MississippiCAN Program
RFP #20090127

Responses to Submitted Questions

Question #	RFP Section #	RFP Page #	Question	Response
1	Data book		Please provide the summary level cost exhibit for Targeted High Cost Individuals, broken out into its 5 distinct categories of eligibility.	
2	Data book		How do DOM/ Milliman intend to account for the increase in utilization that is to be expected with the removal of member cost sharing? If different, what mix controlled utilization impact was there in the period immediately following the implementation of the cost sharing?	
3	Data book		Please provide a summary showing the top 10 facilities and top 50 physicians / groups in terms of utilization & spend for each region.	
4	Data book		Please provide a summary of out-of-state utilization and spend, including the facilities / physician names for those who have material spend.	
5	Data book		Regarding the reinsurance requirement in section 9.7; Can the CCO demonstrate "evidence of its ability to accept risk for claims in excess of $50,000 annually per Enrollee for coverage of Enrollees for all services as required under this contract and additional services the Contractor may provide to Enrollees" through another mechanism (solvency test, parent guarantee, etc)?	

Question #	RFP Section #	RFP Page #	Question	Response
6	Data book		Regarding the refund and recoupment provision in section 9.5; Can the CCO recoup funds from the provider as well or only from the member?	
7	Data book		Please provide additional detail on two items; show Outpatient ER as a separate breakout from Outpatient or provide detail on ER utilization and unit cost, show the Physician category broken out by provider specialty	
8	Data book		Please provide any other detail regarding possible risk-sharing arrangements for NICU babies.	
9	2.1.2.3		Please provide clarification on services provided through the Healthier Mississippi 1115 Waiver and Family Planning 1115 Waiver. Section 2.1.2.3 states that waiver program services will be included, yet populations in waiver categories are excluded. Please clarify. Please provide the list of services that are included by waiver type in addition both the specific populations that are included and excluded.	Section 2.1.2.3 is an overview of the Medicaid program in Mississippi. It is not a list of services or groups included in the MississippiCAN Program.
10	Data book		Will DOM provide prior information for members currently enrolled in HCBS waiver programs to enable effective Coordination of Care? Can the format and mode of transmitting such information be developed jointly with the contracted CCOs?	
11			Please provide additional detail on what psychotropic medications are covered, by which specialties, and what authorization rules are in place or will be expected for prescribing by medical practitioners.	

Question #	RFP Section #	RFP Page #	Question	Response
12			How many Health Plans filed a letter of intent to submit a proposal for RFP# 20090127?	This information cannot be released during the procurement process.
13			What are the names of the Health Plans that filed a letter of intent?	This information cannot be released during the procurement process.
14	General		In addition to Milliman for actuarial services, who are the consultants that assisted the State with the writing of the RFP, and that may also assist with the evaluation of proposals received?	
15	1.4.3.3		Under what circumstances will the State permit CCOs to reimburse contracted providers using payment amounts other than the State Medicaid Fee Schedule?	
16	1.4.3.3		For the initial and renewal periods of this contract, is it the State's intent that CCOs will only be permitted to pay contracted providers as per the State Medicaid Fee Schedule?	
17	1.4.3.3		How often has the State Medicaid Fee Schedule been changed in the past 3 years? What provider reimbursements have been increased, by provider category, procedural codes and dollar amounts? Please disclose.	
18	1.4.3.3; 3.5; 5.6, questions 22, 30		Under what circumstances would the State consider the leasing of a provider network to be an administrative subcontractor arrangement rather than a provider relationship?	

Question #	RFP Section #	RFP Page #	Question	Response
19	1.4.3.3; 5.6, questions 22, 30		How will the State provide the opportunity for bidders to develop and submit statewide provider networks that meet the State's requirements, both during the procurement process and up to the final contract execution date? Will the State consider phasing in provider networks by each of the three proposed geographic regions, or permitting updates to an original provider network submission presented in a bidder's proposal?	
20	1.4.3.3; 5.6, questions 22, 30		For organizations new to Mississippi, and in light of the short turnaround timeframe necessary to propose a statewide provider network, what alternative provider network submission requirements will the State find acceptable other than the current provider Letter of Intent requirement? Would the State accept a good faith effort by a bidder in working with the Division of Medicaid and the Department of Insurance to build satisfactory provider networks during the period between the proposal due date and the time of HMO licensure approval by the Department of Insurance through submission of additional provider Letters of Intent and signed contracts during that time?	
21	1.4.3.3; 5.6, questions 22, 30		What reimbursement adjustments to the Medicaid Fee Schedule will the State consider implementing for reducing payments to non-participating MississippiCAN providers who refuse to contract with a CCO, as is implemented in other states' Medicaid managed care programs?	
22	1.4.3.3; 5.6, questions 22, 30		What regions or counties are considered by CMS to be Professional Health Shortage Areas? Please disclose by provider type.	

Question #	RFP Section #	RFP Page #	Question	Response
23	1.4.3.3; 5.6, questions 22, 30		Given the resources and costs necessary to implement a statewide managed care program simultaneously across all regions of the state, would the State consider phasing in the MississippiCAN program in phases by each of the three proposed regions? In our experience, we have found that beginning a program with the largest populations in urban areas works more effectively, and then applying lessons learned to rural areas. Our concern is that with the aggressive timeline currently established by the State, by going statewide simultaneously (all regions on October 1, 2009), may result in unintended and unforeseen consequences for both members and providers with such an approach.	
24	1.4.3.3; 5.6, questions 22, 30; Data book		As respectfully submitted, would the State extend the proposal due date so as to facilitate a more competitive procurement for its consideration, resulting from the further development and submission of more comprehensive statewide provider networks from bidders? In doing so, the State will achieve its procurement goals by permitting bidders necessary time for adequate analysis of current and yet to be released data and network activities.	
25	3.3; Contract paragraph 2.1		Under what circumstances will the two year contract renewal period(s) not be included in the draft contract?	
26	3.5		For the contract resulting from this procurement, in what circumstances will the State permit any subcontractor that is either not a provider or not an affiliate of the prime bidder to perform more than 10 percent of this contract's scope of work requirements, by total contract value?	

Question #	RFP Section #	RFP Page #	Question	Response
27	4.2, 6.2.2		As part of a bidder's proposal, how will the State effectively ascertain and evaluate, as part of a bidder's Medicaid qualifications and experience, the appropriate disclosure of those instances and circumstances where a bidder has itself voluntarily initiated (not the state) and completed the termination of any state Medicaid managed care contract in the past four (4) years?	
28	5.6, questions 7 and 49; Contract 4.9		With regards to member materials at the 3rd grade reading level (lower than existing standards), and program information at the 6th grade reading level, what criteria were used to establish these requirements? Also, please clarify the apparent discrepancy in reading levels – 3rd or 6th grade level – which reading level is to be used?	
29	5.6, questions 23 and 30		What mechanisms will the State consider implementing during the procurement process so that providers are required to enter into Letters of Intent with all proposing CCOs (e.g., providers cannot withhold its possible participation in the MississippiCAN program at the Letter of Intent stage for network development)?	
30	RFP paragraph 5.6, questions 23 and 30		What procurement mechanisms will the State put in place so that all bidders can obtain Letters of Intent from providers in a timely fashion for proposal submission and network contracting activities?	
31	RFP paragraph 5.6, questions 23 and 30		What required information is to be included on each provider Letter of Intent that will be rendered satisfactory by the State in the proposal evaluation process? What is the state's preferred format for an acceptable provider Letter of Intent? Please confirm that a signature from each provider, provider group or respective authorized representative is required for provider Letters of Intent to be submitted with proposals.	

Question #	RFP Section #	RFP Page #	Question	Response
32	RFP Attachment 1, Definition of Assignment; Contract paragraph 4.1		To assist with the development and maintenance of the financial viability of the selected MississippiCAN CCOs, what will be the minimum enrollment threshold that the State will use for each CCO, and how will the auto-assignment algorithm be adjusted so that CCOs having enrollments below such threshold will be offered the opportunity to reach such minimum enrollment level?	
33	RFP Attachment 1, Definition of Assignment; Contract paragraph 4.1		How will the auto-assignment algorithm be designed so that CCOs having enrollments below an estimated minimum financial viability threshold receive necessary enrollment increases in order to meet such threshold?	
34	RFP Attachment 1, Definition of Assignment of Members; Contract paragraph 4.1		21. How will the auto-assignment algorithm be designed to function and reflect potential variations in enrollment patterns in the three proposed geographic regions of the state?	
35	RFP Attachment 1, Definition of Assignment; Contract paragraph 4.1; Data book		How will the potential financial impacts of adverse selection to a CCO be addressed by the State through the auto-assignment algorithm? How will such adverse selection characteristics be addressed regionally if certain high cost conditions and membership are more likely to occur in a given region of the state rather than another?	
36	Contract paragraph 3.3		If a pregnant woman is not enrolled in a CCO and delivers, how will the newborn's information be captured to facilitate enrollment in a CCO?	

Question #	RFP Section #	RFP Page #	Question	Response
37	Contract paragraph 4.18		On October 1, 2009, will the State or a CCO be financially responsible for inpatient stays beginning prior to that date? Please confirm the understanding that per this contract paragraph, the State will be financially responsible in this circumstance.	
38	Data book		How will bidders be provided an additional opportunity to ask questions regarding the capitation rates and supporting information upon release?	
39	Data book		What completion factors, if any, were applied to the data?	
40	Data book		What percentage of the allowed claims represents enrollee cost sharing?	
41	Data book		What percentage adjustments, if any, were made to the Mississippi State Medicaid Fee Schedule for CY 2006, CY 2007, CY 2008, and CY 2009?	
42	Data book		What changes, if any, were made to the Mississippi State Medicaid eligibility requirements?	
43	Data book		Is it correct to assume that if a member enrolled in MississippiCAN changes status to an ineligible COE Code (e.g., enters a nursing home, becomes Medicare eligible, etc.), then the member transfers back to Mississippi Medicaid and the CCO is no longer financially responsible for that member's experience?	

