

VENDOR QUESTIONS AND ANSWERS
MEDICAID MANAGED CARE PLAN SELECTION PROJECT
R-89-07-8016
RFA CLARIFICATION QUESTIONS AND ANSWERS
Q & A period ended February 27, 2009
Final Question and Answer Document

Debby Brutsman, PMP
Schaller Anderson, an Aetna Company
2/26/2009 (Date of inquiry)

Q1. Does the state plan to end this contract on June 30, 2010?

A1. With the continuation of the Medicaid managed care system being supported in the current budget, ODJFS expects to be able to continue operating a Medicaid managed care system. In addition, there have been no decisions made by ODJFS that would prevent the renewal of Medicaid managed care provider agreements beyond June 30, 2010. On the other hand, while ODJFS has not made any decisions at this time that would result in the non-renew of the Medicaid managed care provider agreements it does have broad authority in how the system is organized and administered. This means ODJFS could conduct a re-procurement in the future should it feel such an action would benefit Medicaid consumers or the Medicaid program.

Q2. How far in advance of the Initial Program Implementation date must the Applicant have its Health Insuring License approved and in place?

A2. Applicants must have a valid Health Insuring License before providing services to Medicaid consumers. Obtaining a HIC license can be a lengthy process, so Applicants should begin the process of obtaining a Health Insuring License from the Ohio Department of Insurance as soon as possible. The timeline outlined in the RFA allows ODJFS, in its sole discretion, to extend the readiness review period to accommodate a reasonable delay due to an Applicant's interaction with the Ohio Department of Insurance.

Q3. After award of the contract to an HIC, may the HIC assign the contract to an affiliate once that affiliate obtains its own foreign HIC license?

A3. Article XI – ASSIGNMENT of the baseline portion of provider agreement sets forth the criteria that must be met in order to transfer membership and an interest in the agreement. In addition, an applicant should take note that current Ohio law places a franchise permit fee on HICs that participate in the Medicaid program. While the current tax is expected to expire at the end of October of this year, a replacement tax is being considered in the current budget process. More information regarding the current and proposed tax can be found in the Ohio Administrative Code 5101:3-26-09.2 and the most recent version of the SFY 2010-11 budget bill (HB 1 of the 128th General Assembly).

Q4. Is ODJFS guaranteeing that the MCP will have at least 5,000 enrollees with the first two months after execution of the ODJFS agreement?

A4. The ABD eligible population in Northeast is approximately 25,000 and Northwest is approximately 12,000. We typically phase in the number of members so as not to overwhelm

inquiries and voluntary enrollment activities at the managed care enrollment center. Membership depends on a number of factors including a consumer's choice and how an MCP fits into the assignment algorithm (e.g. provider history, county exclusions, etc.). ODJFS cannot guarantee 5,000 enrollees within the first two months of executing the ODJFS agreement.

Q5. Are the capitation rates set by the State based on a minimum enrollment of 5,000 enrollees within the first two months after execution of the ODJFS agreement?

A5. No. The capitation rates are not based on a minimum enrollment amount. The capitation rates for the ABD population are risk adjusted using the Chronic Illness and Disability Payment System (CDPS). The initial three month period of enrollment will be risk adjusted monthly. Following the initial three months, the capitation rates will be risk adjusted on a semi-annual basis.

Q6. Given past enrollment data and history (including growth of eligibility and any open enrollment incentives ODJFS intends to offer) how many months will it take the MCP to reach 5,000 enrollees?

A6. The ABD eligible population in Northeast is approximately 25,000 and Northwest is approximately 12,000. We typically phase in the number of members so as not to overwhelm inquiries and voluntary enrollment activities at the managed care enrollment center. Membership depends on a number of factors including a consumer's choice and how an MCP fits into the assignment algorithm (e.g., provider history, county exclusions, etc.). Enrollment history does not take into account allowing ABD consumers to select regular Medicaid as has been the case in the Northeast and Northwest Regions over the past several months. It is impossible to predict how long it will take to reach 5,000 members.

