ODJFS Question Reference #	Reference Provided by Questioner	Detailed Question / Clarification	Question Submitted By	ODJFS Response
93	General	Please confirm that the term “Applicant” as used in questions throughout all Appendices includes both the Applicant and the Applicant’s Corporate family.	Amerigroup Ohio, Inc.	As part of the application, the Applicant may provide information related to other members of the corporate family or partner, as applicable, unless specifically directed not to do so by an instruction in the RFA.
184	General	In the RFA will applicant companies be allowed to use medical experience outside of Ohio?	Catapult Capital Management, LLC	Yes.
61	General	Please indicate if the "data book" summarizing historical claim costs, utilization and membership for several years will be provided at a later date. Please indicate the expected timeframe.	Coventry Health Care, Inc.	A data book with population and historical claims experience information is planned for release. Timing is subject to review and approval of both CMS and ODJFS, but the data book will be released as soon as possible.
62	General	Please indicate if the premium rates are expected to be bid by individual MCOs or developed by state and CMS actuaries and offered for MCOs successfully selected for this procurement?	Coventry Health Care, Inc.	Premium rates will be developed and offered by CMS and ODJFS actuaries.
63	General	Please indicate the expected timeframe for premium rate release to the MCOs and expected turn-around time for MCOs to evaluate and accept the rate.	Coventry Health Care, Inc.	The methodology for capitation rate development is currently being discussed by CMS and ODJFS. More information will be provided to plans when it is available. Final rates will be shared with the selected applicants, but the rates will not be negotiated.
64	General	Please indicate if the benefit design will be allowed to be modified once premium rates become available.	Coventry Health Care, Inc.	Selected Applicants will not be allowed to eliminate the types or scope of services except as allowed in a final CMS approved program.
65	General	Please indicate if the actuarial soundness requirement applicable to rate development in Medicaid programs would be applicable for all components of the dual population rate development.	Coventry Health Care, Inc.	The methodology for capitation rate development is currently being discussed by CMS and ODJFS. More information will be provided to plans when it is available.
66	General	Please indicate if the actuarial certification of premium rates will be provided by CMS or state actuaries.	Coventry Health Care, Inc.	The methodology for capitation rate development is currently being discussed by CMS and ODJFS. More information will be provided to plans when it is available. It is our assumption that the Medicaid portion of the rate will be certified by the state actuary.
67	General	Please indicate if rate development process in development of the baseline overall costs before impact of managed care would include state and federal administrative costs in addition to claim costs for the dual population. Please indicate the range of these administrative percentages currently applicable to Medicaid and Medicare operations of dual programs. Please indicate their basis and sources.	Coventry Health Care, Inc.	The methodology for capitation rate development is currently being discussed by CMS and ODJFS. More information will be provided to plans when it is available.
68	General	Please indicate if the premium rate development process would allow for interim rate adjustments based on either Medicare or Medicaid program changes, such as fee schedule changes, benefits, coverage or enrollment program basis.	Coventry Health Care, Inc.	The methodology for capitation rate development is currently being discussed by CMS and ODJFS. More information will be provided to plans when it is available.
69	General	Please indicate how the provider contracting environment, fee schedule basis and applicability of default language would be considered in development of managed care savings factors. Please indicate if the cost basis before applying managed care savings factored in premium rates would include assumption of a 100% of Medicaid and Medicare fee schedules respectively.	Coventry Health Care, Inc.	The methodology for capitation rate development is currently being discussed by CMS and ODJFS. More information will be provided to plans when it is available.
141	General	Will the State provide its Preferred Drug list to interested bidders in an excel format so that formularies can be properly developed for approval by CMS?	Meridian	An excel file containing the state's preferred drug list will be posted in the RFA Applicant Library.

ODJFS Question Reference #	Reference Provided by Questioner	Detailed Question / Clarification	Question Submitted By	ODJFS Response
155	General	When ODJFS provides the RFA data book to prospective applicants, will you provide the following: summarized utilization and cost information for the Medicaid Medicare Enrollees (MMEs) eligible for the ICDS program by region, major service category (such as nursing home mix), and current delivery model (Medicaid/Medicare)? Could you elaborate on the types of information that will be provided to potential applicants?	UnitedHealthcare Community Plan	The planned data book will include summarized eligibility and experience data by region, major service category, and current delivery model.
156	General	Is ODJFS able to provide guidance as to when the capitation rates for the MME demonstration will be released?	UnitedHealthcare Community Plan	The methodology for capitation rate development is currently being discussed by CMS and ODJFS. More information will be provided to plans when it is available.
176	Main Text, III. B. Application Process, Essay Requirements, p 15 of 25	Please confirm, it would be our understanding that repeating the question would not be counted towards the word count and page limits?	Aetna	Repeating the question in an essay does count toward the word count. However, the selection team will have the questions when reviewing the essays; repetition of the question is unnecessary. Citing the appendix, page, section, and question number will not affect the word count and is expected.
178	Main Text, Section III.B.1.c -- Application Process: Mandatory Application Requirements, p 14 of 25	In light of the statement in Appendix A, Section 10, does "Applicant" include Applicant's corporate family in this context?	Aetna	Yes.
179	Main Text, Section 9.B -- Attestation/Acknowledgment, p. 3 of 5	In light of the statement in Appendix A, Section 10, does "Applicant" include Applicant's corporate family in this context?	Aetna	Yes.
181	Main text, Section III.B.1.h -- Application Process: Mandatory Application Requirements, p 15 of 25	Is a “Medicaid only” HIC certificate of authority an “appropriate Ohio Certificate of Authority”?	Aetna	Yes.

ODJFS Question Reference #	Reference Provided by Questioner	Detailed Question / Clarification	Question Submitted By	ODJFS Response
94	Main Text, RFA, III.B, p 15-16 of 25	RFA, III.B, pages 15 - 16 of 25: Please clarify the following related to the responses to Essay Requirement questions:* Please clarify that when specific questions include their own Essay Requirements, that the requirements of the question supersedes the requirements defined in the Base RFA on page 15 of 15, for example, while the essay requirements in the Base RFA stipulate double-spaced pages not to exceed an average of 250 words, the instructions in Question 13, Appendix D (Part A) allow that the essay should be single-spaced. Single spaced pages will provide for many more words per page than the 250 word count requirement.* Are graphics allowed, and how are they counted with respect to word count?* Are tables allowed, and if so, are there different type size/type face allowances? Can spacing be single in tables?* Please define the State's interpretation of "double spacing" in terms of the actual number of points from baseline to baseline.* Please define the official reference for word counting (for example, Microsoft Word highlighting of passage and use of MS Word "word count" function, or other official reference). If official reference is not specified, please indicate whether punctuation and spaces are counted; whether hyphenated words are counted as one or two words, whether line or paragraph breaks are counted as a word, etc.* Average words per essay page are limited to 250. Times New Roman, the required font, is a proportional font and double-spaced, as required, type with one-inch margins, as required, could generate well over 400 words per page (with an average of 5 letters per word). Even greater numbers of words per page could be created with single spaced quotations, as required, or with shorter average words. We encourage ODJFS to remove, or increase the word per page limit. If not, how should Applicants proceed if their essays exceed 250 words per page? Are Applicants allowed to Increase the margin layout and/or line spacing?	Amerigroup Ohio, Inc.	ODJFS will amend the terms of Appendix D question 13 on page 18 as that should state "double spaced." Use the MS Word count function. The requirements as set forth in this section, and the reasons for them, were derived generally from the 6th Circuit Court of Appeals rules of federal practice. ODJFS is aware that there are ways to fit many additional words on a page through the use of small fonts, kerning alterations, and margin adjustments. However, none of those are acceptable practices for the purpose of this RFA. Spacing and font requirements are intended to facilitate reading during the scoring process. If an Applicant exceeds the 250 words per page limit, or page limit requirements, or the other clearly stated requirements such as double spacing, margins, font or any other stated requirement, the essay will be rejected. Tables or graphics are allowed, but do not excuse the page or word limit, and words in graphics or tables will count towards the word limit.
95	Main Text, RFA, III.D, p 18 of 25	RFA, III.D on Application Scoring (page 18 of 25), 2nd paragraph, notes a number of application characteristics - "assumptions, insufficient detail, are poorly organized, have not been proofread, and contain unnecessary use of self-promotional claims will be evaluated accordingly." Please specify how these characteristics will affect scoring. What discretion do evaluators have to waive issues that are non-material? For example, will evaluators have discretion to waive an obvious typo or missing word or should Applicants assume that any errors can result in disqualification?	Amerigroup Ohio, Inc.	Evaluators will have discretion to waive typos, etc. However, poorly constructed essays are less effective at communicating important substance.
96	Main Text, RFA, I.E., p 5 of 25	RFA, I.E, page 5 of 25: Please confirm whether or not the required key in-state staffing positions must be fully dedicated to the ICDS program or if individuals can also be designated as key staff for CFC/ABD business for plans that currently serve the Ohio Medicaid program.	Amerigroup Ohio, Inc.	In-state positions can be designated to serve more than one program (i.e., ABD/CFC and ICDS) except for the LTSS/HCBS Director and the Care Management Director. These positions, which must be dedicated to the ICDS, may report to executive level staff whose responsibilities extend beyond the ICDS. Additionally applicants must have provider services representatives dedicated solely to ICDS providers.

ODJFS Question Reference #	Reference Provided by Questioner	Detailed Question / Clarification	Question Submitted By	ODJFS Response
97	Main Text, RFA, III. E, p 21 of 26	RFA, III.E, page 21 of 26: Within Section III.E at the top of page 21, it indicates “However, ODJFS reserves the right to vary from this methodology if necessary to complete the selection process.” Thus, ODJFS will use discretion in selection. Please specify the basis such discretion would be exercised (for example, will the methodology be based on best value or a different method). We believe that ODJFS has an obligation to communicate publically how it exercises any discretion and how it varies from its own pre-established scoring criteria.	Amerigroup Ohio, Inc.	ODJFS will communicate publicly if it exercises its discretion under this scenario.
98	Main Text, II. F, p 21-22 of 35	RFP, II.F, pages 21 - 22 of 25: Given that the RFA has limited the scope of potential protests, is there another administrative remedy that Applicants should seek, if appropriate, for issues out-of-scope?	Amerigroup Ohio, Inc.	No.
99	Main Text, RFA, III.G, p 22 of 25	RFA, III.G, page 22 of 25: ODJFS indicates that the "Selected Applicants will be required to demonstrate adequate provider capacity to meet the Medicare-Medicaid Panel Adequacy requirements for the region(s) for which they have applied." However, there is no information requested of Applicants to demonstrate Ohio Medicare-Medicaid panel adequacy. How will Respondents be evaluated to meet this critical requirement? What points will be assigned and how will this be evaluated? How will the State score this factor if there is no information provided by Respondents showing their network of providers?	Amerigroup Ohio, Inc.	This RFA process is not being used as a basis to evaluate the adequacy of provider networks. ODJFS and CMS will evaluate the adequacy of provider networks as part of the readiness reviews of selected health plans.
158	Main Text, Section I. E. Staffing Requirements - In State Positions, p 5	Per the RFA, the state has listed a number of required in-state positions. Can the state please clarify if the staffs that will be reporting to these managers also be expected to be in-state as well? As a national company, we have a few operational departments that are able to perform at an enterprise level, and thus, we allow staff to be located in their home state. This ensures that we are able to recruit the top talent for the work needed.	Anthem	Staff reporting to the in-state positions listed in the RFA are not required to be located in-state except for staff reporting to the LTSS/HCBS Director, Care Management Director, and Behavioral Health Director. It is expected that applicants will maintain a local workforce that is adequate to meet the needs of their members. Ohio will review and approve staffing plans prior to implementation of ICDS. Additionally, a significant portion of provider services representatives must also be located in Ohio.
159	Main text, III. B. Application Process, Section 3. Essay Requirements, p 16	The RFA states: " Page numbers may be placed in the margins, but no text may appear there." In order to ensure each page is clearly identified, may the health plan's name and/or logo be displayed in the header? May the section reference also be included in the footer?	Anthem	Yes, but substantive language will be counted against the word limit.
142	Main text, III.A. Definitions, p 13 of 25	Please consider expanding the definition of Participant-Directed Care to the following: A model for individuals receiving long-term services and supports that allow individuals greater choice and control along a continuum of hiring, firing, training, supervising, or paying independent providers. Individuals receiving participant-directed care have choice and control over the arrangement and provision of long-term services and supports. For purposes of this application, participant-directed care refers to 1) employer authority - enabling individuals to hire, dismiss, and supervise individual workers (e.g., persona care attendants and homemakers); and/or, 2) budget authority - provides participants with a flexible budget to purchase a range of goods and services to meet their needs.	Buckeye Community Health Plan	Specific decisions around all of the features of participant direction have not yet been established.
143	Main text, III.A. Definitions, p 13 of 25	Please consider adding geriatrics to the list of acceptable PCP specialty types in order to be consistent with the CMS definition of a PCP.	Buckeye Community Health Plan	Yes. For the purposes of completing Appendix B, Geriatrics is considered an "other specialized field" and may be included as a Primary Care/Specialty Care.

