid for RIte Care, Rhody Health Partners and ACA imply also winning the bid for children substitute care? Does winning the bid for children in substitute care imply also winning the bid for the other programs? Or can these decisions be taken independently (and how)?

Answer to question 74: **No, winning the bid for Rite Care, Rhody Health Partners and ACA does not guarantee an award for children in substitute care. The State reserves the right to award the children in substitute care population to one or more bidders. The bidder(s) who are awarded children in substitute care will also serve all other populations.**

Question 75: P. 14 -Can a bidder participate if it doesn't have NCQA rating?
Can alternative (international) quality ratings substitute / complement such rating

Answer to question 75: **Please see response to question 19**

Question 76: P. 15 - The EOHHS sees remaining opportunity for improvement.
What key improvements does the Executive Office see beyond the 10 goals set out in section 2.3 of the LoI?
What items were historically not satisfactory?

Answer to question 76: **Please refer to page 16 of the LOI for historical context.**

Question 77: P. 20 - CMS approval and support for the "transformation program".
By when is the approval by CMS due?
How will the program be impacted if such approval and support are not given?

Answer to question 77: **Approval is anticipated in Fall 2016. Stakeholders will be notified if such approval is not granted.**

Question 78: P. 21 - What are the expectations to the MCO in terms of management of patients that are already in nursing home facilities?

Answer to question 78: **The long term care nursing facility resident population is not included in this procurement.**

Question 79: P. 23 - Can you share more detail on the capabilities of the CurrentCare platform? What data points are included, incl. EMRs, prescription data?
What historical data is available? What percentage of currently enlisted patients show complete data sets? How is the currently enrolled 50% of the population split into plans, patient groups and morbidity compared to the overall population?

Answer to question 79: **Please refer to the following: http://www.currentcareri.org/**

Question 80: P. 23 -New specialized services included: What are the current costs and respective number of members associated with:

- Specialized programs for adults with serious mental illness
- Specialized home and community based services for individuals less than 21 years of age?

Answer to question 80:

Please see answer to Question 71 for members in OTP health home.

Please see answer to Question 69 for members in IHH health home.

Please note that since July 1, 2016 a member cannot be enrolled in both an OTP health home and an IHH health home. A member that is receiving substance abuse treatment and electing to receive health home services would need to choose one of the two health home.

Average distinct users of CEDARR services by month:

Service Month	RIte Care	SubCare	CSHCN	Expansion
Dec-15	799	60	1,151	8
Nov-15	807	61	1,163	6
Oct-15	813	61	1,165	5
Sep-15	826	61	1,173	4
Aug-15	827	67	1,183	4
Jul-15	838	73	1,183	4
Jun-15	862	81	1,189	2
May-15	850	75	1,189	3
Apr-15	856	79	1,183	2
Mar-15	843	76	1,184	3
Feb-15	804	71	1,184	3
Jan-15	811	77	1,191	3
Dec-14	797	75	1,187	1
Nov-14	823	76	1,192	1
Oct-14	848	84	1,196	1
Sep-14	859	79	1,204	2
Aug-14	861	94	1,203	2
Jul-14	881	95	1,213	1
Jun-14	881	99	1,221	1
May-14	871	92	1,201	1
Apr-14	865	92	1,182	1
Mar-14	852	84	1,186	1
Feb-14	832	78	1,172	1
Jan-14	841	83	1,183	

Please see Appendix A for PMPM impact of "OTP Health Home", "IHH and Other BH Services" and "CEDARR services" for the two rating periods.

Question 81: P. 25 - If not an HMO, the Bidder may be a health insurance entity licensed by DBR that meets certain requirements, including certification as a Health Plan. Can an international player also participate to the bidding process? By when must the certification as a Health Plan be obtained?

Answer to question 81: **Please see response to question 2 above**

Question 82: P. 30 -How is continuity of care between MCOs organized? Which billing / costs are charged to which MCO (before and after transition)?

Answer to question 82: **Please refer to Section 3.2.4.1 (Provider Network) which is addressed on pages 29 and 30 of the LOI. Continuity of care between MCO's will be addressed at the time of readiness reviews.**

Question 83: P. 30 - To ensure smooth transition from one MCO to another, is there a process for patient information transfer? Which patient information is transferred?

Answer to question 83: **Inter-plan transitions will be addressed at the time of readiness reviews with successful bidders.**

Question 84: P. 47 - Risk Share/Gain Share Methodology:
When should such alternative arrangements be discussed? In the Bid or can they also be discussed in a negotiation period after the bidding?