Q7. In order for MCPs to include a provider on our provider panel spreadsheet, do we need to submit a signed LOA, LOI or Contract at time of the application submission?

A7. No. Applicants are not to submit supporting documentation at the time of filing an application. However, applicants must complete the Appendix F worksheets including the worksheet that provides detailed information about the contracts. If an applicant is selected through the application process then copies of Medicaid contracts, which include copies of executed/incorporated Medicaid addenda, must be submitted to ODJFS for review. Only fully executed and operational contracts can be reported as part of Appendix F. Letters of Intent are not sufficient.

Q8. If we must demonstrate compliance during the readiness review process, what is expected as "compliant" for the application submission?

A8. Readiness Review occurs after an applicant is selected. Applicants must follow the instructions included in the RFA when completing an application.

Q9. Since there is no listing heading for Commercial Providers, are we to assume that commercial network providers can not be included in the Northeast Region panel numbers?

A9. The Appendix F instructions and the application worksheets are correct and applicants must combine Medicare/Commercial into this single category. On the other hand, column three of the scoring document for the Northeast Region panel ([Appendix F - Scoring Page 1](#)) is incorrectly labeled “Medicare”. The column should read “Medicare/Commercial” and the points will be applied to the corresponding column on the application worksheet.

Q10. Please detail the terms and conditions that we would be required to provide behavioral health services under these circumstances.

A10. Please refer to Appendix G.2.b.iii of the provider agreement located in the Applicant Library.

Q11. How will MCP’s know when services are being performed by “a board of alcohol, drug addiction, and mental health services or a state agency other than ODJFS.”?

A11. Please refer to Appendix G.2.b of the provider agreement located in the Applicant Library. In addition, in order to enhance care coordination efforts between MCPs and Medicaid paid providers including community mental health centers, ODJFS provides MCPs the following member level Medicaid data – 1) monthly two-year fee-for-service claims history for newly enrolled members, 2) weekly fee-for-service claims run out for existing members, and 3) enhanced claims data for services received at the community mental health system for all members.

Q12. Please specify the ODJFS requirements as referenced in section I.C.

A12. The requirements being referred to are those contained in chapter 5101:3-26 of the Ohio Administrative Code and throughout the provider agreement.

Q13. Is a 24/7 toll-free medical advice line a mandatory service?

Q13. Yes. See Ohio Administrative Code 5101:3-26-03.1(A)(6) and Appendix C.25 of the provider agreement.

Q14. Is it the States intent to hold an open enrollment period when a new MCP begins operations? Or will the new MCP grow enrollment based only on: 1) member choice and 2) auto-assignment?

A14. Member choice and assignment activity will be the primary methods an MCP will obtain membership. All ABD members in the Northeast and Northwest regions will be afforded the opportunity to choose between the MCP selected through this process and the pre-existing managed care plan.

Q15. Is it the State’s intent to favor a new MCP through the auto-assignment process until the new MCP’s membership reaches a pre-determined level?

A15. There has been no pre-determined level of membership, but ODJFS is sensitive to the need for a new managed care plan to obtain a workable base of membership.

Q16. Does the State have any plan or approach to assist a new MCP in building critical membership mass, especially as noted above the MCP may be required to re-bid before June 30, 2010?

A16. See A15 above

Q17. We request that the RFA Submission due date of 4/06/09 be moved back two weeks to 4/20/09 and Readiness Review also be moved back two weeks from 5/05/09 - 6/19/09 to 5/19/09 - 6/30/09. Is the State willing to move back these deadlines?

A17. ODJFS will not be changing the application submission date, but the RFA does provide ODJFS with the sole discretion to extend the readiness review period.

Q18. Please describe, as detailed as possible, the Readiness Review process that will be used by ODJFS. Please include: checklists; review guides; if the Readiness Review Process is pass/fail or scored; and any other material, documentation, specifications, requirements, items or elements that ODJFS may use or rely on for the Readiness Review process.