ODJFS Question Reference #	Reference Provided by Questioner	Detailed Question / Clarification	Question Submitted By	ODJFS Response
1	Main Text, III.A.Definitions, p 11 of 25	Upon review of the application on page 11 in the definition sections, Applicant is defined as a health plan that submits an application in response to this RFA. The Applicant must use its name as it appears on the license issued, or the licensure application currently under review by the Ohio Department of Insurance (ODI). Would this definition be used except where specifically mentioned "Corporate family and/or partner"? For example, appendix B, part I, page 1 of 13, "... may include the experience/compliance of the Applicant and/or any entity within its corporate family and/or a partner as defined in Section III.A of this RFA.".	Coventry Health Care, Inc.	As part of the application, the Applicant may provide information related to other members of the corporate family or partner, as applicable, unless specifically directed not to do so by an instruction in the RFA.
2	Main Text, II.A - procurement timeline, applicant inquiries and letter of intent, p 7 of 25	Will ODJFS push back the due date for the RFA response as a result of the delayed release of the RFA?	Coventry Health Care, Inc.	The due dates for the RFA will not be modified.
4	Main Text, I.B.ii, p 4	Please clarify intent of the statement, "Applicants are advised that Ohio's Demonstration Proposal to integrate care for Medicare-Medicaid enrollees submitted to CMS on April 2, 2012 is subject to approval and amendment by CMS and is incorporated herein, even to the extent that amendments are inconsistent with the initial proposal document." Confirm that Applicants would ultimately be held to the final, amendment version approved by CMS and not to the original 4/2/12 version if it is not the version ultimately approved by CMS.	Coventry Health Care, Inc.	Applicants will be held accountable to the final version as approved by CMS.
5	Main Text, III.B., p 14	Are references to 'applicant' throughout this section only intended to mean the applicant itself, or can information about the corporate family to the extent it is responsive be included instead?	Coventry Health Care, Inc.	As part of the application, the Applicant may provide information related to other members of the corporate family or partner, as applicable, unless specifically directed not to do so by an instruction in the RFA.
6	Main Text, III.B.1.a, p 14	If, due to an internal corporate change in decision-making around how to structure this product, the entity that submitted the NOIA to CMS by 4/2/12 is not the entity that we want to proceed with this RFA, is it possible to make that change and use the revised entity as the applicant herein if both companies are affiliates (in same corporate family)?	Coventry Health Care, Inc.	Issues relating to Notices of Intent are resolved by CMS. The Applicant should resolve questions with CMS on NOIA prior to submission of a response to the RFA.
7	Main Text, III.B.3, p15	Define "second business day following the day ODJFS returns the essay for correction." If returned Monday morning, would that count as the first business day, or would Tuesday be the first business day such that the response would be due on Wednesday?	Coventry Health Care, Inc.	In this example, the response would be due on Wednesday. See Ohio Revised Code 1.14.
8	Main Text, III.D, p 18	What criteria will be used for determining how many applicants will be selected for the NE Region?	Coventry Health Care, Inc.	The number of plans to be selected for each region, including the NE region, has already been determined. See RFA section III.E.
19	Main Text, III.A.Definitions, p 11	Does the "Applicant" include it's vendors and subcontractors? Can vendor or subcontractor experience be used if they have greater than 12 months of experience, even if it is not with the Applicant?	Coventry Health Care, Inc.	The "Applicant" must have had a contractual obligation to provide the service or function and must have provided the service, directly or by delegation or subcontract. Services provided by vendors or subcontractors that were not provided as a result of a contract with the Applicant are not considered part of an Applicant's experience.

ODJFS Question Reference #	Reference Provided by Questioner	Detailed Question / Clarification	Question Submitted By	ODJFS Response
48	Main Text, RFA: III.B.1.c Appendix A: 9B. Attestation/Acknowledgment, p 14, App. A:3	In this context regarding maintaining an approved Medicare Advantage Plan contract with CMS in at least one state, is Applicant strictly the entity submitting the application or is the Applicant's Corporate Family acceptable for maintaining an MA Plan contract in at least one state? Also, please confirm that Medicare Advantage Plan can be any type (e.g. HMO, PPO, SNP).	Coventry Health Care, Inc.	As part of the application, the Applicant may provide information related to other members of the corporate family or partner, as applicable, unless specifically directed not to do so by an instruction in the RFA. Yes, the Medicare Advantage Care Plan can be any type.
50	Main Text, RFA: II.A Appendix A: 9C, p 14, App.A: 3	Please confirm that it is acceptable for the CMS Notice of Intent to Apply submission to have used a Corporate Family name rather than the Applicant's name.	Coventry Health Care, Inc.	Issues relating to Notices of Intent are resolved by CMS. The Applicant should resolve questions with CMS on NOIA prior to submission of a response to the RFA. This includes whether or not one letter of intent presents the Applicant with an opportunity to apply.
131	Main Text, III. A., Definitions, p 13	For the term "partner," provide the legal citation to the definition of contractual partnership under the laws of the State of Ohio.	Molina Healthcare of Ohio	Applicants must submit a written instrument documenting the working relationship between the parties claiming to be partners.
72	Main Text, III.A., p 13	The RFA defines "partner" as "[a]n entity with which the Applicant has a contractual partnership as defined under the laws of the State of Ohio." Is ODJFS referring to a collaboration between two parties memorialized by a formal written agreement or is ODJFS referring to the partnership form of entity as set forth in the Ohio Uniform Partnership Act, Chapter 1776, Ohio Revised Code?)?	WellCare of Ohio, Inc.	Applicants must submit a written instrument documenting the working relationship between the parties claiming to be partners.
180	Appendix A, Section 10 -- Attestation/Acknowledgment, p. 4 of 5	Does this provision control Section III.B.1.c of the Forepart and Section 9.B of Appendix A, so that Applicant may respond to the RFA if a member of its corporate family maintains a currently approved Medicare Advantage (MA) Plan contract with CMS in at least one state?	Aetna	Yes.
182	Appendix A, Section 9.E -- Attestation/Acknowledgment, p. 3 of 5	Is a “Medicaid only” HIC certificate of authority an “appropriate Ohio Certificate of Authority”?	Aetna	Yes.
160	Appendix A, Applicant Information & Attestation Acknowledgement, p 5	For item 11, the RFA states "Applicants must provide the name, company, address, phone number, fax number and email address for all individuals who participated in or provided information used to complete this application. Please attach additional pages if necessary." Please explain the scope of this requirement. Does this apply to any health plan staff member who provided any amount of information related to the health plan's proposal? Does this also apply to project managers who organize internal proposal development meetings? Depending on how this requirement is defined, there is the possibility to submit attestations for a significant number of individuals.	Anthem	Appendix A will be amended to clarify this requirement.
149	Exhibit B-1 - Item 10, 11, 12, 13, 14, p 1 of 1	There appears to be a typo for item 10 where 10% reduction is reflected. All other sanctions which are of the same severity reflect a 30% reduction.	Buckeye Community Health Plan	Corrections to Appendix B have been made and will be posted to the website dedicated to this RFA.
9	Appendix A, # 9, p 2-4	Are references to 'applicant' throughout this section only intended to mean the applicant itself, or can information about the corporate family to the extent it is responsive be included instead?	Coventry Health Care, Inc.	As part of the application, the Applicant may provide information related to other members of the corporate family or partner, as applicable, unless specifically directed not to do so by an instruction in the RFA.
10	Appendix A, # 11, p 5	What is the purpose of # 11? Do applicants need to identify individuals who provided administrative support (typing, formatting, etc) or just substantive information?	Coventry Health Care, Inc.	Appendix A will be amended to clarify this requirement.
132	Appendix A, Statement 10, p 4	If multiple Applicants have a partnership with the same entity, may all such Applicants submit the entity's information? If yes, will the full amount of points be available to each Applicant?	Molina Healthcare of Ohio	Yes

ODJFS Question Reference #	Reference Provided by Questioner	Detailed Question / Clarification	Question Submitted By	ODJFS Response
73	Appendix A, Section 10, p 4	This section of Appendix A requires the Applicant to submit a letter that specifies any information on the Application from other entities with which the Applicant is or was in a partnership. Is ODJFS looking only for those entities with which the Applicant has established a formal partnership entity under the Ohio Uniform Partnership Act or entities with which the Applicant has entered a formal contract for the provision of services? This is related to our more general question above regarding the definition of "Partner" in the RFA, but we would also like to clarify whether the term has the same meaning in this section.	WellCare of Ohio, Inc.	Applicants must submit a written instrument documenting the working relationship between the parties claiming to be partners.
100	Appendix B	Appendix B, Parts I and II: Appendix B.II assigns scoring for in-state Ohio experience. The scoring methodology allocates 7,500 points for each region to plans that provide services in the commercial line of business for all counties in that region. Thus, the methodology awards or 37.5 percent of the Appendix B score for commercial experience. Such experience has little relevance to management of the complex co-morbid conditions typically found in the dual eligible population. Conversely, Appendix B.I awards 'coverage' points for LTC Institutional and HCBS services experience held by a plan in any state. LTC Institutional services represent a total of 500 points if the plan in question provided the services for all three years. HCBS services (note: referred to as LTSS on Exhibit B-1) represent a similar points allocation. A total of 1,000 points is available between these two categories. This represents 5 percent of the total Appendix B score, for experience that is of significantly greater relevance and importance to the needs of dual eligibles. The difference is stark: 5 percent of the points for relevant experience; 37.5 percent of the points for irrelevant experience. In light of this obvious imbalance in the scoring, would the State consider revising the Appendix B scoring methodology to consider the significant and relevant experience of health plans that are already serving the complex needs of dual eligible beneficiaries of other markets by giving LTC experience at least the same number of possible points as commercial experience in Appendix B?	Amerigroup Ohio, Inc.	Weighting and score values are provided for LTSS in other Appendices of the RFA.
101	Appendix B	Please clarify the following regarding Appendix B, Item 9, page 3 of 13:* Please clarify the type of NCQA accreditations that are permitted to be included in Item 9 of Appendix B. Is this limited to Health Plan accreditation or are other program accreditations acceptable?* Please confirm that in order for an Applicant to report an accreditation under Item 9 of Appendix B, that the accreditation must be held by the entity whose experience is being reported on that specific form.	Amerigroup Ohio, Inc.	Accreditation that is reported under Item 9 must be held by an entity whose experience is being reported on that specific form. Only NCQA health plan accreditation may be reported.
102	Appendix B, p 2 of 13	In Appendix B, Item 4 (page 2 of 13) please clarify the following regarding “providing services:” Will the State please confirm that if an Applicant manages any or all of these benefits or services that it should check “Yes” in the appropriate line items.	Amerigroup Ohio, Inc.	No.
103	Appendix B, p 1 of 13	Appendix B, page 1 of 13: Please confirm that if an Applicant and its Corporate Family operates Medicare and/or Medicaid lines of business in five or more states that it must submit a total of five forms (For example, Applicants are not permitted to submit fewer than five forms if they offer those lines of business in at least five states).	Amerigroup Ohio, Inc.	If the Applicant provides Medicaid and/or Medicare services in five or more states then the Applicant must submit experience from five states.