Question #	RFP Section #	RFP Page #	Question	Response
44	Data book		How were claims reimbursed for services received by Mississippi Medicaid enrollees from out-of-state providers?	
45	Data book		Will the first-year offered capitation rates be the same for all participating CCOs? What about in subsequent years?	
46	Data book		For pregnant women in the month of delivery, will the CCO receive the monthly capitation revenue in addition to the kick payment?	
47	Data book		What is the process determining capitation rate increases for the second and subsequent years of this contract?	
48	Data book		What percentage of the capitation rates is allocated for the CCOs' administrative expense?	
49	Data book		What percentage of the capitation rates is allocated for the CCOs' profit?	
50	Data book		Since more than one CCO will participate in MississippiCAN, it is virtually certain that one CCO will have a higher acuity member mix than another. This dictates that a member-level risk adjustment mechanism be implemented to ensure a level playing field for all CCOs. What are the State's plans in this regard?	

Question #	RFP Section #	RFP Page #	Question	Response
51	Data book		What further detailed pharmacy claims data can be made available to bidders, specifically an analysis of psychotropic drug utilization?	
52	Data book		What claims data is available for hemophilia cases? How can this information be provided to bidders by region and eligibility group for the past 2 years?	
53	Data book		What claims data is available for transplant cases? How can this information be provided to bidders by region and eligibility group for the past 2 years? In what transplant networks does the Division of Medicaid currently participate?	
54	General Questions and Comments		Please provide a list of the organizations to which the Program Design Summary was sent.	
55	General Questions and Comments		Please provide a status on the 1915(b) waiver the State is seeking for MississippiCAN. When do you anticipate the waiver will be approved?	
56	General Questions and Comments		The defined mandatory population for this initiative is relatively limited and specifically excludes certain populations such as mothers and children over age one who could benefit significantly from the program through care management and health promotion activities including education on childhood asthma and diabetes management, and obesity prevention, inter-generational health promotion and teen pregnancy prevention initiatives. Please provide the rationale for the populations *in*cluded and *ex*cluded from the program. What regulatory, legislative or other actions are needed to expand MississippiCAN to other	

Question #	RFP Section #	RFP Page #	Question	Response
			Medicaid populations? What are the DOM plans for expansion of MississippiCAN to other Medicaid populations?	
57	General Questions and Comments		We understand that the MS SCHIP program, currently operated as an Administrative Services Organization by a separate state agency, will be re-procured in 2009. Has the State considered including SCHIP in MississippiCAN and/or implementing a capitated approach for SCHIP? Like the populations noted in Question 3 above, the SCHIP population can benefit greatly from the program initiatives envisioned by MississippiCAN.	
58	General Questions and Comments		Please detail the process and methodology that will be used to score the RFP responses. Given the challenges of launching a new Medicaid managed care program for a population with complex health care needs, we strongly recommend the following weighting in the scoring methodology. First, given the innovative nature of this program, it will be essential that the scoring methodology appropriately values demonstrated experience working with similar populations and delivering program outcomes. Second, demonstrated competency and experience in implementing new programs successfully and timely should also be high in the scoring methodology. Third, oral evaluations and presentations by Offerors should be used to allow the State to fully understand the Offerors' programs and expertise. Finally, Offerors' ability to demonstrate development work plans and expertise in launching new programs, the Offeror's ability to demonstrate strategies to engage local and community based organizations in planning and implementation and a mission that enhances and supports the program goals of MississippiCAN are additional factors that should be included in the State's evaluation methodology.	

Question #	RFP Section #	RFP Page #	Question	Response
59	General Questions and Comments		How will MississippiCAN CCOs interface with the vendors selected for the electronic health records/e-prescribing initiative that is currently being procured?	
60	General Questions and Comments		Please describe how discharge planning and coordination procedures for NICU infants would be implemented, particularly when the mother returns to fee-for-service and the infant remains in the NICU for a period of several months.	
61	General Questions and Comments		Mississippi is one of only two states with a requirement of in-person eligibility re-certification. Has the State considered changing this requirement for MississippiCAN beneficiaries?	
62	General Questions and Comments		Please describe how FQHCs would be reimbursed for behavioral health services for a MississippiCAN member who receives a physical health service on the same day as one for behavioral health.	
63	General Questions and Comments		Please provide confirmation that DOM will exchange standard x12 transactions such as 834, 837, 820/835 for applicable data transactions with the CCOs supporting enrollment, encounters, premium payment. Please provide a list of data interfaces and an indication of frequency and format/layout standard.	
64	General Questions and Comments		What is the expected award date? How will DOM determine whether two CCOs are selected versus three?	
65	RFP Section 1.3 Organizations Eligible to Submit Proposals		As currently written, the language requires that the CCO itself have at least 5 years contractual experience in Medicaid managed care AND also requires that the company be licensed in another state if they are not already licensed by the State of Mississippi. As currently written, a newly licensed organization could not meet the	

Question #	RFP Section #	RFP Page #	Question	Response
	(and also Section 1.5 (a) and (g) of the draft contract).		experience requirement and thus, this requirement appears to preclude from bidding organizations that are not currently licensed in the State. We believe this is contrary to the State's intent. We recommend that the State allow affiliate experience and licensure to be considered to meet this requirement. As a national company, AMERIGROUP Corporation typically establishes a new subsidiary in each of the states where we operate to establish a local health plan and domestic company to apply for licensure and to contract with our State partners. Our operating model gives our State partners strong national experience coupled with a local health plan that brings a community-based understanding of the health and community. Through our local health plan subsidiaries, we blend our broad experience and strong national operations with a local plan that is deeply rooted in the local community and understands the local health issues, the provider and member environment and can be both a knowledgeable and experienced partner to the State and community. AMERIGROUP Corporation currently has 12 operational subsidiaries in 12 states. Each of these subsidiaries currently participate in their respective states' Medicaid and/or SCHIP managed care programs with our oldest subsidiary having 13 years experience in these programs. The experience of AMERIGROUP Corporation and our subsidiaries with Medicaid managed care and other publicly funded programs will support and greatly benefit our new health plan in Mississippi should it be awarded a contract even though our new subsidiary (the "Offeror") will not have the direct 5 year experience requested per the bid. We believe it is the Division of Medicaid's intent to capitalize on the years of experience of organizations like ours. As such, we strongly urge the Division to reword the referenced sections to allow an	

Question #	RFP Section #	RFP Page #	Question	Response
			Offeror to include affiliate or parent company experience to meet this requirement to recognize the experience that national companies can offer the program. Further, we recommend changes throughout the documents to establish consistency of this approach wherever experience and licensure are referenced. Specifically, we recommend the following revisions to the language in Section 1.3. “Offerors must have at least five years of Medicaid program experience. Experience can be demonstrated through the Offeror or an Affiliate(s) of the Offeror. Offerors must be licensed or in the process of obtaining a Certificate of Authority from the Mississippi Department of Insurance at the time the bid is submitted and be fully approved and licensed to operate as of the program implementation date”.	
66	RFP Section 1.3		Section 1.3 states that the Offeror must have *never* been sanctioned by the state/federal government in the last 10 years. Please clarify the definition of ‘sanction’ referred to in this section of the RFP. We believe that, as written currently, there are few, if any, organizations with at least 5 years of experience that could respond affirmatively to this absolute statement because even high performing plans will, from time to time, be subject to some form of sanction. We believe the DOM can achieve the objective of understanding the Offerors performance under current contracts by establishing a materiality standard and a period of time for reporting. We recommend including the following, “For the purpose of this question, sanctions imposing monetary fines or penalties shall be material if the fine or penalty was in excess of $50,000. Please report material sanctions for the last three years."	
67	RFP Section 1.4.1.4		Section 1.4.1.4 references mandatory enrollment for all targeted populations. How will this be enforced? How does DOM verify and guarantee these individuals sign up?	