A18. See Section IV.F. in the Request for Applications. All information that will be released for this RFA is placed in the Applicant Library located at <http://www.jfs.ohio.gov/ohp/bmhc/rfa1.stm>

Marilee Smith
Business Development & Retention
AmeriChoice/Unison
2/26/2009 (Date of inquiry)

Q19. On the Contract Compliance/Experience Form, we will record Administrative Expense Ratio and Medical Expense Ratio. (item 10 and 9). In a given state and a given line of business, we may have more than one company represented. When this is the case, is it then appropriate to record the separate Ratios for each of the companies, or should we somehow combine them (through a weighted average?) into a single ratio?

A19. Applicants should combine the expense experience from all companies within the corporate family and report a single figure for each item on the application form. In a case where a certain entity performs services in different states and for different lines of business, an applicant is expected to adopt a reasonable method of dividing the costs between the states/business lines. The RFA does not provide a specific method for dividing such costs, but applicants must use a method that fairly represents those expense represented with each state/business line being reported.

Q20. Exhibit F-1 only indicates Provider Type "Medicare" in Column (3), however in the Appendix F Spreadsheets and in the text it refers to Commercial/Medicare. Is it the State's intent that Column (3) include Medicare and Commercial provider types?

A20. The "Scoring – Page 3" document reflects an example in which Commercial/Medicare is the header of Column 3. This "Scoring – Page 1" document does not match. However this will be amended.

Q21. Will ODJFS issue a data book?

A21. ODJFS will be posting a rate book to the Applicant Library that will provide more detail regarding the rates.

Q22. Please clarify whether an MCP is required to be approved in the counties affected by the RFA in the NE and NW regions prior to the award of the contract (estimated to be 7/1/09).

A22. An applicant must successfully pass the ODJFS readiness review process before ODJFS will execute a provider agreement. The readiness review process looks at an applicant's compliance with requirements contained in the Ohio Administrative Code and the provider agreement.

John Kunkle
Director Solutions Development
Coventry Health Care
2/26/2009 (Date of inquiry)

Q23. For the readiness review process that is scheduled to commence on or about May 5, can ODJFS provide any templates or outline of specific requirements that the health plan could use to focus the preparation for, and thereby facilitate, the readiness review?

A23. The readiness review tools will be made available to the selected applicant(s) once one is selected for this RFA.

Aaron Graham
Medical Mutual
2/27/2009 8:13 AM (Date of inquiry)

Q24. How will managed care plan be paid in terms of the formula (in ABD provider agreement which doesn't seem to be on the applicant website and ORC 5101.2-26-03)?

A24. MCPs will be paid according to the ABD rates outlined in Appendix F and the methodology outlined in Appendix E of the ABD provider agreement. OAC 5101:3-26-03 (the managed care rule for covered services) and the ABD provider agreement are available in the Applicant Library.

Q25. What are the performance standards (indicates in ABD provider agreement)?

A25. Please refer to the most current version of ABD provider agreement, effective January 1, 2009, located in the Applicant Library.

Q26. Who is the other managed care plan(s) already in place?

A26. CareSource is the Managed Care Plan in the Northwest Region. Buckeye Community Health Plan is the Managed Care Plan for the Northeast Region.

Q27. Please provide a 10 year history of companies that have provided ABD coverage in the past in these regions.

A27. Buckeye Community Health Plan and WellCare have provided ABD coverage in the Northeast and Buckeye Community Health Plan and CareSource have provided ABD coverage in the Northwest.

Q28. Please provide capitation rates (revenue) by rate cell (including the CFC population) and 3 years of history of these rates. Are these risk adjusted and if so, in what manner?

A28. All information regarding this topic is housed in the Applicant Library. See A21 for more information on rates.

Q29. Please provide 3 years of claims and enrollment history by county and by rate cell (age/gender eligibility category, etc. again including the CFC population), either FFS data or from prior MCP's. Also provide claims data and member months by detailed service category for each eligibility category separately (Age, Blind, Disabled, Children, Pregnant Women, etc.).

A29. See A28 above.

Q30. Please provide enrollment by rate cell of those that were in a MCP (when there were at least 2 MCP's in the NE and NW regions) and are now in FFS. 3 years claims experience of these enrollees as well.