ODJFS Question Reference #	Reference Provided by Questioner	Detailed Question / Clarification	Question Submitted By	ODJFS Response
104	Appendix B	Appendix B, Part One focuses on Medicare and Medicaid. Part Two focuses on Medicare Advantage, Medicaid and Commercial. Does ODJFS consider Medicare Special Needs Plans part of Medicare or Medicare Advantage or both?	Amerigroup Ohio, Inc.	Special Needs Plans are also Medicare Advantage Plans and may be reported in that column only.
105	Appendix B, Exhibit B-1	Exhibit B-1 illustrates how ODJFS will score the "Applicant Contract/Compliance Experience Forms" LTSS (Long Term Support and Services) is listed as being worth 10 percent of the points, on Exhibit B-1. Where as, Appendix B on the Applicant Contract/Compliance Form, LTSS is replaced with, "HCBS" (Home and Community Based Services). While these two terms, LTSS and HCBS, refer to similar types of services, there is a significant difference; LTSS specifically includes care provided in institutions, while HCBS specifically excludes care provided by a long-term nursing facility. Please clarify the type of experience, LTSS or HCBS, which is eligible for up to 10 percent of the points on Exhibit B-1.	Amerigroup Ohio, Inc.	Exhibit B-1 has been corrected and will be posted to the website dedicated to this RFP.
106	Appendix B, p 2 of 13	Appendix B, Item 3, page 2 of 13. Both the Appendix B form (starting on page 5 of 13) and Exhibit B-1 illustrates three calendar years - 2009, 2010, 2011. The instructions reference four years - 2008, 2009, 2010, 2011. Please confirm which is correct and supply an updated form if four contract years are required to be reported.	Amerigroup Ohio, Inc.	Corrections to Appendix B have been made and will be posted to the website dedicated to this RFP.
107	Appendix B, p 10 of 13	Appendix B Scoring Methodology, Part I, Step 1, Number 3 on page 10 of 13. The requirement for Item 6 states that “for each calendar year, the member months reported for the three lines of business (i.e. Medicaid, Medicare, and Medicare-Medicaid) are totaled. If this total is less than 36,000 Member Months then zero points will be given for that particular calendar year.” Please clarify the following regarding this requirement:* The RFA instruction above (Number 2) refers to “three lines of business”. Please clarify what this means. The Exhibit B form (see page 5 of 13) has only Medicare and Medicaid, NOT Medicare-Medicaid. Was there an intent to include a “Medicare-Medicaid” line of business plans who served duals? Please clarify.* Please verify our understanding that the State’s scoring methodology will be as follows: to ADD the Medicare member months to the Medicaid member months for EACH year, then compare THAT total against 36,000. Also, if the Applicant does not meet this threshold, will evaluators throw out the form and apply zero points for the forms.	Amerigroup Ohio, Inc.	Corrections to Appendix B have been made and will be posted to the website dedicated to this RFP.

ODJFS Question Reference #	Reference Provided by Questioner	Detailed Question / Clarification	Question Submitted By	ODJFS Response
108	Appendix B, Exhibits B-1 and B-2	Exhibits B-1 and B-2: Please clarify the following:* Is the intent of ODJFS to weight experience with Medicare 50 percent more than experience with Medicaid in the calculation of Scoring Appendix B? Given the type of population to be served by the ICDS program, it seems disproportionate to value Medicare Advantage experience so much more than Medicaid plans that have extensive experience managing complex populations.* Additionally, the scoring values included in Appendix B-1 and B-2 appears to value Medicare Advantage experience equally with Medicare Special Needs Plan experience. Is it ODJFS intent to score experience with each of these populations the same? Plans serving Special Needs Populations today would appear to have much more relevant experience and are likely already coordinating dual-eligible care across Medicare and Medicaid. Will ODJFS consider revising these weights to provide greater weight to Medicare SNP experience vs. Medicare Advantage experience?	Amerigroup Ohio, Inc.	The scoring methodology is set forth in Appendix B of this RFA. ODJFS will not revise the scoring methodology for Appendix B because the requirements around service delivery and care coordination for SNPs vary from state to state.
161	Appendix B, Part I: Statewide Experience, Item 4: Coverage & Line of Business, p 2-3	If an applicant provides a service via a subcontractor, can the applicant check "yes" for that service? For instance, if an applicant subcontracts to a DME vendor, can the applicant mark "yes" for DME?	Anthem	If the Applicant was under contract with the payor to provide the service to its consumers then experience of subcontracts and delegated entities for that service may be reported.
162	Appendix B, Part I: Statewide Experience, Item 4: Coverage & Line of Business, p 2-3	The RFA states: "If the Applicant provided services during the identified calendar year under contract for any of the following lines of business (i.e. Medicaid, Medicare) then check the appropriate box..." For Behavioral Health, the RFA also clarifies this to mean 'providing access to mental health and substance abuse services including, but not limited to, acute/sub-acute psychiatric inpatient, medication management, day/residential rehabilitation, intensive outpatient, day treatment, partial hospitalization, crisis stabilization, opioid maintenance therapy." Please clarify the wording "Providing access to mental health and substance abuse services". If health plans currently coordinate behavioral health services (such as with county mental health departments), can they check the box? Or, can health plans only check the box if behavioral health services are included in the health plan's capitation payment?	Anthem	Applicants may only check the box for behavioral health services if it was under contract to provide and received payment for providing behavioral health services.
163	Appendix B, Part I: Statewide Experience, Item 4: Coverage & Line of Business, p 2	The directions indicate that applicants should list their Medicaid and Medicare lines of business in each reported state for Item 4. Please confirm that this means Applicants should include all member months, including the member months of all subsidiaries of the Applicant and the Applicant's parent company, that meet the Medicaid and Medicare definitions in the RFA.	Anthem	Yes.
164	Appendix B, Part I: Statewide Experience, Item 4: Coverage & Line of Business, p 3	The RFA defines HCBS as "Home- and Community-Based Services (HCBS): A range of home and community services and supports designed to meet an individual's medical, personal and safety needs as an alternative to long term nursing facility care to enable a person to live as independently as possible." Based on this definition, can Applicants assume that HCBS includes any service a health plan might have provided that meets this definition (excluding home health which is defined separately)? For example, if a health plan provided supplemental benefits such as respite care, or nutritional services or adaptive equipment, then can the Applicant check the box for HCBS?	Anthem	A range of services is required to meet this element; a single service such as respite or nutritional services or adaptive equipment is not adequate to meet the definition in Appendix B.

ODJFS Question Reference #	Reference Provided by Questioner	Detailed Question / Clarification	Question Submitted By	ODJFS Response
146	Appendix B - Instructions - Item 3, p 2 of 13	The instructions include reporting CY 2008 results, but the form begins with CY 2009.	Buckeye Community Health Plan	Corrections to Appendix B have been made and will be posted to the website dedicated to this RFP.
147	Appendix B - Item 2, p 5 of 13	Please consider adding the plan name(s) along with the name of the State being reported.	Buckeye Community Health Plan	Corrections to Appendix B have been made and will be posted to the website dedicated to this RFP.
148	Appendix B - Item 5, p 6 of 13	Item 5 indicates whether or not ABD consumers have been served, but doesn't seem to factor that item into the scoring.	Buckeye Community Health Plan	Corrections to Appendix B have been made and will be posted to website dedicated to this RFA.
135	Appendix B, Part I, Statewide Experience, Item #2, p 2 of 13	May experience with providing Medicaid managed care services in one of the U.S. Territories be included in Appendix B?	CareSource	No
136	Appendix B, Part I, Statewide Experience, Item #5, p 3 of 13	ABD Medicaid experience is asked for when completing the Contract/Compliance Experience Form, but is not included in the scoring methodology. Was this an oversight?	CareSource	Corrections to Appendix B have been made and will be posted to website dedicated to this RFA
137	Appendix B, Part I, Administrative Expense Ratio, Item #7, p 3 of 13	Does this mean that expenses currently sitting in administrative, e.g. salary expenses for medical departments, i.e. quality improvement, medical management, etc.; that a portion of staff time and salary directly related to improving health quality should be allocated to medical instead of administrative? Is this consistent with the NAIC definition of MLR?	CareSource	Please refer to item #7 of Appendix B which clearly outlines Ohio's definition of the Administration Expense Ratio related to the ICDS RFA.
138	Appendix B, Exhibit B-1, Total Points Allowed, List under #5	Under the list of services for Item 5 it appears that "LTSS" should be "HCBS". Is this correct?	CareSource	Corrections to Appendix B have been made and will be posted to the website dedicated to this RFP.
11	Appendix B, Item 4, p 2	Does Medicaid include SCHIP? Can applicants report on contracts that include both Title XIX and XXI populations?	Coventry Health Care, Inc.	Medicaid includes SCHIP enrollees only in a Medicaid expansion program. Medicaid does not include SCHIP enrollees in a separate child health program. Therefore, Applicants should not include SCHIP experience with a separate/stand-alone child health program. See 42 CFR 457.70 for more information.
12	Appendix B, Item 9, p. 3	Will URAC or AAAHC accreditation be considered?	Coventry Health Care, Inc.	No, URAC or AAAHC accreditation will not be considered.
13	Appendix B, Item 10 & 12, p 4	Explain what is intended by "proposed" - state contracts may include these types of sanctions, among others, as types of recourse that are available to a state to use. In seeking resolution of an alleged issue, states may speak generally to their rights under such contracts without specifying revocation of a license or termination of a contract. In many cases, the issues are promptly resolved to the satisfaction of the state agency. What specific scenarios must be disclosed here? Can a threshold dollar amount in controversy or other limitation be set?	Coventry Health Care, Inc.	Revisions have been made to the instructions for Item 10 to better reflect the formal nature of such a proposed termination. The changes will be posted on the website dedicated to the RFA.
14	Appendix B, B-1	Will any preference be given to Ohio domiciled companies?	Coventry Health Care, Inc.	In accordance with the scoring methodology, no additional points are awarded in Appendix B, Part B-1 for Ohio specific operations.
49	Appendix B Part II, p 8	For this section, is Applicant strictly the entity submitting the application or is the Applicant's Corporate Family acceptable for regional experience?	Coventry Health Care, Inc.	As part of the application, the Applicant may provide information related to other members of the corporate family or partner, as applicable, unless specifically directed not to do so by an instruction in the RFA.

ODJFS Question Reference #	Reference Provided by Questioner	Detailed Question / Clarification	Question Submitted By	ODJFS Response
59	Appendix B, p 3 of 25	Appendix B, Item 3 on Page 2, should the example of months include the first 3 months for 2012?	Coventry Health Care, Inc.	Applicants are required to report all requested experience irrespective of whether an item may or may not receive a score. In the case of member months, the Appendix B application requires Applicants to report experience for calendar years 2009, 2010, and 2011.
70	Appendix B, Exhibit B-1	For the total member months to be scored, is total member months a combination of the total for Medicare and Medicaid member months?	Coventry Health Care, Inc.	The total member months being reported should be reflective of all business lines being reported on the form (i.e Medicaid and Medicare). This is a correction to the instructions in Appendix B, page 3.
71	Appendix B, part I, p 6 of 13	In Appendix B, part I, for items 8 and 9, can the information be reflective of either the Medicare or Medicaid program? As this is to be filled out by state, the answers may be different for each program.	Coventry Health Care, Inc.	Portions of the form require the Applicant to make a distinction between Medicaid and Medicare (e.g. Items 4, 6, and 7). In the case of items that do not request specific information about one business line or another the Applicant should combine information in order to respond to the item. For example, Item 3 is a combination of all Medicaid and Medicare member months being reported on the form and Item 9 should be marked if any one health plan's experience being reported on the form obtained NCQA accreditation.
140	Appendix B, Part II	This element states that applicants must have experience as of April 1, 2012 for the regions to which they apply. Will the state modify this date, or update the requirement, to enable winning applicants of the Medicaid RFA to be eligible, if they can demonstrate ability in other required elements of (RFA)#: JFSR1213078038?	Meridian	Appendix B, Part II is related solely to scoring the RFA. If an Applicant receives an award under this RFA, it must successfully complete readiness review.
129	Appendix B, C, D, E, F	In which Appendices are we not allowed and/or will points be deducted if we use an affiliate or member of the corporate family?	Molina Healthcare of Ohio	As part of the application, the Applicant may provide information related to other members of the corporate family or partner, as applicable, unless specifically directed not to do so by an instruction in the RFA.
130	Appendix B, C, D, E, F	In which Appendices are we not allowed and/or will points be deducted if we use a partner?	Molina Healthcare of Ohio	As part of the application, the Applicant may provide information related to other members of the corporate family or partner, as applicable, unless specifically directed not to do so by an instruction in the RFA.
134	Appendix B, Exhibit B-1, item #5	Appendix B - Applicant Statewide Contract/Compliance Experience Form items do not agree to items numbers 3,4,5 on Exhibit B-1: will Exhibit B-1 be corrected?	Molina Healthcare of Ohio	Corrections to Appendix B have been made and will be posted to the website dedicated to this RFP.
74	Appendix B, Part 1: Statewide Experience, p 2	Coverage and Line of Business: If an Applicant provides a portion of services listed within a definition (e.g., dental exams but not orthodontia), should the box be checked?	WellCare of Ohio, Inc.	No. The service being rendered must include all the core services listed in the definition.
75	Appendix B, Part 1: Statewide Experience, p 2	Coverage and Line of Business: If an Applicant has 12 months of experience for one LOB and 11 months for the other LOB in a given year for the same state, how should the months of experience be reported on the form?	WellCare of Ohio, Inc.	The Applicant should report the longest length of experience of all the experience being reported on the form. In the case of the example that was provided in the question, the Applicant would report 12 months since it had a relevant line of business operating for 12 months.
76	p. 6	Is an Applicant awarded additional points for indicating ABD experience for a State/Line of business? We do not see the ABD check box addressed in the scoring methodology.	WellCare of Ohio, Inc.	Yes. The error has been corrected and will be posted to the website dedicated to this RFA.