Question #	RFP Section #	RFP Page #	Question	Response
68	RFP Section 1.4.1.6		Section 1.4.1.6 indicates that DOM may offer risk sharing for NICU babies. Please describe the State's approach to this offering including the timing of this program change, the process for decision-making and details of the program. Milliman and DOM have requested suggestions regarding potential NICU risk sharing arrangements. While many States use various types of stop loss arrangements to share the risk of large claims with CCOs, an approach other States (such as Maryland and Nevada) have taken with regard to NICU is to establish a low-birth weight (LBW) kick payment. This works in a fashion similar to the maternity kick payment, whereby the State makes a onetime payment to the CCO (in addition to the normal monthly capitation payment), but the payment is predicated upon gram weight of the baby at birth. So, for example, DOM could establish a LBW kick payment which would provide CCOs a one-time payment if the baby is less than 1500 grams at birth. The CCO would receive the delivery kick (if the mom is enrolled with the CCO) and the LBW kick if the baby is less than 1500 grams, plus any monthly capitation payments for the mom and the baby. DOM could establish multiple tiers within the LBW kick payment, for example, there could be a LBW kick for a baby between 1500 and 2500 grams, and another for babies weighing less than 1500 grams. The LBW kick payments are very large relative to other capitations rates, generally between $60,000 and $100,000 for babies weighting under 1500 grams. The under age 1 capitation rate is adjusted to reflect the revenue the CCOs will receive for the LBW kick payment, just like the pregnant women rate is adjusted to reflect delivery kick payment. The LBW kick payment approach has several advantages over the traditional stop loss approach, including: a. The CCO retains the financial incentive to manage the	

Question #	RFP Section #	RFP Page #	Question	Response
			NICU case; b. The payment can be tied to encounter data easily so that the State's liability for the baby is known shortly after birth, and the CCO receives payment for the LBW baby quickly, as opposed to a stop loss arrangement where the CCO must submit claims data and the State then needs to determine which expenses are covered and which aren't and settle the stop loss claim with the CCO (a process which can take over a year given the long length-of-stay of LBW babies.)	
69	RFP Section 1.4.2.2.		Please provide the details of the process for the development of capitated rates including the value of the adjustments and the expected timing of when rates will be published. How will bidders and contractors be involved in the development and refinement of rates initially and in future contract years?	
70	RFP Section 1.4.3.1		Section 1.4.3.1 states that CCOs must schedule an appointment with a medical home provider for new members within 90 days of enrollment. What is the State's expectation for fulfilling this requirement at the time of program implementation? Given the number of enrollees that would be enrolled on the same date, we recommend that the State allow a waiver of this requirement for a period not to exceed 90 days during the initial implementation of the program. Further, we recommend allowing contractors to perform initial health risk assessments to target for initial appointments the higher risk individuals during the initial stages of implementation for intervention.	
71	RFP Section 1.4.3.2		Section 1.4.3.2 states that the DOM will establish minimum standards for financial and administrative accuracy of claims processing. Please provide the standards for accuracy of claims processing. When and how will these requirements be finalized? We recommend that the State establish a stakeholder work	

Question #	RFP Section #	RFP Page #	Question	Response
			group to develop standards and processes for measurement collectively.	
72	RFP Section 1.4.3.2		Section 1.4.3.2 (and Sections 1.10(m) and 1.11 of the proposed contract) require the CCO to maintain a member call center 24 hours per day, 7 days per week. Please confirm that maintaining member services staff to respond to routine questions, inquiries and other administrative matters during standard business hours and maintaining an after-hours nurse helpline to respond to clinical inquiries will satisfy this requirement.	
73	RFP Section 1.4.3.3		Section 1.4.3.3 indicates that provider networks will be approved by DOM. Given that MississippiCAN is a new program and focused solely on Medicaid recipients, we urge the State to establish DOM's as the administrative authority to approve the CCOs networks in lieu of but in cooperation with, the Mississippi Department of Insurance and the Mississippi Department of Health to meet licensure requirements. We request that the DOM work directly with the Departments of Insurance and Health to achieve this goal. The Mississippi DOI should defer to DOM for those organizations only participating in MississippiCAN. Consistent with the Provider Network requirements in Section 5.6 (Methodology/Work Statement) of the RFP, the DOM should accept from Offerors "a detailed plan to ensure that the provider network meets the network and access requirements of the Program." DOM should review the experience of the Offerors developing networks and implementing new programs. The plan should be supplemented by Letters of Intent and Contracts as they are finalized and final network approval should occur near the implementation date. The unique population to be served in this program warrants DOM's review and approval of the provider	

Question #	RFP Section #	RFP Page #	Question	Response
			network. Further, as Section 1.4.3.3 of the RFP confirms that “provider networks will be approved by the Division of Medicaid prior to implementation by the CCOs.” As the Division of Medicaid will be conducting this review prior to implementation, we believe that this requirement will provide the Departments of Insurance and Health with adequate assurances that access to services will be monitored and assured. The following provides two state examples that we strongly recommend the State consider. These examples show a direct relationship between the Medicaid Agency and the other State authorities but ultimately the Medicaid Agency provides the network review and approval for licensure for those entities participating solely in Medicaid/SCHIP managed care programs. In the State of South Carolina, HMO Applicants are given the opportunity to identify in writing in their Certificate of Authority application to the Department of Insurance that they plan to participate solely in the Medicaid/SCHIP managed care program. For these applicants, the Department does not require any network submission because the HMO is only authorized to offer a Medicaid/SCHIP line of business unless it chooses to file a modification to its license at a later date. The Department forgoes the network review because prior to enrolling any members under the Medicaid/SCHIP program, the State Department of Health and Human Services reviews and certifies the network adequacy for the plan’s service area. If the plan does not meet adequacy standards, members cannot be enrolled into the HMO. In the State of Tennessee, for HMO Applicants that indicate they intend to participate in the State’s Medicaid program (“TennCare”) only, the Department of Commerce and Insurance (“TDCI”) forgoes any network adequacy review of the plan through their application review process. Rather, prior to issuing a final certificate	

Question #	RFP Section #	RFP Page #	Question	Response
			of authority to the plan, TDCI requires a certification from the Bureau of TennCare that the plan's network is adequate to support the proposed membership and covered services. Once the certification is received, TDCI then issues the COA. If the plan intends to offer any other products in the future, it is required to file a Major Modification request with TDCI.	
74	RFP Section 1.4.3.3		Section 1.4.3.3 states "CCOs will be required to pay network providers no less than the rates paid by Mississippi DOM." Please clarify this requirement. Was this language intended exclusively for out-of-network providers or is it intended to apply to both in-network and out-of-network relationships?	
75	RFP Section 2.1.2.3		Section 2.1.2.3 states that waiver program services will be *included,* yet populations in waiver categories are *excluded*. Please clarify. Please provide the list of services that are included by waiver type in addition both the specific populations that are included and excluded.	
76	RFP Section 4.4.8		Section 4.4.8 states, "An Offeror's proposal shall not include variable or multiple pricing options." However, Section 1.4.2.2 states, "There will be no need for the CCOs to submit a cost proposal when submitting their response." Please clarify to what extent, if any, a cost proposal should be submitted.	
77	RFP Section 5.5.2		Section 5.5.2 states that resumes for all key staff (CEO/COO, Chief Medical Officer, Provider Services Manager, Member Services Manager) must be submitted with the RFP response, and that experience working with CCOs be documented. Because potential new entrants in the state may not have all positions filled at the time of the RFP submission, we request that position descriptions, a recruitment plan, and/or information on prospective candidates be considered acceptable to meet this requirement if positions have not been filled at the time of RFP response. Further, we recommend that the State accept resumes of	

Question #	RFP Section #	RFP Page #	Question	Response
			personnel with experience both in Medicaid managed care and implementing new programs as demonstration of the Offerors experience.	
78	RFP Section 5.6		Section 5.6 Methodology/Work Statement, Item 2 states "Describe the policies, procedures and processes you will put in place to encourage members to engage in wellness programs including the approach you intend to use to ensure that members receive a physical exam annually and appropriate intervention to ensure improved health outcomes." Similarly, Item 5 states, "Describe the process you will have in place to ensure that any new member has an appointment scheduled with the selected medical home within at least 90 days of enrollment." How will compliance with these requirements be measured?	
79	RFP Section 5.6		Section 5.6, Item 8. Will DOM provide the CCOs with an electronic provider file of all providers enrolled in Medicaid and if so, will this file be available on a regular basis such as monthly or is the online tool all that is electronically available?	
80	RFP Section 6.2		Section 6.2 Evaluation of Proposals states, "At its option, the State may request an interview with selected Contractors." We recommend that an oral evaluation and interview process be established as part of the process. In our experience, the oral evaluation provides States a more complete picture of an organization's offering and will allow the State to fully understand the depth and breadth of experience in the Offeror's response.	
81	RFP Section 6.2.1		Please provide further clarification on expectations envisioned in the statement, "Additional consideration will be given to Offerors that provide a distinct added benefit to DOM beyond the basic requirements of the RFP."	

Question #	RFP Section #	RFP Page #	Question	Response
82	RFP Section 1.7 and 13.8		Sections 1.7 and 13.8 of the proposed Contract require the plan to provide advance notice prior to any change of ownership or assignment of beneficial ownership of 5% or more. Although our Mississippi subsidiary will be wholly-owned by AMERIGROUP Corporation, AMERIGROUP Corporation is a publicly traded company and advance notice is not possible for these changes in beneficial ownership. We receive updated information regarding our beneficial owners (5% or more) on a quarterly basis (45 days after the quarter) through U.S. Securities and Exchange Commission required reports." We recommend that these sections be revised to identify that advance notice should be provided for direct ownership changes of the CCO itself, but that for entities with publicly traded parent companies, changes in beneficial ownership must be reported within 60 days of the end of each quarter.	
83	RFP Section 1.11		Section 1.11, second paragraph states "CCOs must maintain a health information system…and disenrollments for other than loss of Medicaid eligibility." Please confirm DOM manages all enrollee/beneficiary enrollments and disenrollments and this is simply a requirement for CCOs to track this information as provided to them by DOM.	
84	RFP Section 3.3 Newborn Infants.		Please describe the enrollment process and assignment to a CCO of infants of mothers who have not selected a CCO? Please describe the transition process (eligibility, transition of care, etc.) of short term infants that have just a few months of eligibility before being returned to fee for service once they reach the age of 1?	
85	RFP Section 4.1		Section 4.1 states, "Children enrolled in MississippiCAN will have 12 months of continuous Medicaid eligibility and beneficiary over 19 years of age will have eligibility determined annually." What is the difference between 12 continuous months and annually?	Children are guaranteed full 12 months eligibility regardless of changes in circumstances that effect eligibility. The guaranteed 12 months eligibility ends when the child reaches 19 years of age.