A30. See A28 above.

Q31. Are there any carve-outs (such as mental health)?

A31. Please refer to Appendix G.2.b.iii of the provider agreement located in the Applicant Library.

Q32. What services are excluded?

A32. Please refer to Appendix G.2.a of the provider agreement located in the Applicant Library.

Q33. How often are rates revised and in what manner does that happen (e.g., competitive bidding)?

A33. Rates are developed on a calendar year basis and may be amended if and when necessary. Rates are always developed and certified by the state's contracted actuary with input from the plans and they become effective upon approval from CMS. Please see Appendix E of the Provider Agreement for the entire methodology. Ohio does not engage in competitive bidding.

Q34. Is there any cost sharing (e.g. copays or deductibles) on the part of the enrollees?

A34. OAC 5101:3-26-12(E) specifies the allowable co-payments for specific services. Contracted MCPs must receive prior approval from ODJFS to implement co-payment programs.

Q35. Any information they have on trends per member per month (MCP and FFS separately if available). Preferably, these would be at least demographically adjusted.

A35. See A28 above.

Q36. Will ODJFS accept Provider contracts that were executed 10 to 15 years ago? If not, will ODJFS allow us to add an amendment to our old agreements without requiring provider signature?

A36. For purposes of the Appendix F of the application, as long as an applicant has a fully executed and operational Medicaid contract (with a Medicaid addendum) the contract can be counted as a Medicaid contract on the application. During readiness review, ODJFS will be reviewing the Medicaid contracts for compliance with current regulations. In regards to a provider signature, the addendum must be part of a fully executed contract. Any amendment to old agreements must be done in a way that provides for an enforceable agreement with the provider.

Q37. Will ODJFS accept provider executed Medicaid Addendums that are 10 to 15 years old? If not, will we be required to obtain new Medicaid Addendums requiring new signatures?

A37. No, ODJFS will not accept provider executed Medicaid Addendums that are that old. New Addendums will need to be signed before exiting the readiness review period.

Q38. Do currently contracted Medicaid Providers also have to have Commercial or Medicare contracts with the MCP?

A38. No. Scoring is determined on the basis of the type of contract the provider has with the Applicant with the understanding that in some cases one contract might cover more than one product line.

Chris Heldman
Business Development Analyst
CareSource
2/27/2009 9:28 AM (Date of inquiry)

General Questions

Q39. When will the "fillable" application forms be available? How will they be accessed?

A39. The only fillable application form is an Excel worksheet that relates to Appendix F and it is currently available in the Applicant Library.

Q40. Can ODJFS provide a list of rural counties or a link to a site where a listing of rural counties by state can be found?

A40. Rural Counties for the Northeast Region Include:
Ashtabula
Huron
Urban Counties for the Northeast Region Include:
Cuyahoga
Erie
Geauga
Lake

Lorain
Medina

Rural Counties for the Northwest Region Include:

Auglaize
Defiance
Hancock
Hardin
Henry
Mercer
Paulding
Putnam
Sandusky
Seneca
Van Wert
Williams
Wyandot

Urban Counties for the Northwest Region Include:

Allen
Fulton
Lucas
Ottawa
Wood

Request for Application

Q41. Accreditation. The instructions indicate the following: Applicant may check "Yes" if at least one member of the corporate family for this line of business/population in the reported state has a current accreditation level..." Our Medicare line of business is not accredited by URAC or NCQA, but we are URAC accredited for other lines of business. We believe therefore that for on our Medicare experience form we would not check that we are URAC accredited. Is this correct?

A41. That is correct. A separate "APPLICANT CONTRACT/COMPLIANCE EXPERIENCE FORM" form must be completed for each state and line of business. The answers contained in a particular form relate solely to that state and line of business.

Q42. Item 12 - Indicates the following: Was Applicant subject to any official government action revoking or proposing to revoke its licensure since January 1, 2005. However, the instructions for Item 12, on page 3 indicate the following: Check "Yes" if since January 1, 2007 a government entity issued notice stating it will, or may, revoke a license of one of the health plans for which experience has been reported on the form. Instead of "2005" should the date be "2007"?