ODJFS Question Reference #	Reference Provided by Questioner	Detailed Question / Clarification	Question Submitted By	ODJFS Response
77	Appendix B, Part II, p 12	Is Medicare Part D membership included in the definition of Medicare Advantage and applicable to Appendix B Part II?	WellCare of Ohio, Inc.	A plan that does not include all of Part A (Hospital Insurance) and Part B (Medical Insurance) coverage is not a Medicare Advantage Plan. Medicare Advantage Plans may offer extra coverage, such as vision, hearing, dental, and/or health and wellness programs. Most include Medicare prescription drug coverage (Part D). Part D membership alone is not adequate to respond to Appendix B, Part II.
79	Appendix B, Item 7, p 6	Appendix B Item 7 administrative expense ratio. The sales costs associated with the smaller Medicare membership product line may significantly increase your overall administrative expense ratio? Should we remove sales costs associated with the Medicare product line to report administrative costs? This will help create a more accurate reflection of the cost to administer the dual program.	WellCare of Ohio, Inc.	Expenses related to sales activities should be treated as administration expenses for the purpose of computing the Administration Expense Ratio as defined in item #7 of Appendix B.
80	Appendix B, Exhibit B-2	Exhibit B-2. In the examples in Exhibit B-2 it would appear that the Applicant with multi state experience (example 2) and higher member months scores lower than the Applicant with single State experience (example 1) . Why would an Applicant with higher member months and multi state experience score lower than the Applicant with lower member months and single state experience in Appendix B? In part 1 of the Appendix B scoring methodology (page 10 of 13) ODJFS indicates that forms will be combined by multiplying individual state form scores by a set factor to derive a single score for the Applicant." What is the "factor" ODJFS will be using in this case, and why does it seem to penalize plans with multi-State experience?	WellCare of Ohio, Inc.	The experience sought in appendix B is not based solely on aggregate member months. The examples are demonstrative of how the weighting works. ODJFS would expect that most Applicants will be reporting experience from multiple states. See number 3 in "Step 2" on page 11 for the multiplier factor.
91	Appendix B	In Appendix B, ODJFS asks applicants to report up to 5 States that reflect combined information regarding Medicaid and Medicare. The applicant is able to answer this question using the experience of the Applicant, any entity within the corporate family, and /or a partner. In other Appendices ,such as Appendix C, ODJFS asks only the "Applicant" to report experience. The RFA instructions in Appendix C however, then direct the Applicant back to the state reported in Appendix B with the largest number of member months. There may be States reported in Appendix B that are part of the corporate family or partner and are not part of the "Applicant" experience. The same topic is relevant to Appendix E, in that ODJFS is directing plans to use "Applicant" experience, but the Grid on page 2 of 6 - directs applicants to a State or LOB reported in Appendix B (which may contain more than just the Applicant experience). Can ODJFS clarify that we can use all reported experience in Appendix B to answer questions in the remaining appendices?	WellCare of Ohio, Inc.	Appendices C, D, E and F all draw from answers provided in Appendix B, so page 1, paragraph 1 of Appendix B applies. As part of the application, the Applicant may provide information related to other members of the corporate family or partner, as applicable, unless specifically directed not to do so by an instruction in the RFA.
78	Appendix B, Items 11-14. p. 7 of 13	If an Applicant has a regulatory action for one line of business, but not the other, how should this distinction be made, so that the evaluation penalty does not get applied to both lines of business?	WellCare of Ohio, Inc.	Even if multiple boxes are checked, the score shall only be reduced once by 30%.

ODJFS Question Reference #	Reference Provided by Questioner	Detailed Question / Clarification	Question Submitted By	ODJFS Response
109	Appendix C, p. 1-3, and 9-11	Appendix C: Medicare Advantage HMO/PPO and SNP HEDIS Scoring - Comparability of 19 versus 24 measures (pages 1-3 and 9-11): Depending on whether the Applicant had only a Medicare Advantage HMO/PPO or a Medicare Advantage HMO/PPO and a Medicare SNP in the given state, the RFA instructs the Applicant to submit either 19 or 24 HEDIS/CAHPS results, respectively, for Section I.a. In the scoring methodology, the score obtained for 24 measures is pro-rated by the ratio 19/24 to obtain comparability to scores for 19 measures. However, this pro-rating scheme is correct only for full-scale scores; that is, where the Applicant achieves a maximum score for every measure. For the full scale score, a plan that has 19 measures achieving the maximum 750 points per measure will receive 14,250 points. A plan that has 24 measures achieving the maximum 750 points per measure will receive 18,000 points, which when pro-rated by the factor of 19/24, will also receive 14,250 points. However, because of the differences in scoring levels assigned for various HEDIS measures, the pro-rating scheme does not translate correctly to anything less than full-scale scoring. Here are two examples that demonstrate the issues in the methodology. Example 1: Consider a plan that achieves level 2 scores for all measures, but was only a MA plan, not MA-SNP. They receive a score as follows: (1 x 350) + (18 x 300) = 5,750 points. Suppose another MA plan has MA-SNP also, and achieves level 2 scores for all measures. They receive a score as follows:((5 x 350) + (19 X 300)) X 19/24 [pro-rating factor] = 5,897 points. The difference is 147 points; thus, the scores are not comparable. Example 2: A similar scenario exists if the compared plans each achieve all level 3 scores. (1 x 550) + (18 x 450) = 8,650 points. ((5 x 550) + (19 x 450)) x 19/24 = 8,946 points (rounded). The difference is almost 300 points; the scores are not comparable. Conclusion and Recommendation: The scores differ because the number of levels for the different HEDIS/CAHPS measures do not correspond; some have five levels; others have six. While the design of the scoring might have attempted to minimize this through assignment of the points for each level, the result of pro-rating the 24 factors is not correct for anything less than full scale. One alternative is to equalize the number of levels used to score each measure; this may be difficult because of attempting to build correspondence to HEDIS percentile groups. Another is to make the factoring method mathematically correct; that is, to address the imbalance in the number of levels by using different factors to pro-rate each of the two groups of levels. This would be done by multiplying the total of the 5-level scores by 1/5 and adding that to the multiplication of the total of the 6-level scores by 18/19. However, this method does discriminate against the 5-level measures in the total, which might or might not be appropriate. Would ODJFS consider revising the scoring methodology to address this imbalance by one of these methods or another alternative that simplifies the scoring methodology?	Amerigroup Ohio, Inc.	ODJFS has revised the scoring methodology to increase the value of the five Medicare SNP measures and has eliminated the pro-rating methodology.
110	Appendix C	Appendix C Scoring includes no value or assessment of an Applicant's experience with the management of a quality program for LTSS or HCBS. Given the importance of quality program for this fragile population, would ODJFS consider revising the Appendix to include a third component for Applicant's to describe the process and quality metrics they would use for improving the life experience and independent living for the long-term services and supports population.	Amerigroup Ohio, Inc.	The topics for the structured quality improvement initiatives in Section II of Appendix C will not be revised.
111	Appendix C, Section I.a, p 1 of 24	Appendix C, Section I.a, page 1 of 24: Instructions for Completing Section I.a (1) states the following: "Reported HEDIS results must be the final, auditor-locked version reported to NCQA's Interactive Data Submission System (IDSS). Reported Consumer Assessment of Healthcare Providers and Systems (CAHPS) results must be generated from the final data sets submitted to NCQA's IDSS."* Will the State utilize the National Committee for Quality Assurance (NCQA) Quality Compass website and tool to verify that the HEDIS and CAHPS results submitted by each Applicant in I.a and I.b of this section are the final, auditor-locked version reported to NCQA's IDSS tool? * If not, what verification process will the Participating Plan Selection Team (PPST) utilize to validate the results submitted by each Applicant?	Amerigroup Ohio, Inc.	Applicants will be required to submit the final, auditor-locked IDSS data-filled workbook and audit designation table for self-reported audited HEDIS data<u>and</u> the NCQA HEDIS Survey Results Report as downloaded from NCQA's IDSS for CAHPS results for each set of HEDIS results reported for Appendix C.

ODJFS Question Reference #	Reference Provided by Questioner	Detailed Question / Clarification	Question Submitted By	ODJFS Response
112	Appendix C, Sections I.a and I.b, Measure #24	Appendix C, Sections I.a and I.b, Measure #24: While NCQA audited results publishes the Rating of Health Plan CAHPS results as a "percentage", it appears the RFA is requesting Applicants to report the 2-digit NCQA "mean point score" in both set of instructions for Sections I.a and I.b of Appendix C. Furthermore, within the standard reporting from "auditor locked version reported to NCQA's IDSS," the reported results represent percentage vs. a mean point score. Will ODJFS please consider using a percentage for reporting CAHPS scores in Measure #24 (vs. a mean point score)?	Amerigroup Ohio, Inc.	Applicants will be required to submit the NCQA HEDIS Survey Results Report for CAHPS results for each set of HEDIS results reported in Appendix C. Applicants will be evaluated based on the three point mean scores in the NCQA HEDIS Survey Results Report.
113	Appendix C: Section II, p 6 of 24	Appendix C: Section II, page 6 of 24: The instructions within Appendix C (Structured Quality Improvement Initiatives) state that "initiatives may have been implemented ….within the timeframes of CY 2010 and CY 2012" and further, "An initiative may have been initiated prior to but no later than CY 2010…" Please confirm that any initiative that has been implemented before CY 2012 is acceptable to report as long as there is sufficient time since implementation to evaluate the results of the initiative.	Amerigroup Ohio, Inc.	The reported structured quality improvement initiatives must have been operational at some point between CY 2010 and CY 2012, but may have started prior to CY 2010. The initiatives may have been initiated prior to but no later than CY 2010.
114	Appendix C, Section II.d, p 7 of 24	Appendix C, Section II.d, page 7 of 24. "The Applicant must present evidence that any reported improvement can be attributed to the initiative and represents true improvement. Real changes must result in sustained improvements over time." Please clarify what additional evidence would be required as acceptable proof of "true improvement" other than the defined criteria of sustained and statistically significant improvement measured over time?	Amerigroup Ohio, Inc.	Please see *Scoring Methodology* for section II, at the end of Appendix C for a description of the scoring methods for structured quality improvement initiatives.
115	Appendix C: Section 1.b(2), p 4 of 24	Appendix C: Section 1.b(2), page 4 of 24: Please clarify that the second sentence of paragraph (2) under the instructions for Completing Section 1b should read, "In addition, the reported HEDIS measures must represent Medicaid populations within one of the reported States for which the Applicant provided managed care services as referenced in Appendix B.	Amerigroup Ohio, Inc.	Yes. The language in Appendix C will be revised and the revised Appendix C will be published on the website dedicated to this RFA.
116	Appendix C: Section 1.b, p 12	Appendix C: Section 1.b, page 12: The Scoring table lists "1 through 5" for the highest five measures which is also consistent with the instructions under item (2). However, the table header in the first column is labeled "Top Ten Highest Scores." Please clarify which table header is correct.	Amerigroup Ohio, Inc.	Yes. The header column will be corrected and revised and the revised Appendix C will be published on the website dedicated to this RFA.
117	Appendix C, Scoring Medicaid Measure #9, p 5 of 24	Appendix C, page 5 of 24: In the Appendix C Scoring Medicaid Measure #9, "Cholesterol Management for Patients with Cardiovascular Disease," there are irregularities in the values associated with Levels 0 through Level 2. Level 0 awards no points for values between 0.0 and 42.7 but Level 1 awards points for values between 29.0 and 42.8. Similarly, Level 2 awards points for values between 28.9 and 43.9. Yet, most of the values that are awarded points in Level 1 and Level 2 are also in the scoring range for Level 0. Please clarify the appropriate scoring for this metric.	Amerigroup Ohio, Inc.	The *Appendix C Scoring Key: Appendix 1.b.* will be revised and published on the website dedicated to this RFA.