Question #	RFP Section #	RFP Page #	Question	Response
86	RFP Section 4.1		Please clarify the enrollment and assignment rules for members eligible for MississippiCAN on the initial "go-live" date. Please describe the mechanics of the random auto assignment methodology, particularly any differences in this methodology if two CCOs are selected versus three. We recommend that after a period of one to two years using a random auto-assignment methodology, that MississippiCAN transition to an auto-assignment formula based upon service and health care quality metrics. A performance-based auto-assignment system should emphasize objective and quantifiable indicators that promote and maximize the quality and level of service to both members and providers. Indicators selected should have a reliable method of data collection. We firmly believe that using a performance-based approach is in the best interests of the State, its Medicaid recipients, and the managed Medicaid industry as a whole.	
87	RFP Section 4.1		Will CCOs receive redetermination dates for members? If so, what is the process and periodicity of this information? Will CCOs receive, or will DOM consider making available, historical enrollment data spanning further back than 2007? Post go-live, will CCOs receive an enrollment report with all CCO's membership broken out by product, method of enrollment and method of disenrollment? If a member involuntarily disenrolls, will CCOs be allowed to do a reminder outreach over the 2 months re-enrollment period?	
88	RFP Section 4.12		Section 4.12 states, "The Contractor must make available enrollee handbooks in languages other than English when five percent (5%) of the Contractor's enrolled population is non-English speaking and speaks a common language." Please provide the current prevalent non-English languages spoken among the targeted population. Please define what is meant by	

Question #	RFP Section #	RFP Page #	Question	Response
			"make available." Does DOM track enrollees' primary language and does DOM provide this data point to CCOs on its enrollment file (Enrollee Listing Report)?	
89	RFP Section 4.15 a		Please define the requirements for the schedule that must be submitted to the Division two weeks prior to any marketing event. Please define "event" in this context. Please confirm that the State is referring to events that *involve potential members.*	
90	RFP Questions by Section		How long does the member's annual CCO choice period last? When does it begin and when does it end relative to their re-determination date?	
91	RFP Section 4.7 and 4.14		Section 4.7, Enrollment Verification and 4.14 Enrollee Listing Report. Will DOM or its duly authorized representative be providing the 834 to the CCOs as the "enrollment report" or will this report be a proprietary format? Is this the same as the "Enrollee Listing Report" referenced in Section 4.14? Is the weekly roster referenced in 4.14 sent to the CCOs and if so, is it in the 834 format or a proprietary format?	
92	RFP Section 4.9		Section 4.9 of the proposed Contract requires that member materials be written at a 3rd – 4th grade reading level, however Sections 4.12 and 4.13 require no more than an 8th grade reading level. Please clarify which standard is used for member materials.	
93	RFP Section 8.1		Contract 8.1 states, "All records shall be maintained at one central office in Mississippi." Please confirm that this statement allows electronic access to paper records housed elsewhere and that electronic records can be available online at the office in Mississippi or made available after retrieval from a secure storage vendor if offline.	

Question #	RFP Section #	RFP Page #	Question	Response
94	RFP Section 8.2		Contract 8.2, Monthly Management Report. The section states, “In addition, the Contractor shall document all telephone calls from Medicaid beneficiaries. This information must be available in the Contractor’s Mississippi office for Division review upon request.” Please confirm this information can be made available electronically from the CCO’s systems, which may not be housed in the Mississippi office but are accessible from the Mississippi office.	
95	RFP Section 9.1		Please provide confirmation that DOM will exchange standard x12 transactions such as 834, 837, and 820/835 for applicable data transactions with the CCOs supporting enrollment, encounters, premium payment. Please provide a list of data interfaces and an indication of frequency and format/layout standard.	
96	RFP Section 9.7		The contract specifies that the CCO must maintain $50,000 stop-loss insurance. In our experience, this is a very low attachment point and will likely cost the CCOs a significant amount to purchase, increasing the cost of the program to the State significantly. Will the State consider increasing this requirement to a higher level, such as $500,000, or a level to be determined based on the financial resources of the CCO and its affiliated companies?	
97	Data Book Questions		How will non-SOBRA pregnant women be identified? Will they be enrolled retro-actively into CCOs? Rates should reflect actual DOM enrollment polices.	
98	Data Book Questions		Please provide all adjustments made to the Data book data, including but not limited to the following: a. IBNR b. Managed care savings assumptions c. Utilization and unit cost trends d. Fee schedule or other FFS reimbursement changes e. Rx Rebates	

Question #	RFP Section #	RFP Page #	Question	Response
			f. Non-system payments (e.g. certain TPL recoveries) g. Benefit changes h. Eligibility changes (such as FPL changes) i. Any programmatic changes which could impact experience, such as changes in policies regarding citizenship etc. (Note: Please describe the nature of any benefit, programmatic, reimbursement or eligibility changes)	
99	Data Book Questions		Please describe how the State will pay the 0-2 month rate cell, and confirm that the rate development will be consistent with the payments. Specifically, confirm how the CCO will be paid for the birth month of the newborn, and that the rate development is consistent with payment methodology.	
100	Data Book Questions		Although people residing in institution are excluded, many individuals can have short-term stays in nursing facilities (typical post-acute care). Would DOM consider letting institutionalized people to stay in MississippiCAN for a limited period of 60 to 120 days, so that short-term stay people are not disenrolled unnecessarily from the program?	
101	Data Book Questions		Please provide data from SFY2006 data in a format similar to the data supplied for SFY2007 and SFY2008 to aid respondents in evaluating historical trends.	
102	Data Book Questions		Please provide more detailed category of fee breakdown, especially for outpatient services. At a minimum, please provide emergency room utilization and unit cost experience for each rate cell	
103	Data Book Questions		Please provide a list summarizing DRG payments to hospitals, by each DRG. If possible provide separate summary by region. Also, if possible, provide separate summary for out-of-state facilities.	

Question #	RFP Section #	RFP Page #	Question	Response
			The summary should include: a. Number of admits b. Number of Discharges c. Average length-of-stay d. Total days e. Total payments.	
104	Data Book Questions		Please provide a supplies summary report showing physician claims paid by procedure code including: number of procedures, total allowed payments.	
105	Data Book Questions		Please provide a summary of hospital experience by facility including total admits, days, allowed payments for inpatient service, and total encounters and allowed payments for outpatient service.	
106	Data Book Questions		Please provide a report detailing hospital allowed payments by county of residence of member.	
107	Data Book Questions		Please provide claim triangles used to develop IBNR factors that are applied to the data. If possible, provide separate claim triangles by rate cell, region, and type-of-service. With regard to type-of-service breakdown, please divide hospital inpatient, hospital outpatient, physician, Rx and ancillary providers.	
	Data Book Questions		We have seen in other states that many newborns are enrolled retroactively. Will DOM enrollee newborns retroactively?	
	Data Book Questions		How will individuals who are hospitalized on the go-live date be addressed? Will they be enrolled into a CCO? If enrolled into a CCO, will the CCO be responsible for the admission?	

Question #	RFP Section #	RFP Page #	Question	Response
	Data Book Questions		Please provide the raw claims data used to develop the data book.	
	Data Book Questions		Please provide Rx utilization and unit cost data split between generic and brand? Can this data be provided at a rate cell level? Can we get Rx data by NDC code by rate cell	
	Data Book Questions		Please provide a distribution of NICU claims by length-of-stay.	
	Data Book Questions		Please provide a distribution of NICU claims by allowed dollars.	
	Data Book Questions		Please confirm that for children under 1, that at program go-live, all children under 1 will be enrolled on the go-live date and then be disenrolled in the month they turn 1 year old. For example, for a child born on Jan 1, 2009, they will be enrolled in a CCO at go-live on Oct 1, 2009 and disenrolled Dec 31, 2009?	
	Data Book Questions		Will FQHC/RHC encounters be reprocessed into a procedural counts and unit costs? If so, will Milliman describe how they performed the reprocessing?	
	Data Book Questions		Will an allowance for the cost of capital be including in the administrative allowance? If so, will Milliman describe how it is developed?	

Question #	RFP Section #	RFP Page #	Question	Response
	Data Book Questions		Will DOM schedule a meeting to review the rates and their development with the bidders and Milliman?	
	Data Book Questions		Will DOM consider establishing a policy that allows a default for out-of-network providers for emergent services at a percentage less than Medicaid?	
	Questions on RFP Attachments		Attachment 3 of the RFP includes language regarding debarment, suspension and other matters of responsibility. It appears that the scope of this form is based on a part of the CFR that is no longer in effect. The language of the form extends beyond the federal requirements of 45 CFR Part 76 Appendix A which addresses civil judgments related to exclusion, not civil judgments standing alone. We strongly recommend that this Certification be revised to match the language of Section 13.5 of the Contract which addresses debarment, suspension and exclusion which is consistent with current federal law. The following provides two examples of methods to address this issue: First, the State of South Carolina's Certification form states the following: "By signing and submitting this lower tier proposal, the prospective lower tier participant, as defined in 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principles: (a) Are not presently debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded from participation in this transaction by any federal department or agency. (b) Where the prospective lower participant is unable to certify to any of the above, such prospective participant shall attach an explanation to this proposal. The prospective lower tier participant further agrees by	

Question #	RFP Section #	RFP Page #	Question	Response
			submitting this proposal that it will include this clause entitled Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion – Lower Tier Covered Transactions without modification in all lower tier coverage transactions and in all solicitations for lower tier covered transactions." Second, in the State of Nevada, the Agency has included the affirmation in the contract language as follows: "In the event that federal funds are used for payment of all or part of this contract, the Contractor certified by signing this Contract that neither it nor its principals presently are or could be debarred, suspended, proposed for debarment, declared ineligible, voluntarily excluded from participation in this transaction by any federal department or agency.	
	1.4.2.1	8	Will there be any provision for risk adjustment of the capitated rates based on risk or health assessment of members? One common methodology used is the Chronic Illness and Disability Payment System (CDPS) which allows for calculation of a risk score for each CCO by analyzing the perceived impact of chronic and disabling conditions on the demand for care.	
	1.4.2.1	8	Will there be a separate band for estimated cost by ages and gender above 21, i.e. 21-40, 40-60, >60?	
	1.4.2.1	8	What time period will the CCOs have to review the offered rates and when will that occur in the process?	