Answer to question 84:

The bidder may propose alternative risk arrangements in its bid.

The bidder should indicate whether or not their decision to execute the contract is contingent on the State's acceptance of the alternative risk arrangement as the State reserves the right to reject any alternative arrangement, in which case the State will consider the bid with the risk/gain share methodology included in LOI.

Question 85: P. 47 -In the calculation of Risk Share/Gain Share Methodology, do the Medical Expenses also include health plan Quality Improvement Initiatives as defined by the Affordable Care Act?

Answer to question 85:

Unless explicitly allowed by the State only direct care management expenditures can be included as an allowable medical expense for risk share claiming.

However, the State reserves the right to consider quality improvement initiatives that the health plan can demonstrate improve quality, transparency, and outcomes and support meaningful use of health information technology. 45 CFR § 158.150(b)(2)

Question 86: P.78- How are quality of care initiatives accounted for in costs? Are they included in medical costs or in admin costs in the capitation fees?

Answer to question 86: **Capitation reflects actual medical claims expenses and administrative expenses incurred by the two managed care plans participating in Medicaid managed care. Medical expenditures are adjusted to reflect any non-claim based medical expenditure included in the health plan's financials.**

Question 87: P. 88- Can you share details on how the state envisions to set capitation rates beyond 2018 until 2021 and then in the potential 5 year prolongation period?

Answer to question 87:

Rates will be set annually except when state legislation requires adjustments to rates.

Rates are to be actuarially certified in accordance with CMS rate setting guidelines.

Rates are based on the health plans historical experience trended to midpoint of rating period. E.g. the FY19 rates effective July 1, 2018 through June 30, 2019 would be based on the health plan's historical experience for FY17 (July 1, 2016 through June 2018), FY16, and FY15, trended to December 31, 2018.

Any adjustment to the established rating methodology will be subject to a contract amendment and be done in accordance with CMS rating guidelines and actuarial certification.

Question 88: Given the population and the program, what additional community based allied healthcare services (including mental health) fall underneath the scope of the program? For example, does the program support social workers to support children in foster homes?

Answer to question 88: **Please refer to the Model Contract**

Question 89: Does responding to the LOI pre-qualify the responders for an RFP to be released later? Or does EOHHS intend to award contracts to all applicants that meet required functional competencies?

Answer to question 89: **Awards will be made based on responses to this solicitation. The State reserves the right to award contracts to one or more of the respondents.**

Question 90: When do the current RI Medicaid managed care contracts expire? How many contracts are there, and what organizations hold the contracts? When were the contracts last awarded? What was the aggregate contract value?

Answer to question 90: **Current contracts expire June 30, 2017. There are currently two contracts. Neighborhood Health Plan of Rhode Island and United Healthcare Community Plan. New contracts were previously awarded in 2010. The aggregate contract value is $1.250 billion dollars.**

Question 91: Why is RI Medicaid rebidding the MCO contracts? Is this a straight rebid of the current RI Medicaid managed care contracts, or are there changes to the scope or reimbursement?

Answer to question 91: **The State is re-bidding the managed care contracts per the State purchasing rules and regulations. There are enhancements and new requirements in this procurement contract.**

Question 92: Is the requirement that all bidders include a proposal to serve children in substitute care a new requirement? The LOI states that the population of children in foster care are carved out of the MCO contracts; why is RI requiring bidders to include a proposal for serving an excluded population?

Answer to question 92: **Yes, all bidders must submit a proposal to serve children in substitute care. Children in substitute care are not excluded/carved out of this procurement.**

Question 93: How will the next contracts handle behavioral health integration? Are the current MCOs responsible for delivering behavioral health services? Will the next contracts require the MCOs to deliver behavioral health services?

Answer to question 93: **Please refer to the LOI requirements and the model contract**

Question 94: What entity will be responsible for the behavioral health RI Health Homes? Are the Health Homes carved in or out of the current contracts, and will they be carved in or out of the next MCO contracts?

Answer to question 94: **Please see response to question 93**

Question 95: Will the next MCO contracts have more value-based provisions that affect the capitated rate paid to the MCOs? Will they have more performance or value-based provisions that the MCOs must implement with their provider networks? Will new populations be added to the MCO responsibility?

Answer to question 95: **Please see response to question 93**

Question 96: Who can our readers contact for additional information about the RI EOHHS plans for its Medicaid managed care program?

Answer to question 96: **This is currently an active procurement all inquiries must be made according to the requirements contained within this LOI.**