ODJFS Question Reference #	Reference Provided by Questioner	Detailed Question / Clarification	Question Submitted By	ODJFS Response
165	Appendix C, Section I: Healthcare Effectiveness Data and Information Set (HEDIS) Results, p 1	In Section I.a, Item 3, the RFA states "If the Applicant was both a Medicare Advantage HMO/PPO and a Medicare SNP, the Applicant must report results for both the Medicare Advantage HMO/PPO and the Medicare SNP columns..." Can the state confirm that an Applicant can use the HEDIS experience from any of its affiliated business under its parent company that would meet the requirements? Can an Applicant use the experience of an affiliated business that would meet the Medicare Advantage requirements and another affiliated business that would meet the Medicare SNP requirements? Would the State consider posting its response to this question immediately since the State's response impacts development of several sections of our proposal?	Anthem	If the corporate family or partnership reported several audit designation tables to NCQA's IDSS for the Medicare Advantage population within the state with the largest number of Medicare member months as submitted in Appendix B, the Applicant may choose the Medicare Advantage Plan's HEDIS results on which to report in Appendix C as reported to NCQA's IDSS for that state. The reported HEDIS results must be from the same audit designation table for the Medicare Advantage Plan. If the corporate family or partnership reported one or more audit designation tables to NCQA's IDSS for Medicare SNP(s) in the same state, the Applicant must also submit a Medicare SNP's audit designation table as reported to NCQA's IDSS. If the corporate family or partnership reported several audit designation tables to NCQA's IDSS for the Medicare SNP population within the state with the largest number of Medicare member months as submitted in Appendix B, the Applicant may choose the Medicare SNP HEDIS results on which to report in Appendix C as reported to NCQA's IDSS for that state. The reported HEDIS results must be from the same audit designation table for the Medicare SNP. If the corporate family or partnership reported several audit designation tables to NCQA's IDSS for the Medicaid population within the state with the largest number of Medicaid member months as submitted in Appendix B, the Applicant may choose the Medicaid HEDIS results on which to report in Appendix C as reported to NCQA's IDSS for that state. The reported HEDIS results must be from the same audit designation table for the Medicaid MCO. For both Medicare and Medicaid HEDIS results, the Applicant may only submit one result per measure.

ODJFS Question Reference #	Reference Provided by Questioner	Detailed Question / Clarification	Question Submitted By	ODJFS Response
51	Appendix C I.a(3), p 1	In this context regarding reporting Medicare Advantage HMO/PPO results from the State referenced in Appendix B with the largest number of Medicare Advantage HMO/PPO member months..., is Applicant strictly the entity submitting the application, and therefore, the state has to be an Applicant state OR is a state referenced in Appendix B for the Applicant's Corporate Family acceptable?	Coventry Health Care, Inc.	If the corporate family or partnership reported several audit designation tables to NCQA's IDSS for the Medicare Advantage population within the state with the largest number of Medicare member months as submitted in Appendix B, the Applicant may choose the Medicare Advantage Plan's HEDIS results on which to report in Appendix C as reported to NCQA's IDSS for that state. The reported HEDIS results must be from the same audit designation table for the Medicare Advantage Plan. If the corporate family or partnership reported one or more audit designation tables to NCQA's IDSS for Medicare SNP(s) in the same state, the Applicant must also submit a Medicare SNP's audit designation table as reported to NCQA's IDSS. If the corporate family or partnership reported several audit designation tables to NCQA's IDSS for the Medicare SNP population within the state with the largest number of Medicare member months as submitted in Appendix B, the Applicant may choose the Medicare SNP HEDIS results on which to report in Appendix C as reported to NCQA's IDSS for that state. The reported HEDIS results must be from the same audit designation table for the Medicare SNP. If the corporate family or partnership reported several audit designation tables to NCQA's IDSS for the Medicaid population within the state with the largest number of Medicaid member months as submitted in Appendix B, the Applicant may choose the Medicaid HEDIS results on which to report in Appendix C as reported to NCQA's IDSS for that state. The reported HEDIS results must be from the same audit designation table for the Medicaid MCO. For both Medicare and Medicaid HEDIS results, the Applicant may only submit one result per measure.

ODJFS Question Reference #	Reference Provided by Questioner	Detailed Question / Clarification	Question Submitted By	ODJFS Response
52	Appendix C I.b(3), p 5	In this context regarding reporting Medicaid results from the State referenced in Appendix B with the largest number of Medicaid member months..., is Applicant strictly the entity submitting the application, and therefore, the state has to be an Applicant state OR is a state referenced in Appendix B for the Applicant's Corporate Family acceptable?	Coventry Health Care, Inc.	If the corporate family or partnership reported several audit designation tables to NCQA's IDSS for the Medicare Advantage population within the state with the largest number of Medicare member months as submitted in Appendix B, the Applicant may choose the Medicare Advantage Plan's HEDIS results on which to report in Appendix C as reported to NCQA's IDSS for that state. The reported HEDIS results must be from the same audit designation table for the Medicare Advantage Plan. If the corporate family or partnership reported one or more audit designation tables to NCQA's IDSS for Medicare SNP(s) in the same state, the Applicant must also submit a Medicare SNP's audit designation table as reported to NCQA's IDSS. If the corporate family or partnership reported several audit designation tables to NCQA's IDSS for the Medicare SNP population within the state with the largest number of Medicare member months as submitted in Appendix B, the Applicant may choose the Medicare SNP HEDIS results on which to report in Appendix C as reported to NCQA's IDSS for that state. The reported HEDIS results must be from the same audit designation table for the Medicare SNP. If the corporate family or partnership reported several audit designation tables to NCQA's IDSS for the Medicaid population within the state with the largest number of Medicaid member months as submitted in Appendix B, the Applicant may choose the Medicaid HEDIS results on which to report in Appendix C as reported to NCQA's IDSS for that state. The reported HEDIS results must be from the same audit designation table for the Medicaid MCO. For both Medicare and Medicaid HEDIS results, the Applicant may only submit one result per measure.

ODJFS Question Reference #	Reference Provided by Questioner	Detailed Question / Clarification	Question Submitted By	ODJFS Response
56	Appendix C, p 9-12	If a state has more than one plan/product for either the Medicare or Medicaid LOB, resulting in multiple HEDIS reports, can the bidder select which HEDIS report to include for that state?	Coventry Health Care, Inc.	If the corporate family or partnership reported several audit designation tables to NCQA's IDSS for the Medicare Advantage population within the state with the largest number of Medicare member months as submitted in Appendix B, the Applicant may choose the Medicare Advantage Plan's HEDIS results on which to report in Appendix C as reported to NCQA's IDSS for that state. The reported HEDIS results must be from the same audit designation table for the Medicare Advantage Plan. If the corporate family or partnership reported one or more audit designation tables to NCQA's IDSS for Medicare SNP(s) in the same state, the Applicant must also submit a Medicare SNP's audit designation table as reported to NCQA's IDSS. If the corporate family or partnership reported several audit designation tables to NCQA's IDSS for the Medicare SNP population within the state with the largest number of Medicare member months as submitted in Appendix B, the Applicant may choose the Medicare SNP HEDIS results on which to report in Appendix C as reported to NCQA's IDSS for that state. The reported HEDIS results must be from the same audit designation table for the Medicare SNP. If the corporate family or partnership reported several audit designation tables to NCQA's IDSS for the Medicaid population within the state with the largest number of Medicaid member months as submitted in Appendix B, the Applicant may choose the Medicaid HEDIS results on which to report in Appendix C as reported to NCQA's IDSS for that state. The reported HEDIS results must be from the same audit designation table for the Medicaid MCO. For both Medicare and Medicaid HEDIS results, the Applicant may only submit one result per measure.
57	Appendix C, p 12	Should the header in the 1st column of the table say "Top Five Highest Scores" instead of "Top Ten"?	Coventry Health Care, Inc.	Yes. The header column will be corrected and revised in Appendix C. This will be made more clear in a revised appendix to be published by ODJFS
58	Appendix C, p 6 of 13	Can either Medicaid or Medicare membership be used for Structured Quality Improvement Initiatives 2 and 4? Initiatives 1 and 3 specify the membership to use, please clarify for initiatives 2 and 4.	Coventry Health Care, Inc.	Structured quality improvement initiatives submitted for numbers 1 and 2 must be for Medicaid populations. Structured quality improvement initiatives submitted for numbers 3 and 4 may be for either Medicaid and/or Medicare populations. This will be made clear in the revised appendix that will be published to the website for this RFA.
60	Appendix C, p 6 of 13	Appendix C, Section II--Instructions on Page 6, states the applicant may submit an essay for 3 out of the 4, but then changes to must submit 3 out of the 4. Please clarify.	Coventry Health Care, Inc.	The Applicant may report on three out of four initiatives and will be scored according to the scoring methodology as specified in Appendix C.
81	Appendix C, Section 1.b, p 12 of 24	Appendix C - Section 1.b Scoring. First column contains language related to "Top 10 Highest Scores". Should this read : "Top 5 Highest Scores?"	WellCare of Ohio, Inc.	Yes. The header column will be corrected and revised in Appendix C.
82	Appendix C, Section 1.a & 1.b, p 1&4 of 24	Appendix C pg 1, section 1,a: 2 NCQA has two codes for HEDIS data that are not reportable - NA and NR- NR is that the plan did not choose to submit and NA is that the denominator was too small to be statistically valid - so the IDSS software will not allow the plan to submit the numerator. How should applicants report measures that according to NCQA guidelines, qualify as NA (small denominator).	WellCare of Ohio, Inc.	The Applicant must report HEDIS results as N/A for "Not Applicable" in Appendix C if results were not submitted in the final auditor-locked results to IDSS for any reason, including those that received either an NR or NA designation by NCQA.

ODJFS Question Reference #	Reference Provided by Questioner	Detailed Question / Clarification	Question Submitted By	ODJFS Response
177	Appendix D, Essay Describing Care Management Model, Part A: Question 13, p 19 of 48	The RFA states that the response to Appendix D, Part A, Question 13 shall not exceed 20 single spaced pages, however it also says that it must comply with the Essay Requirements described in Section III.B.3. which state all essay responses must be double spaced. Please clarify: Is the essay response to Question 13 an exception to the rule stated in section III.B.3 that says all essay responses must be double spaced?	Aetna	The page limitation for the Care Management Essay will be revised to 20 double spaced pages. Applicants should adhere to the essay requirements outlined in Section III.B.3 of the RFA.
118	Appendix D, pp. 19-20	Appendix D: Various changes were made in the corrected version of this Appendix. The page count at the bottom of page 19 is now 20 pages. Please confirm this is the final number.	Amerigroup Ohio, Inc.	It is the Applicant's responsibility to ensure it completes the most recent version of any posted RFA documents as this will be the basis of the Application evaluation and scoring conducted by ODJFS.

ODJFS Question Reference #	Reference Provided by Questioner	Detailed Question / Clarification	Question Submitted By	ODJFS Response
119	Appendix D, Part A, Question 12a-b, p 13 of 48	In Appendix D, Part A, Question 12a-b, page 13 of 48 and following, the State asks Applicants to "provide the following information about a care management program evaluation that was conducted…" relating to readmission rates and emergency department visits for a Medicaid non-LTSS population and for a Medicaid LTSS population. The question assumes the care management programs will have a fixed implementation date and that the Applicant has access to and can provide pre-implementation baseline data. In our experience, outside of academic studies, this is rarely the case. Managed care plans typically institute care management programs at the outset of a contract period and enroll eligible members on a rolling basis. Since multiple other interventions such as utilization controls and network limitations will be introduced simultaneously, a pre-post study design to evaluate only the care management component would not be valid even if prior period data for the study population were available. Typically managed care organizations evaluate care management programs using trends in key metrics. These data are much more readily available and will assist the RFA evaluators in making comparisons between programs. Will the State accept year-over-year comparative readmission and ED visit rates for the populations defined in the denominator specifications as an alternative to the pre-post criteria specified in the question?	Amerigroup Ohio, Inc.	Yes.
120	Appendix D, Instructions for Completing Part A	Appendix D, Instructions for Completing Part A, page 1, states the following: 1. For all questions, the Applicant may use experience of the Applicant or the Applicant's corporate family. 2. If the Applicant has no Medicaid or Medicare experience as reported in Appendix B, the Applicant shall not complete Appendix D. The Applicant will not receive points for completing Appendix D. Please confirm that these instructions allow the reporting of any experience in Appendix B in either Part 1 or II.	Amerigroup Ohio, Inc.	This is confirmed.
121	Appendix D	Appendix D: There are an additional 50 points achieved for many questions if the line of business chosen is either Medicare or Medicare-Medicaid. Since the latter term is a new requirement, and not defined within the RFA, please confirm the population that this term represents and which Applicants should use when determining the line of business to report.	Amerigroup Ohio, Inc.	If the Applicant reported experience in serving either a Medicare and Medicaid population (also known as dual eligibles) or a Medicare population in Appendix B, then the Applicant may receive the additional points as indicated in Appendix D.
122	Appendix D, Question 2, p 2 of 48	Appendix D, Question 2, page 2 of 48 indicates that the State will favor health plans that have experience serving members in nursing homes. Best practice for the dual eligible population requires health plans that also have experience in serving members who reside in community settings, using home and community based services. Please consider revising the questionnaire to include evaluation of this critical component of a comprehensive program.	Amerigroup Ohio, Inc.	For question 2, ODJFS is interested in evaluating an Applicant's experience in care managing individuals who reside long term in an institutional setting. Therefore, Question 2 will not be revised.