Question #	RFP Section #	RFP Page #	Question	Response
	1.4.3.1	9	Will there be the opportunity to manage/require prior auth on psychotropic medications?	
	1.4.3.1	9	Regarding the requirement for scheduling appointments for any new member within 90 days of enrollment - Does that mean scheduling must occur, or the appointment must occur within that time frame? How will the requirement be enforced for that and the annual physical? Literature does not support physical annual exams for all age groups. Would annual risk assessment be considered sufficient? Or would use of a nationally accepted protocol for exams and screening, such as USPSTF be acceptable?	
	1.4.3.3	9	If a provider is contracted by the CCO, must the provider also agree to see non-CCO Medicaid patients, since providers are required to be enrolled in Medicaid program?	
	1.1	5	When does the State anticipate submitting its 1915(b) waiver request to CMS?	
	1.4.1.3	6	Will the State provide to CCOs the historic claims/health status data that leads to the identification of these members to enable the CCO to respond more quickly to each member's needs?	
	1.4.1.4	6	Will the State consider "locking in" the child to the CCO that covered the mother's birth?	

Question #	RFP Section #	RFP Page #	Question	Response
	1.4.1.4	6	Will the State commit to working with the selected CCOs in creating the process for counseling beneficiaries on CCO selection?	
	1.4.1.6 and 1.4.2.1	7-8	When will the State decide whether to allow NICU risk sharing?	
	1.4.2.1	7	Will the State consider facilitating appropriate meeting(s) among State and CCO actuaries regarding rate setting? In our experience, the actuarial process is enhanced by the sharing of perspectives and understanding, and the result is a collaborative “win-win” for both State and vendor.	
	1.4.2.1	8	Will the State consider collaborating with CCOs to ensure the expeditious enrollment of pregnant women into the CCO of their choice? Doing so will enable the CCO to provide the beneficiary with care and support services at the earliest possible point in her pregnancy, thus enhancing the opportunity for a healthy, full-term birth.	
	1.4.2.1	8	When will the State decide whether to allow rates by region?	
	1.4.3.3	9	Will the State implement a provision that allows CCOs to pay providers at State Medicaid rates in the event contract terms cannot be reached? Alternatively, will the State consider adding a requirement indicating that if at least three documented attempts have been made by the CCO to contract with an out-of-network provider, then the CCO is not required to pay the out-of-network provider more than State Medicaid rates for the applicable service, less a percentage such as ten percent (10%)? These types of provisions have been successful in other	

Question #	RFP Section #	RFP Page #	Question	Response
			states to facilitate the timing of network development by CCOs to meet state timelines.	
	1.4.3.3	9	What type of educational outreach does the State plan to provide to providers across the state to familiarize them with the new MississippiCAN program?	
	1.4.3.3 and 3.5	9, 19	Are there specific provisions related to the MississippiCAN program or otherwise required by Mississippi law that are required to be included in CCO's contracts with providers and other subcontracts?	
	1.4.4.1 and 5.7 & 5.8	10, 45-46	When does the State anticipate that readiness reviews will begin? An estimate is needed to appropriately respond to Sections 5.7 and 5.8 of RFP response.	
	1.4.4.2	11	For required reports, does the State have specific formats that the CCO must use and if so, will the State provide those formats prior to RFP response due date?	
	4.3 and 5.7 & 5.8	31, 45-46	When does the State anticipate announcing contract awards? An estimate is needed to appropriately respond to Sections 5.7 and 5.8 of RFP response.	
	5.4.2	37	Regarding financial statements, if the entity bidding is a start-up in the state of MS, what information should be provided to meet the requirements of this section?	

Question #	RFP Section #	RFP Page #	Question	Response
	5.4.3	37	Regarding corporate experience, if the entity bidding is a start-up in the state of MS, what information should be provided to meet the requirements of this section?	
	5.6, Question #7 and #49; Contract sections 4.9, 4.12, and 4.13	39, 43	Please confirm that reading levels are required to be at sixth grade level or less as Questions #7 and #49 suggest. There are conflicting statements about reading levels in RFP vs. Contract.	
	5.6, Question #7	39	This question asks for a description of proposed informational materials, but page limit specifies "excluding copies of materials." Is the bidder required to include copies of materials or just the description? If copies of materials are required, can they be samples from another state?	
	5.6, Question #39	43	The contract defines "Medically Necessary." This component asks the bidder to provide its definition of "medically necessary care." What is meant by this question given that the term is already defined by contract and must be used by the CCO.	
	6.2	47	What is the scoring/point structure for evaluating RFP responses? If detailed structure cannot be released, what is the weighting for each major category?	
	Contract; 1.5; Contractor Requirements		Bidder is in the process of obtaining licensure as an HMO in MS, and is the subsidiary of a national managed care company that has subsidiaries in other states that have 5+ years Medicaid experience. Will that satisfy the requirements of the Contract and RFP regarding licensure and contractor experience?	

Question #	RFP Section #	RFP Page #	Question	Response
	Contract; 1.11; Base of Operations		What is meant by “The member call center must be available to member 24 hours a day, seven days a week”? Must there be live assistance for all member matters on a 24/7 basis? May some functions be available on an automated basis?	
	Contract, 4.12		Are there any non-English languages that are currently spoken by 5% or more of MississippiCAN targeted populations?	
	Contract; 5.7; Authorization of Services		Do initial authorization requests need to be reviewed by a peer-matched physician, similar to how appeals are reviewed? What is meant by a “health care professional who has appropriate clinical expertise in treating the Enrollee’s condition or disease”?	
	Data Book , page 2, Executive Summary Section		Please elaborate how did you account in the claims data buildup for a likelihood of incomplete submissions for newborn neonates during a 3 month claims run-out? Newborn NICUs often have much longer length of stays, have multiple submissions of interim inpatient claims for the same admit date and are usually processed much longer than any other claims due to extensive clinical and financial review from exposure to outliers.	
	Data Book, page 4, Background Section		Please indicate how auto-assignment process will work and ensure equitable distribution of members in absence of separate enrollment broker that will be procured. Please indicate how potential selection issues resulting from the absence of uniform auto-assignment process will be addressed in actuarial rate-setting and rate design?	
	Data Book, page 3-4, Background Section		Please indicate how newborn will be assigned to CCO after birth: do they automatically enroll in the CCO that mother was enrolled into at the time of birth, or will mother need to make a choice within a certain period of time? Where would the state enroll this newborn during the time pending the decision of newborn’s mother?	

Question #	RFP Section #	RFP Page #	Question	Response
	Data Book, page 3-4, Background Section		Please indicate how newborn will be assigned to any given CCO in case a mother that delivered early a premature NICU had not been enrolled in any of the CCOs? How will selection risk and adverse impact on a CCO from a known NICU be addressed? How will claim payments originating to the date of birth of that newborn be handled in this case?	
	Data Book, page 4, Background Section		Please elaborate what exactly the 12 month continuous Medicaid eligibility would mean with a few illustrative examples, especially during the first year of the program.	
	Data Book, page 4, Background Section		Please indicate how the 12 month continuous Medicaid eligibility will be applied in case a 10 month old newborn is enrolled at the beginning of the CCO program: will it be disenrolled when it is no longer a newborn 2 months later?	
	Data Book, page 4, Background Section		Please elaborate if “for cause” disenrollments described in the first paragraph of page 4 will be allowed between CCOs when, for example, there is a difference in provider networks between them? How will this disenrollment and enrollment process address potential selection issues? How will this potential selection risk for CCOs with greater access to specialists and specialty hospitals be addressed in the rate development and structure (as required by CMS in the checklist for actuarial soundness) in the absence of risk adjusters?	
	Data Book, page 5, Methodology Section		Please indicate if newborn rate cell was excluded from retroactive eligibility adjustment.	
	Data Book, page 5, Methodology Section		Please indicate how many months on average of claims and enrollment data were removed as a result of the retroactive eligibility adjustment? Please summarize by rate cell (including the kick rate-cell) to evaluate varying	

Question #	RFP Section #	RFP Page #	Question	Response
			impact of retroactive adjustments by population type of MississippiCAN and potential data abnormalities.	
	Data Book, page 6-7, Methodology Section		In reference to removal of "any of the institutionalized beneficiaries," please elaborate how short term stays in long term care facilities and members affected will be treated from the eligibility and covered benefit perspective of MississippiCAN?	
	Data Book, page 2, Executive Summary		Please indicate how a potential longer lag in claim submissions from out of state hospitals was accounted for in data book development based on claims data with just 3 months run-out. Please indicate the percent of claims from out of state facilities by each of the 3 regions and percent of their claims that would have been missed if 3 month run-out criteria were applied to SFY07 data.	
	Data Book, page 7, Methodology Section		Please illustrate reasonability and sensitivity of assumption about 5 months of average eligibility for MississippiCAN pregnant women rate-cell. Please summarize distribution of members by month, number of months before delivery for each of the 3 regions to detect variability and potential regional anomalies. Please also summarize resulting non-kick pmpms for each of these subgroups of women (i.e. average pmpm of 6 months of prenatal services, 2 months before delivery, etc) – also by each of the 3 regions.	
	Data Book, page 7, Methodology		Please indicate if data grouping for 0-2 months newborns is consistent with expected basis for 0-2 month premium payment to CCOs: please indicate if any adjustment to data groupings was made to account for potential differences.	