A42. No. The date contained in the instructions is the wrong date. The date on the form is correct and applicants must report since January 1, 2005.

Appendix D - Performance Improvement and Care Management

Q43. Page 4, question 3. Our plan contracts with a disease management vendor to provide services to ABD members identified with one of the six medical mandated condition states who may benefit from care management. As the contract was between our plan and the State, we were responsible for the members' managed by the vendor. In addition, we provided management services to those members determined by the vendor to be too complex or identified with a primary behavioral health diagnosis. For the purposes of this RFA, can we utilize the services rendered and members managed through the delegation relationship as a part of our submission/experience?

A43. ODJFS would like to clarify that there are no mandated medical conditions that require care management.

Q44. Page 4, question 3. Applicants are to include in the table information including the number of members enrolled in the Care Management program during any month for CYs 2005, 2006, and 2007. Can CY 2008 experience be added? (CY 2008 is counted in the contract experience section).

A44. CY 2008 experience will not be added to Appendix D-1: Care Management. ODJFS is interested in Applicants that have seasoned experience with care managing any managed health care population.

Q45. Page 8, question 6. Could you please verify that it is permissible for an applicant to select different product lines within their corporate family to respond to each of the selected health care conditions on pages 9 - 10? As an example, can an applicant select one experience from one product line, such as CFC for one health care condition, and select a different experience from a different product line, such as ABD, to respond to a different health care condition?

A45. The Applicant may select different product lines within their corporate family to respond to Question 6; however, the Applicant should select the one product line that best demonstrates the capacity and capability to manage the selected health care condition(s). It is acceptable for the product lines to vary for each of the health care conditions.

Q46. Page 9, question 6. Can CY 2008 experience be included, in addition to CYs 2005 - 2007?

A46. CY 2008 experience will not be added to Question 6.

Clinical Performance Measures

Q47. Page 12, question 1. Is the direct experience reference "during and after Year 2005" representative of HEDIS measurement or reporting year? (HEDIS 2008 is reported in 2008 for measurement year 2007)

A47. The reference is to the measurement year and not to the reporting year.

Appendix E - Information Technology

Q48. Page 7. Applicant is to list the date where 'the Applicant's information system will meet 1) all Ohio Medicaid managed care program information system requirements; 2) be fully

operational; and 3) have the capacity to service the membership designated by this RFA." If the Applicant already meets these requirements, should they insert a past date when the requirements were met?

A48. Yes.

Appendix F - Provider Panel

Q49. The maximum number of points an applicant can receive for their provider panel is 2,000. If an applicant meets the minimum Medicaid ABD provider panel requirements based on contracted providers they would reach the maximum score of 2,000. It is not clear then why then there is a column for Medicare as well? (In the instructions it states that Applicants will only be scored in terms of how well their current provider panel meets the ABD provider panel requirements).

A49. Per the instructions, for a provider contract to be reported in Appendix F as a Medicaid contract the agreement must have an executed Medicaid addendum as part of the contract. It is expected that not all applicants will meet the Medicaid ABD panel requirements at the time they file an application. The scoring for Appendix F provides points for non-Medicaid contracts with required health professionals/facilities that are in the region. The maximum points for Appendix F are capped at 2,000 per region. Please note that applicants selected through this RFA must meet the ABD provider panel requirements as a condition to receiving a Medicaid provider agreement. During readiness review successful applicants will be required to submit copies of all their ABD provider contracts in order to show compliance.

Angie Milhous

AMERIGROUP Ohio, Inc.

2/27/2009 9:29 AM (Date of inquiry)

Section II.A, Page 4

Q50. If an Applicant submits and application for a region that is not currently covered under its ODI-approved service area, is the Applicant required to submit its service area expansion application to ODI prior to submission of the Application, or can it be submitted after awards are made and service areas are known?

A50. A successful applicant would not be able to provide services to Medicaid consumers in that region until ODI approved the service area. The current time line provided in Section III of the RFA provides approximately 6 weeks for readiness review.