ODJFS Question Reference #	Reference Provided by Questioner	Detailed Question / Clarification	Question Submitted By	ODJFS Response
123	Appendix D, Question 5, p 21 of 48	Appendix D, Question 5, Part B (page 21 of 48) requires the Applicant to report experience from “January 2012 through June 2012.” As this time range, is past the RFA submission due date. Please clarify if the time period should indicate “January 2012 through March 2012.’	Amerigroup Ohio, Inc.	The timeframe is limited to January 2012 through March 2012 so that only recent experience is considered in the evaluation process. Question 5 in Appendix D, Part B will be revised to January 2012 to March 2012.
124	Appendix D, Part A: several references (e.g., question, question 2a, etc.), p 36 of 48	Appendix D, Part A: There are several references (for example, Question 8d on page 36 of 48; Question 2a on pages 39 and 40 of 48); Question 12b on pages 40 - 41 of 48) where “informational only/no points will be awarded” are indicated. Please specify the State's reason for requesting this data and the way in which it will be used in evaluating and selecting contractors, including any use in discretionary evaluation external to the scoring process.	Amerigroup Ohio, Inc.	Data points requested for Question 8d are for informational purposes only. The information will not be used in the scoring process and will not be used in a discretionary evaluation external to the scoring process. ODJFS may use the answer to this question to inform the design of the model. Data points requested for Questions 12 a and b may be used to validate the rates that are reported for the indicators specified in each question.
125	Appendix D, Part A, Scoring Instructions (13)	Appendix D, Part A, Scoring Instructions (13), page 42 of 48 states: “The total score for question 13 will be the sum of the point value for all of the evaluation criteria.” Additionally, it states that the Reviewers will evaluate and assign the appropriate point value, as indicated in the table on page 42 of 48. Please clarify the following:* There are 35 Evaluation Criteria elements with a maximum point value of 100 (for Exceeds Expectations) for each element. If each element receives the maximum score as defined by the point values in the table provided, and the total score is the sum of all 35 elements, then the maximum total score achievable is 3,500 points. This is significantly lower than the maximum points indicated for this section which is 13,500.* Please clarify if the total score for question 13 will actually be calculated by multiplying the point value scored by the Reviewer times the weight indicated in the second column of the scoring table for the particular element? It is recommended that ODJFS revise the scoring instructions as follows: The total score for question 13 will be the sum of the point value awarded multiplied by the Weight for each of the evaluation criteria.	Amerigroup Ohio, Inc.	The "points awarded" for each row are calculated by multiplying the point value (i.e., 0, 40, 70 or 100) by the weight indicated in the second column of the table. The total score for question 13 will be the sum of the values in the points awarded column.
166	Appendix D, Part A: Care Management, Question 12, p 13	The RFA states: "The Applicant must provide information to demonstrate the impact and effectiveness of its care management program(s) as evidenced by performance indicators, such as reductions in emergency department visits and hospital readmissions, for both a Medicaid non-Long Term Care population and a Medicaid Long Term Care population." May the applicant report the results from a SNP program serving duals in institutional settings and that has an I- and D-SNP for LTC results?	Anthem	The Applicant may report only one Medicaid long term care population for Question 12 b and the line of business/state must have been reported in Appendix B. This population must be used to respond to all components of 12 b.
167	Appendix D, Part A: Care Management, Question 10, pp. 11-12	The RFA states: "If the response to Question 10.a. is YES, does the Applicant have at least 12 months of experience as of March 31, 2012 with evaluating whether the participant-directed care model was effective, as defined by criteria such as volume of services received, increased enrollee/family satisfaction, etc., for enrollees using this model?" Is this question limited to health plan evaluations of participant-directed care models or would it include state evaluations of these models implemented by health plans? If this item includes evaluations conducted by states, how should the applicant complete Appendix D? Should the applicant check "yes" but note in the appendix in the section/subsection that the state performs these evaluations?	Anthem	This question is limited to health plan evaluations of participant directed care models. ODJFS is interested in Applicants that have experience with evaluating whether the participant directed model is effective for an individual who elects to use this model. The evaluation is intended to be on an individual level and not an aggregate level.

ODJFS Question Reference #	Reference Provided by Questioner	Detailed Question / Clarification	Question Submitted By	ODJFS Response
168	Appendix D, Part A: Care Management, Question 12, pp. 15-16	The RFA states that Indicator 3 = percent of individuals who reside in a nursing facility. The denominator is: Total number of individuals enrolled in care management. Is the state looking for the percent of individuals who reside in a NF and who are enrolled in care management? If so, please clarify the indicator, numerator and denominator? We have a similar question about indicator 4. Please clarify the indicator, numerator and denominator for indicator 4.	Anthem	Yes, the numerator for indicators 3 and 4 should be for the total number of individuals who reside in a NF or a community setting, respectively, and are enrolled in care management.
169	Appendix D, Part A: Care Management, Question 13 Essay Describing Care Management Model, p. 19	The directions for this section indicate that the response must be single-spaced. However, this contradicts Section III.B.3 of the RFA, which says that all essays must be double-spaced. Please clarify if this section is exempt from the spacing requirement in Section III.B.3 and should be single spaced, 20 pages.	Anthem	The page limitation for the Care Management Essay will be revised to 20 double-spaced pages. Applicants should adhere to the essay requirements outlined in Section III.B.3 of the RFA.
150	Appendix D - Question 3, p 3 of 48	Please provide more specific detail regarding the functional assessment. Do you expect utilization of a separate standardized tool, or may the functional assessment be combined as part a full, comprehensive assessment?	Buckeye Community Health Plan	The functional assessment may either be a separate tool or combined as part of a full, comprehensive assessment. If the functional assessment is a separate tool, the results should be merged into a comprehensive assessment.
151	Appendix D - Question 4c, p 7 of 48	Assessments are also completed at provider offices/facilities. May those in- person assessments be reported as home visits?	Buckeye Community Health Plan	No.
152	Appendix D - Question 13 Note, p 19 of 48	The revised Appendix D changed the essay to 20 single-spaced pages. Since ODJFS is revising the requirement for this essay from double-spaced to single-spaced, will the word limit be increased for this question as well?	Buckeye Community Health Plan	The page limitation for the Care Management Essay will be revised to 20 double-spaced pages. Applicants should adhere to the essay requirements outlined in Section III.B.3 of the RFA.
153	Appendix D - Part B, question 5, p 22 of 48	The question asks for attestation to activities beyond the due date of the application, which could only be speculative in nature. Please adjust the timeline to reflect a period to which the MCPs may attest to facts.	Buckeye Community Health Plan	The timeframe is limited to January 2012 through March 2012 so that only recent experience is considered in the evaluation process. Question 5 in Appendix D, Part B will be revised to January 2012 to March 2012.

ODJFS Question Reference #	Reference Provided by Questioner	Detailed Question / Clarification	Question Submitted By	ODJFS Response
154	Appendix D - Part B, question 8.d., p 36 of 48	Please clarify whether applicants receive points for responding to this particular question.	Buckeye Community Health Plan	Data points requested for Question 8d are for informational purposes only. The information will not be used in the scoring process and will not be used in a discretionary evaluation external to the scoring process. ODJFS may use the answer to this question to inform the design of the model.
139	Appendix D, Care Coordination, #13, p 18	During the CMS trainings on the Model of Care (MOC) for the 2013 Capitated Financial Alignment Demonstration Application, plans were instructed to include any additional MOC elements that states may be requesting from plans at the end of the 11 CMS MOC elements and that CMS would share submitted plans' MOCs with the respective states. Is ODJFS expecting to see additional state-specific elements added to the CMS MOC? If so, what are the elements? Given the large amount of overlap between the CMS and ODJFS requirements regarding the MOC, It would be very helpful if ODJFS streamlined the CMS and ICDS MOC requirements.	CareSource	ODJFS will only review the elements in the RFA response and will use this as the basis for scoring. CMS will review its model of care submissions according to its own standards. The care management expectations for the ICDS project are specified in Appendix D and Attachment 1 of the RFA.

ODJFS Question Reference #	Reference Provided by Questioner	Detailed Question / Clarification	Question Submitted By	ODJFS Response
45	Appendix D - 4a, p 6	Please clarify "Health and Welfare" as it applies to assessing enrollees.	Coventry Health Care, Inc.	Health and welfare has the same meaning as the term used in 42 U.S.C. 1396n('c). "Health and welfare" is a requirement imposed by CMS whereby a state must assure that necessary safeguards are taken to protect the health and welfare of Medicaid recipients. To meet this requirement, the state must implement policies and procedures regarding the following: consumer risk and safety planning and evaluations; consumer critical incident management; housing and environmental safety evaluations; consumer behavioral interventions; consumer medication management; and natural disaster and public emergency response planning. To that end, the selected Applicant may only respond "yes" if it has experience with assessing these elements of health and welfare as part of a comprehensive assessment in order to collect information necessary to report, investigate, and resolve incidents of abuse, neglect and exploitation.
46	Appendix D - 4a, p 5	How will applicants identify documents that are considered proprietary, such as a comprehensive assessment?	Coventry Health Care, Inc.	Proprietary documents and information must not be submitted in response to this RFA. All documents submitted are subject to public records laws.
47	Appendix D - 5 b, p 7	If an MCO communicates the assessment but not the actual risk score - how would the MCO respond to this?	Coventry Health Care, Inc.	If the Applicant communicates the results of the assessment and/or the risk score to the individual, the Applicant should respond with a 'yes' to the question.
53	Appendix D Part B, p 21	The top of page 21 states "The Applicant may report its experience or that of a corporate family member." Do all of the questions' responses have to be about the same entity's experience or can there be a mix (e.g. Response to Question 5 is from Applicant Corporate Family Entity A and Response to Question 6 is from Applicant Corporate Family Entity B)?	Coventry Health Care, Inc.	The Applicant may report any Medicare and/or Medicaid experience from any entity reported in Appendix B.