Question #	RFP Section #	RFP Page #	Question	Response
	Data Book, page 8, Methodology		Please indicate the portion of claims in non-kick pregnant rate-cell category that does represent obstetric and delivery related services as opposed to remaining high cost claims for pregnant high cost members. Please summarize for each of the 3 regions to detect and review for data abnormalities.	
	Data book, page 8, Methodology		Please provide a summary of DRG distribution of pregnant rate cells for each of the 3 regions and statewide including claims paid, days and ALOS.	
	Data book, page 8, Methodology		For resulting newborn rate cells, please provide DRG distribution for each of the 3 regions and statewide including claims paid, days and ALOS.	
	Data book, page 8, Methodology		Similarly to claims distribution provided for other rate cells, please provide claims distributions for each of the 3 regions for newborn and pregnant rate cells including days and ALOS in each of the claim categories used in claims distribution table.	
	Data Book, page 8, Methodology		It appears that there was a decline in number of average pregnant enrollees over two years exhibited in the table – have there been any processing, eligibility or other changes that may have affected lower Medicaid enrollment on the basis of pregnancy? Have there been any changes in FPL (Federal Poverty Level) criteria over these base years and since then for pregnant women applying for Medicaid in Mississippi?	
	Data Book, page 13, Other		Please provide a summary of inpatient, outpatient and emergency services distribution by top 20 facilities for each of the 3 regions indicating separately proportion of claims from out of state facilities and “all other” category; Please group claims data summarizing by facility paid dollars, utilization count (days and admits for inpatient category) and billed dollars if available; This information	

Question #	RFP Section #	RFP Page #	Question	Response
			will be essential in evaluating contracting need and basis specific to each region and will ensure smoother transition when MississippiCAN is implemented.	
	Data Book, p 13, Other		Please indicate if there were any processing changes over the two base years and since then due to enhanced citizenship check requirements. Please comment if difference in resulting population was analyzed for rate-setting purposes.	
	Data Book, Appendix A-1		Please indicate the method of payment for FQHCs and Rural Health Clinics and how this data was adjusted for purposes of rate-setting. Please indicate the magnitude and direction of the resulting adjustment for these line items.	
	Data Book, Appendix A-1		Please indicate what is the definition of utilization statistic for each of the exhibited categories of service: inpatient, outpatient, etc.	
	Data book		Based on the data book discussion, please confirm that the first-year and subsequent year capitation rates will cover an October 1 – September 30 plan year. The historical state fiscal year is defined as July 1 – June 30.	
	Data book		How will DOM reflect the mandated annual Wellness exam in the capitation rates? Does the DOM anticipate 100% of eligibles will successfully complete an exam?	
	Data book		In the data book, for the Infant 0-2 months, do the costs include the cost for the well-newborn (i.e., Well or Normal Newborn" DRG) or is that cost reflected under the Pregnant Woman category?	

Question #	RFP Section #	RFP Page #	Question	Response
	Data book		Please provide, for SFY2007 and SFY2008, the member months, and allowed costs, by age-band and region, for the five separate "High Cost" Categories of Care (COE).	
	Data book		Please provide, for SFY2008 if available or for SFY2007, the top ten most prevalent diagnoses, by age-band and region, for the five separate "High Cost" Categories of Care (COE).	
	Data book		Given the fact that there will be no risk adjustment, would the state consider changing their decision to assign infants <1 who are also in a high-cost eligibility category to the infant rate and instead assign them to the high-cost 0-5 rate?	
	Data book		Based on the data book discussion, please confirm that "behavioral health prescription drugs" administered in an inpatient or outpatient hospital setting were excluded from the data book.	
	Data book		Please provide details of the risk sharing arrangement the DOM will provide for NICU babies.	
	Data book		Based on the data book discussion, please confirm that the proposed risk sharing arrangement was not reflected in the data book for "Infants"	
	Data book		When DOM releases the capitation rates, please provide the adjustments made to the data book source, covered group, by service category, and by utilization and unit cost, and for: a. Trend	

Question #	RFP Section #	RFP Page #	Question	Response
			b. Medical management savings assumptions c. Adjustment for Incurred But Not Paid claim runout d. Benefit changes, including impact of mandatory annual physical exam e. Population changes (if applicable) f. Any other adjustments (please identify separately)	
	Data book		Based on the data book discussion, please confirm that there will be a Q&A session following the release of the payment rates.	
	Data book		Are CCOs responsible for claims between becoming eligible and being assigned to a CCO?	
	Contract 4.9, 4.12, 4.15.a.v RFP 5.6, question #7	27 of 88	Section 4.9 of the contract states all written materials provided to enrollees should be written at a 3rd grade reading level, not exceeding the 4th grade level. Section 4.12 of the contract states: For the purposes of this Contract, no program information document shall be used unless it achieves a Flesch total readability level of eighth grade educational level or below. Section 4.15.a.v. also references eigth grade reading level. Section 5.6 of the RFP states: Address language alternatives that will be available and how you will ensure that reading levels will be at a sixth grade level. Please clarify which readability level the Contractor should achieve for enrollee materials.	
	Contract 5.2	36 of 88	Does DOM intend to provide content for this section of the contract?	

Question #	RFP Section #	RFP Page #	Question	Response
	Contract 8.10	70 of 88	Is there a Subsection 8.10 or should subsections from 8.11 on simply be renumbered so that all are in sequence?	
	Contract 5.4.f	39 of 88	"When an enrollee changes his/her PCP, the Contractor must make the enrollee's medical records or copies thereof available to the new PCP within 10 business days from receipt of request." Based on HIPAA restrictions, only the member can request or authorize their records being sent to the new provider. Please clarify DOM's expectations of the Contractor.	
	Contract 4.7 & 5.4.d	24 of 88 & 38 of 88	Contract 4.1, Parag. 7 - Parag. says that CCOs auto assign if members haven't made a voluntary selection within 14 days of enrollment. RFP 5.6(31) says if members don't choose within 30 days of enrollment, that auto assignment must be within 60 days of enrollment. Contract 5.4d requires CCOs to auto assign if the member does not request a PCP before the 25th day of the month prior to the enrollment effective date. Please clarify applicable timeframes. Please specify what dates "enrollment" and "effective date of enrollment" mean. In the Glossary, enrollment is defined as DOM's adding an enrollee to the enrollee listing. However CCOs will not know when that action takes place. CCOs learn of enrollment only when they receive an enrollee listing from DOM.	
	Contract 5.3	Contract 36 of 88	Please confirm that "payment in full" as referenced in the fifth paragraph of this section means 100% of the prevailing Medicaid fee schedule.	

Question #	RFP Section #	RFP Page #	Question	Response
	1.4.3.3	9	There is a requirement that network providers are paid "no less than the rates paid by Mississippi DOM". Does this mean the rates paid on the claim/encounter? Please confirm that it is NOT inclusive of any cost settlement, subsidy, DSH, UPL, or other supplemental payments made by DOM or the State?	
	1.4.3.3	9	We have agreements with providers that have been negotiated and agreed upon at a national level. Sometimes these agreements may reimburse LESS than State Medicaid rates. Does the requirement in 1.4.3.3 to pay "no less than the rates paid by the Mississippi DOM" prevent us from using these terms in Mississippi?	
	1.4.3.3	10	Please clarify what providers would be classified as "non-hospital…….emergent care providers."	
	2.1.2.3	13	Home and Community Based Services (HCBS) are included as required services in this section. However, Section 3.2.b. of the Contract states that "Beneficiaries enrolled in HCBS Waiver programs…" are not eligible to enroll in the Plan. This seems to be a conflict. Is this RFP section requiring that these HCBS services be available for members NOT enrolled in an HCBS waiver program?	
	5.12.b.	43 of 88	This requirement indicates that the Contract shall "reimburse FQHCs at a rate negotiated between the Contractor and the FQHC. This reimbursement shall be no less than the Division would pay to FQHC provider." Does this floor (minimum reimbursement) refer to the interim claim/encounter fee schedule amount that the Division pays FQHCs, or does this refer to the final amount after any supplemental payments are made as a	

Question #	RFP Section #	RFP Page #	Question	Response
			result of cost settlements or other reconciliations?	
	5.12.c.	43 of 88	This requirement indicates that the Contract shall "reimburse RHCs at a rate negotiated between the Contractor and the RHC. This reimbursement shall be no less than the Division would pay to RHC provider." Does this floor (minimum reimbursement) refer to the interim claim/encounter fee schedule amount that the Division pays RHCs, or does this refer to the final amount after any supplemental payments are made as a result of cost settlements or other reconciliations?	
	5.3	36 of 88	Referring to section: *Emergency medical services shall be available within 30 minutes typical travel time to Enrollees 24 hours a day, seven (7) days a week, either in the facilities of providers who have contracted with the Contractor or through arrangements approved by the Division with other providers. The Contractor must assure that primary care physician services are available, on a timely basis, to comply with the following standards: urgent care - within one day; routine sick patient care - within one week; and well care - within one month.* If it is determined that there is not a hospital (contracted or non-par) within 30 minutes of enrollee, what are the acceptable methods for CCO to demonstrate adequate access to meet this requirement?	