Section II.B, Page 6

Q51. Please explain the rationale for limiting the award to one plan per region?

A51. ODJFS made the decision to limit the award to one plan per region in an effort to assure stability in the system.

Section III.A, Page 11

Q52. Will ODJFS consider providing the RFA and Appendices in Word format?

A52. No, ODJFS will not provide the RFA or any of the Appendices in anything other than a PDF.

Appendix D: Section 1-D, Page 1

Q53. Does ODJFS have specific diagnosis in mind for which the MCP must offer and provide care management/care coordination services? (or does the MCP have the flexibility of identifying potential candidates, then assessing the need for these MCP services?)

A53. ODJFS does not mandate conditions for which an MCP must offer and provider care management services. However, the MCP must, at a minimum, develop identification strategies for assigning members to risk stratification levels according to the *ODJFS Care Management Program Requirements*. This document has been added to the Applicant Library.

Essentially, the MCP has the flexibility to define criteria used to identify members who would be assigned to the low or medium risk stratification levels. The MCP must at a minimum employ the high risk criteria to identify members who would potentially be assigned to a high risk stratification level. The MCP must complete a health assessment for any member identified by the MCP as being potentially eligible for care management.

Appendix D: Section 1-D, Page 1

Q54. Please define "high-cost" and "extensive" services.

A54. ODJFS does not have a standard definition for high-cost and extensive services.

Appendix F, Page 3

Q55. Please clarify the definition of a "current, operational contract with the provider." Is an executed contract, defined as a contract that meets the subcontract requirements listed in OAC 5101:3-26-05 (D) and signed by both parties, including a Medicaid Addendum, sufficient or does the provider have to be fully credentialed and submitted and accepted by the state through the Managed Care Provider Network system?

A55. Providers need not be submitted and accepted into the Managed Care Provider Network, in order to be counted in Appendix F of this Request. A signed Medicaid Addendum is necessary but does not need submitted with the Application response, but selected applicants will be required to submit the addenda during readiness review.

Q56. Is there a restriction on when the executed contract and Medicaid Addendum were signed such as within the past six months, year, etc. If the signature is older than the limit, what documentation is required to prove the contract is still in effect?

A56. Only fully executed and enforceable provider contracts may be including in the Appendix F section of the application. No date restriction applies for purposes of completing the application, but during readiness review successful applicants must produce the addendum for ODJFS review.

Appendix F-1, Page 1

Q57. Please clarify the definition of an Urban Primary Care Physician (PCP) and a Rural Primary Care PCP.

A57. An urban primary care provider (PCP) is a provider who currently treats patients in an office located within one of the urban counties detailed in A40 above. Per the instructions in Appendix F, a PCP may only be counted in one classification (urban, rural or specialty).

General Questions

Q58. Will ODJFS provide the past rate risk scores for each region?

A58. The specific risk scores for individual health plans are not shared with other health plans. Therefore, we will not be providing the health plan risk scores for each region. Please note that the composite risk scores in each region are revenue neutral or 1.0000.

Q59. It is our understanding that ODJFS intends to carve out the pharmacy benefit effective 1/10 but the case management and performance sections refer to experience with pharmacy claims. Is it the intent of ODJFS to carve out the pharmacy benefit and if so, how will the scoring methodology be altered?

A59. The 2010 – 2011 Executive Budget, Section D - Special Analysis Regarding Health Care Initiatives, proposes a pharmacy program carve out for the Medicaid managed care program. However, this proposal is currently being analyzed to determine how this can be implemented and any recommendations will have to be reviewed and approved by the Centers for Medicare and Medicaid Services (CMS). Therefore, because there have been no definitive decisions or approvals on a pharmacy program carve out, the scoring methodology will not be altered.

This concludes the Q&A Document for RFA R-89-07-8016.

As a reminder, as stated in the RFA **Section III B Applicant Inquiries** “Applicant proposals in response to this RFA are to take into account any information communicated by ODJFS in the final Q&A Document for the RFA.”