ODJFS Question Reference #	Reference Provided by Questioner	Detailed Question / Clarification	Question Submitted By	ODJFS Response
128	Appendix D, #13, p 18	Essay Describing Care Management Model - The RFA note on page 19 requires that the essay cannot exceed 20 single-spaced pages and must also comply with the Essay Requirements in Section III. B.3 of the RFA. The Essay Requirements in III.B.3 that the text in essays be double-spaced and no more than an average of 250 words per page. Should the Applicant adhere to the 20 single-spaced pages requirement, or should the Applicant comply with the requirement that essays be double-spaced and contain no more than an average of 250 words per page?	Molina Healthcare of Ohio	The page limitation for the Care Management Essay will be revised to 20 double-spaced pages. Applicants should adhere to the essay requirements outlined in Section III.B.3 of the RFA.
157	Appendix D, Essay Describing Care Management Model, p 19 of 48	The "Note" at the bottom of page 19 states "All essay responses must comply with the Essay Requirements, including the certification, described in Section III.B.3. of this RFA. The response to Question 13 shall not exceed 20, single spaced pages and shall be organized according to the outline provided above with sections clearly labeled and referenced (i.e., a, b, c, d, etc.)." The specification for single spaced pages is in conflict with the requirement defined under Section III.B.3-1 (page 15 of 25) of the RFA that calls for double spacing on all essay responses. Please clarify.	UnitedHealthcare Community Plan	ODJFS will amend the terms of Appendix D question 13 on page 18 as that should state "double spaced". Use the MS Word count function. The requirements as set forth in this section, and the reasons for them, were derived generally from the 6th Circuit Court of Appeals rules of federal practice. We are aware that there are ways to fit many additional words on a page through the use of small fonts, kerning alterations, and margin adjustments. However, none of those are acceptable practices for the purpose of this RFA. Spacing and font requirements are intended to facilitate reading during the scoring process. If an Applicant exceeds the 250 words per page limit, or page limit requirements, or the other clearly stated requirements such as double spacing, margins, font or any other stated requirement, the essay will be rejected. Tables or graphics are allowed, but do not excuse the page or word limit, and words in graphics or tables will count towards the word limit.
83	Appendix D, Part A.4.a, p 6	Please clarify or provide a definition of what is included within the following assessment domain: xiii - Willingness/Readiness to Change	WellCare of Ohio, Inc.	The assessment process should include an evaluation of the individual's willingness and readiness to change relative to behavior modification for disease management/prevention and/or addiction. The assessment process should identify where the individual is on the continuum of change (e.g., "not prepared to change" to "already changing") so that interventions aimed at behavior modification can be adjusted accordingly.
84	Appendix D, Part A.4.a, p 6	Please clarify or provide a definition of what is included within the following assessment domain: xv - Health & Welfare	WellCare of Ohio, Inc.	Health and welfare has the same meaning as the term used in 42 U.S.C. 1396n(c). "Health and welfare" is a requirement imposed by CMS whereby a state must assure that necessary safeguards are taken to protect the health and welfare of Medicaid recipients. To meet this requirement, the state must implement policies and procedures regarding the following: consumer risk and safety planning and evaluations; consumer critical incident management; housing and environmental safety evaluations; consumer behavioral interventions; consumer medication management; and natural disaster and public emergency response planning. To that end, the selected Applicant may only respond "yes" if it has experience with assessing these elements of health and welfare as part of a comprehensive assessment in order to collect information necessary to report, investigate, and resolve incidents of abuse, neglect and exploitation.

ODJFS Question Reference #	Reference Provided by Questioner	Detailed Question / Clarification	Question Submitted By	ODJFS Response
85	Appendix D,Part A.4.a, p 6 of App. D	Please clarify or provide a definition of what is included within the following assessment domain: xix-Health Literacy	WellCare of Ohio, Inc.	The assessment process should evaluate the individual's ability to obtain, process, and understand basic information about health care and services in order to make appropriate decisions.
86	Appendix D, Part A. 8 d, p 11	Please define “home visits” for this calculation? Specifically, is the state referring to home visits as those visits that are performed for purposes of care management or does the definition relate to both care management and the delivery of actual HCBS services in the home?	WellCare of Ohio, Inc.	Only home visits intended for the purposes of care management should be included in the calculation for Question 8d.
87	Appendix D, Part A. 12 a and b, p 13	If a health plan provides an example of a program where all members are enrolled in care management, can we treat the first year as the baseline or pre-implementation period for purposes of the measures?	WellCare of Ohio, Inc.	Yes.
88	Appendix D, Part B, p 20 of 48	Appendix D page 21 Part B - PCMH. In many of the questions related to this section, ODJFS limits the time frame from January 2012 through March 2012? What is the rationale for limiting experience to only a 3 month period of time. Question 5 in that same section limits time from January 2012 to June 2012 - which includes a time period after the RFA is due?	WellCare of Ohio, Inc.	The timeframe is limited to January 2012 through March 2012 so that only recent experience is considered in the evaluation process. Question 5 in Appendix D, Part B will be revised to January 2012 to March 2012.
183	Appendix E Provider Relations and Incident Management, p 3 of 6	Does the Essay Requirement in Appendix E apply only to E2, Incident Management? Also, there are no points identified in the scoring for Appendix E, can you please indicate the scoring methodology for Appendix E essays?	Aetna	The essay requirement includes both E1 and E2. The essay portion will validate the responses scored in E1 and E2.
126	Appendix E, p 3&6 of 6	Please clarify the following regarding Appendix E Essay Questions:* There is a paragraph following the table on page 3 of 6 asking for a description. The wording seems to imply this only applies to question E-2; however, it then asks for one page for each State/line of business referenced. However, E-2 only has one State/line of business. Is there a State/line of missing from the table in E-2, or is only one to be supplied?* Page 6 of 6 illustrates the scoring method for E-2; however, it does not specify how the essay question response will be scored. Please provide the scoring methodology for this question.	Amerigroup Ohio, Inc.	Section E 1 scores additional points for Applicants who have more than one line of business that meets the described requirements. Section E-2 provides for no additional scoring for more than one line of business.
170	Appendix E, Items E-1 and E-2, pp. 2-3	The RFA states: "E-1: Does the applicant have more than 12 months’ direct experience, since January 1, 2007, at contracting with, and reimbursing, community-based long term care providers serving Medicaid populations such as the following? Mark all that apply and reference the form(s) submitted in Appendix B for which the experience applies." Does this mean 12 months or more of experience (e.g. at least 12 months of experience)? This question is worded in a way that implies only applicants with more than 12 months of experience should respond. Please also clarify for Item E-2 as well where there is similar directions.	Anthem	Only Applicants with more than 12 months experience with the activities in E1 and E 2 should mark the box.
171	Appendix E, Items E-1 and E-2, pp. 2-3	If an applicant has a total of 12 months since January 1, 2007 of experience for any of these benefits, but the experience was broken into partial years, can the applicant check the box? For instance, if the applicant had direct experience for 6 months in 2008 and 6 months in 2009, can the applicant check the box since this experience adds up to 12 months?	Anthem	No, continuous experience is required.

ODJFS Question Reference #	Reference Provided by Questioner	Detailed Question / Clarification	Question Submitted By	ODJFS Response
172	Appendix E, Provider Relations and Incident Management, p. 1	The RFA states "Selected Applicants will be required to develop contractual relationships (including for reimbursement) with home and community services providers certified by the Ohio Department of Health, and the Ohio Department of Aging, as well as those that ODJFS approves for the provision of home and community-based services." Can the state provide more details on when Selected Applicants will be expected to provide these contracts?	Anthem	The transition document in appendix D of the ICDS proposal describes transition requirements. The proposal intends to clarify that those provider types that will be required for the delivery of HCBS services at the time of enrollment.
38	Appendix E, p. 3	Please clarify "direct" experience.	Coventry Health Care, Inc.	The questions evaluate whether the Applicant or its corporate family or partner has direct (not delegated) contracting experience with the provider types in E.1, and direct experience (not solely delegated or subcontracted experience) with each element in E.2.
39	Appendix E, p. 3	Please clarify "prevention planning".	Coventry Health Care, Inc.	Prevention planning is a clinical process by which potential health and safety risks are identified and actions and strategies are developed and documented to help mitigate those risks.
40	Appendix E, p. 4	How will points be awarded for one state with two lines of business.	Coventry Health Care, Inc.	Appendix E 1 scores additional points for Applicants who have more than one line of business that meets the described requirements. Section E-2 provides for no additional scoring for more than 1 line of business.
54	Appendix E: E-1 and E-2, pp. 2-3	For Appendix E questions, when using the term "Applicant", is Applicant strictly the entity submitting the application, and therefore, the state has to be an Applicant state OR is a state referenced in Appendix B for the Applicant's Corporate Family acceptable?	Coventry Health Care, Inc.	A state referenced in Appendix B for the Applicant's Corporate Family is acceptable.
89	Appendix E, Sections E-1 and E-2, pp. 2-3	Please confirm that Applicant may respond to Questions E-1 and E-2 of Appendix E based on experience of members of its corporate family.	WellCare of Ohio, Inc.	As part of the application, the Applicant may provide information related to other members of the corporate family or partner, as applicable, unless specifically directed not to do so by an instruction in the RFA.
90	Appendix E, Item E-2, p3	Under item E-2, if an applicant has more than 12 months experience reporting or investigating incidents in two or more states, should it list all of the states within each row of the table?	WellCare of Ohio, Inc.	No, the Applicant should only report on one state that was also reported in Appendix B.
127	Appendix F: Scoring Section F-1, (4), p 6 of 12	Appendix F: Scoring Section F-1, (4), page 6 of 12 state the following: Across all of the (up to five) innovative payment methods described, 500 points will be awarded for up to five of the provider types listed that were affected by at least one of the initiatives (for a maximum of 2,500 points): * The instructions for each initiative submitted state that the Applicant must “respond to the following prompts to describe up to five innovative payment methods the Applicant has implemented, indicate the State and Line of Business from Appendix B for which each initiative was implemented, and describe the results of each initiative.” None of the prompts A through D specifically state that the Applicant should indicate the provider types affected by each initiative. * It is recommended that a prompt E be added for response to each initiative where the Applicant is required to “check” each provider type that is affected by that initiative. For example, if Physicians and Other Clinicians, as well as Pharmacy provider types are described within each initiative, indicate the particular provider types (with an “X”), affected by the stated initiative.	Amerigroup Ohio, Inc.	Appendix F will be revised in response to this feedback. The revised appendix will be posted on the website dedicated to this RFP.
20	Appendix F, p 1 of 12	Are plans to describe their actual experience in this section for Medicaid only, or may plans include experience with innovative payment methodologies in Medicare, dual-eligible populations, and other populations in this response?	Coventry Health Care, Inc.	Innovative payment methods used for any of a health plan's lines of business are acceptable.

ODJFS Question Reference #	Reference Provided by Questioner	Detailed Question / Clarification	Question Submitted By	ODJFS Response
21	Appendix F, p 1 of 12	Please expand on the definition of "health promotion" (paragraph 3) as a potential initiative of interest for innovative payment methods.	Coventry Health Care, Inc.	"Health promotion" refers to initiatives geared to encourage healthy living. Programs that discourage smoking, or that encourage regular exercise, would be examples.
22	Appendix F, p 1 of 12	Please expand on the definition of "individual safety" (paragraph 3) as a potential initiative of interest for innovative payment methods.	Coventry Health Care, Inc.	"Individual safety" refers to initiatives geared to prevent accidents, prevent sexual assault, prevent self-neglect, prevent elder abuse, avoid theft, encourage fire safety, encourage pre-planning for natural disasters or power outages, etc.
23	Appendix F, p 1 of 12	Please expand on the definition of "integrated long-term care" (paragraph 5) as the focus of an applicable innovative payment method.	Coventry Health Care, Inc.	The term "Integrated long-term care" will be removed from a revised Appendix F.
29	Appendix F, p 1	Please confirm that Innovative Payments Methods may include lines of business other than Medicaid such as Commercial and Medicare experience.	Coventry Health Care, Inc.	Innovative payment methods used for any of a health plan's lines of business are acceptable.
30	Appendix F, p 1	Would you clarify the prohibition on using risk-adjusted sub-capitation as an example of an innovative payment method? While capitation payments to a dental vendor may not be innovative, capitation payments to a specialty physician group for a defined set of services with data and clinical support could be.	Coventry Health Care, Inc.	Simple risk adjusted sub capitation by itself will not be considered an innovative payment model. However, models that use risk adjusted sub capitation as part of a more meaningful, comprehensively structured innovative approach that attempts to control costs, improve quality, or improve access to medically necessary services, will be considered.
31	Appendix F, pp 6-8	Does affecting up to five provider types only impact scoring on F-1 (4) and F-2 (1) and thus an applicant could achieve maximum scores on F-1 (1) (2) (3) and F-2 (2) while affecting only one provider type?	Coventry Health Care, Inc.	Yes, points for five provider types are only available in F-1 (4). For that question, an Applicant would score a maximum of only 500 points (out of 2,500) if only one provider type is affected by all of the innovative payment methods the Applicant describes. For F-2 (2), the Applicant should describe five envisioned initiatives, one for each of five different provider types. If only one initiative is described, or if the Applicant describes a set of initiatives that all affect only one provider type, the Applicant could only score a maximum of 1,500 points (out of 7,500). A revised Appendix F will be posted on the website dedicated to this RFA.
55	Appendix F: Experience With Innovative Payment Methods, pp. 2 to 4	For Appendix F Initiative questions, when using the term "Applicant", is Applicant strictly the entity submitting the application, and therefore, the state has to be an Applicant state OR is a state referenced in Appendix B for the Applicant's Corporate Family acceptable?	Coventry Health Care, Inc.	As part of the application, the Applicant may provide information related to other members of the corporate family or partner, as applicable, unless specifically directed not to do so by an instruction in the RFA.
133	Appendix F, pp. 2&5	What is the definition of Other - Provider Type? Would provider master file provider type definition be an acceptable resource to define "Other" provider types?	Molina Healthcare of Ohio	"Other provider type" is any provider type, not already listed, that is relevant to the health delivery model set forth in this RFA.