Question #	RFP Section #	RFP Page #	Question	Response
	RFP		Will attachments other than those specifically requested be allowed?	
	RFP 1.3	5	Please confirm that submission of Attachment 3, DHHS Certification Regarding Debarment, Suspension, and Other Responsibility Matters satisfies the documentation requirement for requirement #1.	
	RFP 1.3-2&4	5	If the Offeror is a newly formed Mississippi-based entity, please confirm that experience of the Offeror's parent organization's health plans in other states would satisfy the requirements for experience referred in #s 2 and 4 of Section 1.3.	
	Attachment 1 Glossary	49 - 55	'PHM contractor' is used in Glossary definitions, but is not itself defined. To what does PHM refer?	
	Contract 2.1 RFP 3.3	Contract 13 of 88 RFP 15	The Contract says the term is two years; RFP 3.3 says term is two years plus two optional one-year extensions - please confirm that there are two one-year optional extensions.	
	Contract 4.18 & 5.14	34 of 88 & 44 of 88	Please clarify if members who are hospitalized at the scheduled time of enrollment will be enrolled in the plan or wait until the month following discharge. These two sections of the contract appear to give conflicting information.	
	RFP 5.6 #43, 46, 47, 48	43	Please confirm whether practitioners prescribing medications for behavioral health conditions who are not CCO-contracted network providers, that is, practitioners with Community Mental Health Centers, will be required by DOM to comply with the CCO's Preferred Drug List	

Question #	RFP Section #	RFP Page #	Question	Response
			and exception process, drug utilization program, and related processes.	
	RFP 5.6-47	44	Please confirm that this question refers to identifying provider utilization patterns regarding prescription drugs, as opposed to utilization patterns for all covered services. (This question is placed among other pharmacy questions, but the question itself does not mention pharmacy services.)	
	Contract 4.6b(i)	19 of 88	Will the State allow the member's effective date and term of coverage be on the ID card, and not in the handbook, since members' dates and terms will be different, and handbooks are not individualized to the member?	
	data book		Please clarify if members will be allowed to remain with CCOs for any period of time (30, 60 or 90 days) after admission to a long term care facility to provide CCOs an opportunity to transition members back to a community-based setting.	
	RFP 5.6 question #10	40	Would the State consider excluding MIS diagrams from the page limit for question #10? If not, please clarify which component of MIS you would like a diagram for (datacenter, systems architecture, application architecture, data and process flows).	
			Will CCOs receive historical utilization data on their enrolled members?	

Question #	RFP Section #	RFP Page #	Question	Response
	ADDITIONAL DATA REQUESTS		For pharmacy data in data book, please provide additional distributions by: a. Generic vs. Brand-Name b. Retail vs. Mail c. Formulary vs. Non-Formulary	
	ADDITIONAL DATA REQUESTS		For Outpatient Hospital line in the data book, please provide distributions by Emergency Room and All-Other Outpatient.	
	ADDITIONAL DATA REQUESTS		For Physician services in the data book, please provide additional utilization and unit cost distributions by Primary Care Physician (PCP) and Specialists.	
	ADDITIONAL DATA REQUESTS		For the Pregnant Woman group in the data book, please provide additional utilization and unit cost distribution for Normal vs. C-Section babies.	
	ADDITIONAL DATA REQUESTS		For all groups, in the In-Patient Hospital line in the data book, please provide additional utilization and unit cost distributions by Medical, Surgical, Substance Abuse, Maternity and Other. Please also provide admit and day rates in order to calculate length-of-stay.	
	ADDITIONAL DATA REQUESTS		Since plans are responsible for all pharmacy costs, including psychotropics, please provide the Behavioral Health utilization and unit cost data that was carved out of the data book to assist in understanding the experience for this population, which will drive the pharmacy expenses.	
	1.1 Purpose, second bullet point		What is the definition of “other programs”?	

Question #	RFP Section #	RFP Page #	Question	Response
	1.2 Authority		Will the state provide the CCOs a list by volume of points and dollars paid of the current FFS providers?	
	1.4.1.3 Program Overview		Discusses excluded population – How many eligibles fall into these categories?	
	1.4.1.4 Mandatory Enrollment and Eligibility		Who will provide enrollment broker services if no separate enrollment broker will be procured? Will it be staff at DOM and/or the Medicaid fiscal agent?	
	1.4.1.4 Mandatory Enrollment and Eligibility		When is the state meeting with local advocates, providers, and beneficiaries? Can potential CCOs attend these meetings to meet the community?	
	1.4.1.4 Mandatory Enrollment and Eligibility		Are there limits to the number of times a member can change their PCP within a month or year?	
	1.4.1.4 Mandatory Enrollment and Eligibility		What type of information will be provided to potential members and how will DOM obtain? What is the enrollment period for members to choose a CCO prior to the 10/1/09 effective date?	
	1.4.21 Capitated Coordinated Care Organizations' Rates		Pregnant Women – Maternity "kick payment" – What is the expected incidence of late-term enrollment, and is this calculated into the kick payment?	

Question #	RFP Section #	RFP Page #	Question	Response
	1.4.21 Capitated Coordinated Care Organizations' Rates		Please describe the programmatic mechanism for communicating the kick-payment information.	
	1.4.3.1 Benefits		CCOs must schedule appointments with medical home (PCP) for any new member within 90 days. Does this mean literally contact the member, coordinate their schedule, and make an appointment for them? How will this work with initial implementation of program? Will the timeframe be longer in order to not inundate the provider offices?	
	1.4.3.1 Benefits		The RFP does not include behavioral services—however psychotropic RX is covered because the RX will be written by the PCP. Will the CCO be required to pay for med management performed by the PCP?	
	Section 1.4.3.1 & 5.6 #5		Indicates a requirement to ensure all new members have a scheduled appt with their medical home within 90 days of enrollment. Does this apply to the initial enrollment group? Does DOM anticipate new CCOs to comply if receiving 10,000 – 20,000 members upon initial enrollment in Oct. 2009?	
	1.4.3.2		What is the anticipated time a DOM staff member would be working onsite at the CCOs administrative office? Is the intent for the office to remain vacant otherwise? CCO's must schedule medical home appointments within 90 days for the member. If we are matching the member with their current provider and that member has been seen within the past 90 days will that requirement be considered to have been met. The Member service call center must be available 24 hours a day seven days a week. If our Member service	

Question #	RFP Section #	RFP Page #	Question	Response
			call center is available and supported by a 24/7 Nurse Advice Line will that requirement be considered to have been met.	
	1.4.3.3		Is it the expectation of DOM that CCOs will have binding contracts with out of state providers at the time of the operational start date? Can an out-of-state provider be reimbursed at the Medicaid rate of their specific state, even if it's lower than those rates paid by Mississippi DOM?	
	1.4.3.4 Care Management		Members shall have the choice of selecting a medical home – If they do not select, can the CCO assign to a medical home?	
	1.4.3.4 Care Management		In addition to the Disease Management programs identified in Section 1.4.3.4 of the RFP, are there other DM programs that the State would see as beneficial (i.e. HIV/Aids)	
	1.4.3.4 Care Management		Does the State have any expectations on the percentage of members that will be managed by the Disease Management and Care Management programs? Some states with which we work do have specific expectations.	
	1.4.3.4 Care Management		Does the State have any expectations on case load size/ratios for care/case management?	
	1.4.3.4 Care Management		Regarding DM and targeted CM—does the state have expectations on the % of members that will be managed?	

Question #	RFP Section #	RFP Page #	Question	Response
	1.4.3.5		"CCO will commit to supporting electronic records in the MD office". Can the state describe in more detail what their expectation is?	
			The RFP does not include behavioral services; however psychotropic medications are covered because the RX will be written by the PCP. Will the CCO be required to pay for med management performed by the PCP?	
	1.4.32 Administrative Services		What are the standards for claims, financial, and administrative accuracy?	
	1.4.32 Administrative Services		When will they be established if not currently in place?	
	1.4.32 Administrative Services		What is the % of errors acceptable in encounter data submissions?	
	1.4.32 Administrative Services		What is the timeframe to meet the metrics for encounter data submissions?	
	1.4.32 Administrative Services		What is the penalty if CCO doesn't meet the standard?	

Question #	RFP Section #	RFP Page #	Question	Response
	1.4.32 Administrative Services		Please provide information on the data format, frequency and transmission protocol for all required interfaces and reports.	
	1.4.32 Administrative Services		Please describe any validation rules for encounter submissions from the plan to the state.	
	1.4.32 Administrative Services		Please specify if the call center service level for members will be different during non-business hour periods. Can our Nurse Advice line satisfy these requirements for non-business hour periods?	
	1.4.33 Provider Network, Network Geographical Standards, first		Are there currently enough providers contracted with DOM that meet this criteria in every county?	
	1.4.4.1		What tentative timeframe does DOM anticipate conducting readiness reviews? How many months prior to the operational start date must the CCO have their systems up and running and be fully operational to meet the readiness review requirements?	
	2.1.23		What are the "other waiver programs"? Which, if any, of the services listed in Sections 2.1.2.1 and 2.1.2.2 of the RFP are not covered by the MississippiCAN program?	
	3.4		Notices - Can notices be sent via e-mail with original to follow via certified mail?	Yes.