ODJFS Question Reference #	Reference Provided by Questioner	Detailed Question / Clarification	Question Submitted By	ODJFS Response
144	Attachment 1, iii. Description of Supplemental Benefits and Ancillary Services, p 12 of 32	Bullet point one states "twenty four hour in-person coverage for all individuals, such that if a person calls at any time of day, a trained health care professional with access to the individual's records will be available to assess their situation and take an appropriate course of action." Is the expectation that if the request for assistance is made after-hours, that this assessment be completed in person face-to-face, or can the assessment be completed telephonically to determine the level of need and necessity for a face-to-face interaction with the member?	Buckeye Community Health Plan	Yes, if health and welfare can be assured by telephonic intervention, this is acceptable.
3	Attachment 1, pp. 22-23	How will the capitation payments be adjusted to address the expectation that ICDS plans will be required to make arrangements to allow individuals to continue to receive services from their current providers who may not be under contract with the ICDS plan? What period of time is contemplated for such transition period -- those set forth in appendix D?	Coventry Health Care, Inc.	Capitation amounts will be established using fee-for-service payment rates. Yes, Appendix D establishes required transition periods for non-contracted existing providers at fee-for-service rates.
15	Attachment 1, p. 11	The attachment to the RFA indicates that ICDS plans will be required to subcontract with an outside entity to provide service coordination for what is known traditionally as 1915(c) home and community based waiver services. Because of the historic role of Passport Administrative Agencies (PAAs) the ICDS plans will be required to contract with the PAAs. In order for the ICDS plans to succeed in achieving managed care savings they will need flexibility in their ability to contract with providers and negotiated related fee schedules. How does the state view the requirement of contracting with certain vendors with the assumptions that it will make with respect to managed care savings of this population?	Coventry Health Care, Inc.	The requirement to contract with specific entities is key to the project's success. The state expects savings to result from better care coordination. Better care coordination will lead to better health outcomes and reductions in unnecessary service utilization.
16	Attachment 1, p 23	ICDS plans will be required to make arrangement for members to be allowed to continue to receive services from their current or existing providers. If ICDS plan is not able to contract with a particular provider that is currently providing services to a member, the services would still have to be provided but by a non-par provider. Further, during the transition period, ICDS plans may not reduce reimbursement rates for services to be provide by certain providers. What is the state's view on how ICDS will be able to reimburse non-par providers and how will this be considered when arriving at the managed care savings assumptions used to develop the rates?	Coventry Health Care, Inc.	Savings is not expected to be achieved through rate reductions but rather through improved care coordination. Better care coordination will lead to better health outcomes and reductions in unnecessary service utilization.
17	Attachment 1, p 20	Except as provided for in Appendix D, Medicare-Medicaid enrollees will be required to receive services within the designated network of each IDCS Plan. Individuals will have freedom of choice within the networks. Please clarify that this is within the contracted network of each ICDS Plan. In addition, please clarify the ability of an enrollee to select an alternate care manager if a member is dissatisfied with their assigned care manager (i.e., is this within an ICDS Plan's contracted network of case managers).	Coventry Health Care, Inc.	In the event Appendix D (from Attachment 1) is not applicable, then individuals would choose from within a plan's network. However, in the event that an individual's needs cannot be met by providers within the plan's network, the plan is required to arrange for care outside its network. Furthermore, if the member is dissatisfied with the care manager assigned to him/her as a result of the care management process described in Attachment 1 (pgs 10-11), then the ICDS plan will be expected to accommodate the member's request to be assigned to another care manager from the ICDS plan.

ODJFS Question Reference #	Reference Provided by Questioner	Detailed Question / Clarification	Question Submitted By	ODJFS Response
24	Attachment 1, pp. 5-6	Please confirm that the covered population will include long-term, permanent nursing home residents who are dually eligible for Medicare and Medicaid.	Coventry Health Care, Inc.	This is confirmed.
25	Attachment 1, p 9	The last sentence of the first paragraph states that "Pre-admission and resident activities and LOC determinations will be performed outside of the ICDS". Does this mean that the ICDS will need to contract with a third-party to perform these functions or the state will be responsible for providing the function?	Coventry Health Care, Inc.	Existing level of care and PASRR processed will continue according to the requirements of the state. The required contract between ICDS plans and the AAA's does not include these functions.
28	Attachment 1, p 28	Do you anticipate oral presentations as a part of the selection process, as the possibility was raised in the proposal to CMS?	Coventry Health Care, Inc.	No.
32	Attachment 1, p 15	What is the timeframe for obtaining NCQA accreditation?	Coventry Health Care, Inc.	ODJFS has not decided a specific timeframe for which an Applicant must obtain NCQA accreditation. ODJFS expects to phase in the requirement based on: 1) the date the Applicant signs the provider agreement with ODJFS; and 2) NCQA's policies that govern when an organization may apply for NCQA Health Plan accreditation.
35	Attachment 1 - Appendix D, pp 1-3	Please clarify the vision and dental transition requirement. Appendix D states "Must honor PA's when item has not been delivered", is the intent of this requirement that if a dental or vision item was not delivered before the start date of the ICDS program the plan would be responsible for providing the item and/or reimbursing the provider?	Coventry Health Care, Inc.	Yes.
41	Attachment 1 - Appendix D, pp 1-3	Is it the intent of the transition process to allow enrollees in Waiver programs Home Health and PDN, Waiver Services - Direct Care and Waiver Services All Other have 365 days to continue to receive services from their existing provider/current providers unless a change occurs or the individual expresses a desire to change providers?	Coventry Health Care, Inc.	Yes, unless the health and welfare exception described in Appendix D of Attachment 1 is applicable.
92	Attachment 1, Section C.ii	This section outlines what the program will cover and that no Medicaid benefit carve outs are proposed. Does this also mean that all Applicants will only cover a uniform set of services and benefits and they will not be allowed to have individual variation for additional benefits that they elect to provide at Applicant cost?	WellCare of Ohio, Inc.	This section does not limit the ability of an applicant to offer benefits outside those required by either Medicare or Medicaid.

ODJFS Question Reference #	Reference Provided by Questioner	Detailed Question / Clarification	Question Submitted By	ODJFS Response
173	Attachment 1, E. Financing and Payment, Section ii., Payments to ICDS health Plans, p. 22	Can the state please provide additional descriptions regarding the risk adjustment mechanisms being considered, and whether and how the state anticipates the risk adjustment will vary for the Medicaid and Medicare components?	Anthem	This question relates to an aspect of the Demonstration Proposal that ODJFS submitted to CMS on April 2, 2012 (Attachment 1). Because that proposal is subject to approval and amendment by CMS, the information requested is either not yet available or subject to change.
174	Attachment 1, E. Financing and Payment, Section ii., Payments to ICDS health Plans, p. 22	Can state please provide additional information on the risk sharing mechanisms being considered? Would the risk sharing mechanism likely be implemented to impact both gains and losses?	Anthem	This question relates to an aspect of the Demonstration Proposal that ODJFS submitted to CMS on April 2, 2012 (Attachment 1). Because that proposal is subject to approval and amendment by CMS, the information requested is either not yet available or subject to change.
175	Attachment 1, C. Care Model Overview, I(b) Enrollment Method, p. 7	Please describe how membership will be assigned to health plans on an ongoing basis. Will members first be given a choice of health plans, and if they fail to choose, have a plan auto assigned for them? If so, will the auto assignment be split evenly between the 2 or 3 health plans in a region, or will there be some other methodology to assign membership?	Anthem	This question relates to an aspect of the Demonstration Proposal that ODJFS submitted to CMS on April 2, 2012 (Attachment 1). Because that proposal is subject to approval and amendment by CMS, the information requested is either not yet available or subject to change.
145	Attachment 1, iii. Description of Supplemental Benefits and Ancillary Services, p. 12 of 32	Bullet point six states "a common or centralized record, provided by the ICDS, for each individual, whose care is coordinated by the ICDS, that is accessible to each individual and all health care practitioners involved in managing the individual's care, so that all encounters with the individual by any practitioner can be shared across the ICDS." Please elaborate further. What is the expectation of this record's contents? Should the record include ancillary services like dental, vision, etc?	Buckeye Community Health Plan	This question relates to an aspect of the Demonstration Proposal that ODJFS submitted to CMS on April 2, 2012 (Attachment 1). Because that proposal is subject to approval and amendment by CMS, the information requested is either not yet available or subject to change.
18	Attachment 1, p. 20	Medicare-Medicaid will be allowed to choose the ICDS plan which provides the higher quality service and best meets their individualized needs. For Medicare, individuals will be allowed to receive their Medicare benefits through the ICDS plan or opt out of the program and continue to receive the services through the traditional fee for service system or an MA plan. If such and opt out is allowed, how has the state considered the additional administration that will be required to coordinate the members benefits between Medicare and Medicaid? This would seem counter to the objective of integrating the financing and service delivery.	Coventry Health Care, Inc.	This question relates to an aspect of the Demonstration Proposal that ODJFS submitted to CMS on April 2, 2012 (Attachment 1). Because that proposal is subject to approval and amendment by CMS, the information requested is either not yet available or subject to change.
26	Attachment 1, p 9	The proposal to CMS references a single provider claim submission that covers both Medicare and Medicaid services. Is there any requirement to provide a single claim payment or are multiple payments for the single claim allowed?	Coventry Health Care, Inc.	This question relates to an aspect of the Demonstration Proposal that ODJFS submitted to CMS on April 2, 2012 (Attachment 1). Because that proposal is subject to approval and amendment by CMS, the information requested is either not yet available or subject to change.
27	Attachment 1, p 9	Does the prohibition on coinsurance and deductibles apply to existing deductibles on current Medicaid benefits such as pharmacy and CMS supplemental benefits?	Coventry Health Care, Inc.	This question relates to an aspect of the Demonstration Proposal that ODJFS submitted to CMS on April 2, 2012 (Attachment 1). Because that proposal is subject to approval and amendment by CMS, the information requested is either not yet available or subject to change.

ODJFS Question Reference #	Reference Provided by Questioner	Detailed Question / Clarification	Question Submitted By	ODJFS Response
33	Attachment 1, p 11	Please explain the risk stratification methodology that will be used to determine care management staffing ratio's.	Coventry Health Care, Inc.	This question relates to an aspect of the Demonstration Proposal that ODJFS submitted to CMS on April 2, 2012 (Attachment 1). Because that proposal is subject to approval and amendment by CMS, the information requested is either not yet available or subject to change.
34	Attachment 1, p 22	Please provide additional information regarding the quality thresholds related to the quality withhold threshold?	Coventry Health Care, Inc.	This question relates to an aspect of the Demonstration Proposal that ODJFS submitted to CMS on April 2, 2012 (Attachment 1). Because that proposal is subject to approval and amendment by CMS, the information requested is either not yet available or subject to change.
36	Attachment 1, p 23	Please explain in more detail the monetary penalty that will first be assessed if the ICDS plan does not meet the prior authorizations standards.	Coventry Health Care, Inc.	This question relates to an aspect of the Demonstration Proposal that ODJFS submitted to CMS on April 2, 2012 (Attachment 1). Because that proposal is subject to approval and amendment by CMS, the information requested is either not yet available or subject to change.
37	Attachment 1, p 27	Please clarify the impact of phased in enrollment in reporting HEDIS measures in 2014 as listed in Appendix G.	Coventry Health Care, Inc.	This question relates to an aspect of the Demonstration Proposal that ODJFS submitted to CMS on April 2, 2012 (Attachment 1). Because that proposal is subject to approval and amendment by CMS, the information requested is either not yet available or subject to change.
42	Attachment 1, p 24	What type of monthly service utilization data reports will be required?	Coventry Health Care, Inc.	This question relates to an aspect of the Demonstration Proposal that ODJFS submitted to CMS on April 2, 2012 (Attachment 1). Because that proposal is subject to approval and amendment by CMS, the information requested is either not yet available or subject to change.
43	Attachment 1, p 24	Will service utilization be posted to the ODJFS public web site?	Coventry Health Care, Inc.	This question relates to an aspect of the Demonstration Proposal that ODJFS submitted to CMS on April 2, 2012 (Attachment 1). Because that proposal is subject to approval and amendment by CMS, the information requested is either not yet available or subject to change.
44	Attachment 1, p 10	Please provide the cultural characteristics of the proposed Enrollee population for the ICDS program by region.	Coventry Health Care, Inc.	This question relates to an aspect of the Demonstration Proposal that ODJFS submitted to CMS on April 2, 2012 (Attachment 1). Because that proposal is subject to approval and amendment by CMS, the information requested is either not yet available or subject to change.