Question #	RFP Section #	RFP Page #	Question	Response
	3.5		This section indicates shall not subcontract any portion of the services without prior written approval from DOM. Would the proposal be deemed non-responsive if the use of subcontractors is included?	
	3.5		What is the timeline prior to the operational start date for approval?	
	3.6.3		Indicates proprietary information must be bound separately which semi contradicts section 5.1 which outlines the response format follows the requirements and order of the RFP. How does DOM anticipate proprietary information be identified/referenced in the proposal body and easily accessible to the reviewer?	
	3.14.3		Will DOM provide extracts in HIPAA compliant formats or proprietary?	
	4.3		Does DOM anticipate a revision to the current Timetable outlined in the RFP? What is the tentative award announcement date?	
	5.5.2		Should the key staff references include business, personal or both?	
	5.6 #15		Will the list of anticipated ad hoc reports become a contractual requirement? Will we be bound to produce all reports included in the submitted list?	

Question #	RFP Section #	RFP Page #	Question	Response
	5.6 #34		if the list of requested diagnosis is nationally recognized does DOM still want a complete list included with the response? Will it suffice to indicate the nationally recognized resource? If not, how does DOM anticipate receipt of the voluminous list imbedded or as an attachment?	
	5.6 #43		Will the PDL required be binding or would the CCO be able to make modifications with the states approval?	
	5.8		Indicates to factor in a 5 day state approval process. If no response is received from the state can the CCO automatically determine the state has approved and move forward? With such a tight timeline and "pending" milestones, deliverables etc. until state approval, is the state staffed to coordinate with each CCO and ensure timely turn around? Will each CCO have a dedicated state contact person to coordinate with? Will the work plan and schedule be binding or will revisions be allowed based on the states guidance and direction?	
	6.2		Indicates a standard evaluation form will be used. Can the CCOs receive a copy prior to the submission of the response?	
	6.2.1		Indicates additional consideration will be give to Offerors who provide a distinct added benefit beyond the basic requirements of the RFP. Are there guidelines to reference to determine what the state would / would not consider to be *a distinct added benefit beyond the basic requirements of the RFP*?	
	Actuarial/Data Book		How does the auto-assignment work in the mandatory enrollment	

Question #	RFP Section #	RFP Page #	Question	Response
	Actuarial/Data Book		What was the data credibility (weights) between SFY 07 and SFY 08?	
	Actuarial/Data Book		Page 12: "If a beneficiary was institutionalized at any time during a month, the MM and related claims were removed from the data book" - What would happen to the other health care cost for a bene with short term stay in SNF/LTC facility and released to home?	
	Actuarial/Data Book		Can Milliman provide health care cost and utilization data by COE and by region? (esp. for OP and ER)	
	Actuarial/Data Book		Can Milliman provide cost and utilization data by Generic vs. Brand by region?	
	Actuarial/Data Book		There will be one cap rate for the "high" cost group, but it might make more sense for Milliman to develop separate rate for Breast/cervical group vs. other SSI (my concern is the high cost chemo drugs in the future).	
	Actuarial/Data Book		Rx rebate was at 25-31% of expenditures, it was too high in two folds: 1. The rebate was for the entire Medicaid program; 2. Federal Rx rebate might include rebate for Generic; (John Meerschaert agreed to revisit this topic)	

Question #	RFP Section #	RFP Page #	Question	Response
	Additional Requests for Data and/or Information		What is the State's contingency plan should the 1915(b) waiver is delayed?	
			What are the top 10 diagnoses for the each of the following populations: • SSI • Disabled Children at home • Working Disabled • Foster Care Kids • Breast/Cervical group?	
			Please provide the number of beneficiaries associated with each diagnosis.	
			Please provide the historical distribution of the SSI, Disabled Children at home, Working Disabled, Foster Care Kids and Breast/Cervical populations by county and by zip code.	
			Please provide the historical distribution of the pregnant women and children under the age of one year populations by county and by zip code.	
			Please provide a list of all providers of mental health services used by the Mississippi Medicaid program.	

Question #	RFP Section #	RFP Page #	Question	Response
			What non-English speaking populations are served by the Mississippi Medicaid program?	
			Please provide a list of all providers currently enrolled with the Mississippi Medicaid program. Please provide associated specialty/type if possible.	
			Please provide a copy of the current Mississippi Medicaid program PDL.	
			Please provide a list of the minority contractors currently contracted with the Mississippi Medicaid program.	
	Contract Section 1.11		When will the claims, financial and administrative accuracy standards be established?	
	Contract Section 1.12		Will DOM provide data that can be broken down to identify the top choice providers by number of patients and dollars paid?	
	Contract Section 1.12		Do the 82 counties covered in this RFP have available providers to meet the stated access standards?	

Question #	RFP Section #	RFP Page #	Question	Response
	Contact Section 4.2		Estimated date when provider directory information required for enrollment packet?	
	Contact Section 4.2		How will the enrollment form data be transmitted to the CCOs?	
	Contract Section 4.3		What are the primary languages spoken in the state of Mississippi?	
	Contract Section 4.4		Does the state enroll all beneficiaries on the first day of each month, or are there daily or weekly eligibility adds?	
	Contract Section 4.6		When does the state disseminate eligibility files to the CCO?	
	Contract Section 4.6		How many days prior to the first day of the month?	
	Contract Section 4.9		States all written material must be at third or fourth grade reading level. Sections 4.12 and 4.13 states documents for program description must be at eighth grade or less. Please clarify.	

Question #	RFP Section #	RFP Page #	Question	Response
	Contract Section 5.1.c		Post-stabilization – What mechanism will be used to measure time the ER called and when an hour of non-response from CCO has occurred?	
	Contract Section 5.12		Requires that CCO distribute criteria for emergency services to all facilities. Where is the starting point for measurement of the 30-mile radius?	
	Contract Section 5.12.b and 5.12.c		Do this negotiated rate and the requirement to pay no less than the Division would pay include the FQHC and RHC enhanced rates?	
	Contract Section 6.1.e		In order to identify the provider appropriately in encounter data submissions, the requirement is to capture and include the “unique physician identifier.” Is this a Mississippi state-specific or Federal NPI number?	
	Contract Section 8.13		This section states the contractor must count an encounter for all “covered” services. How will the non-covered, value-added services be counted/documented?	
	Contract Section 9.5		The contractor cannot recoup payments from an enrollee even if the State recoups premium payments from the contractor due to eligibility loss. Can the contractor recoup from providers payments made under this scenario?	
	Contract Section 9.8		The rates have been adjusted to account for third party resources. What factor or dollar amount was identified for this scenario? If an identified third party does not pay within 60 days, the contractor must proceed with payment and then recover if payment is subsequently made. How does the	

Question #	RFP Section #	RFP Page #	Question	Response
			Division assume the 60-day clock will be met? Does the provider re-bill, or must a process be in place to follow up on those claims denied for third party payment?	
	5.6	n/a	Does the page limit apply to attachments?	
	5.6	n/a	For questions where an attachment is not specifically requested, may we submit attachments that support the response in addition to the page limit?	
	5.6	n/a	What is the page limit for questions number 5 and 62?	
	5.6	39 Question 6	Are there requirements or preference given if the member and provider call centers are located in MS?	
	5.6	42 Question 31	Contract section 5.4.e, states that the enrollee must have an assigned PCP from the date of enrollment with the plan. The RFP asks for a description of the process to assign members to a medical home within 60 days of enrollment. Is the requirement for immediate assignment to a PCP or within 60 days?	
	6.10.	n/a	Please describe the methodology used to calculate the screening rate. What is the current fee-for-service screening rate for the RFP population?	

Question #	RFP Section #	RFP Page #	Question	Response
	1.4.3.5	10	Requests commitment to support electronic medical records. What is the expected type and level of commitment?	
	4.4.12	34	Earlier verbiage stated that the contract was "take it or leave it", but this section refers to requests for submission of a best and final offer. Under what circumstances would a best and final offer be discussed?	This is strictly at the State's discretion.
	2.1.2	12-13	The list of covered benefits does not include Long-Term Care or skilled nursing. On slide 12 of the data book presentation, Long-Term Care claims were removed from the rate-setting process. We would expect to see some short-term utilization of these services in the target population. Are skilled nursing services (facility etc.) a covered benefit under Medicaid, and will it be covered by the CCOs? If so, should some portion of these services be included in the data book?	
	2.1.2	12	On the utilization pages of the data book, Family Planning Services (cos_cd 14) has $0.00 listed for all categories. Family Planning Drug Services (cos_cd 34) contains costs where appropriately to the age. Family planning services are listed as a federally mandated covered service. Please clarify why there would be no expenditures listed in this category.	
	1.6	11	Should any statistical errors be found that have a significant impact on the developed rates, will the DOM adjust the rates accordingly?	
	n/a	n/a	Should the actual number of enrollees be significantly lower than projected by the DOM, will there by an opportunity to adjust the rates in order to reflect the impact of fixed administrative costs?	

Question #	RFP Section #	RFP Page #	Question	Response
	n/a	n/a	Do you anticipate the choice or election period to begin on or prior to 10/1, and over what period will it be completed and processed after the election period? When would the first members be auto-assigned to the CCO?	
	n/a	n/a	What are the actuaries' expected/assumed medical expense trends by service category, by rate cohort, by region?	
	n/a	n/a	Will the state allow for questions and a rate development session to address questions after the rates and rate-setting methodology is released?	
	n/a	n/a	Pregnant women were found to average five months enrollment with Medicaid. How will the lag between Medicaid eligibility and CCO enrollment affect the enrollment period?	
	n/a	n/a	Would the DOM consider furnishing a probability distribution by DRG of admission for each of the rate cells?	
	n/a	n/a	Would the DOM furnish de-identified claims and enrollment data to the prospective CCOs for analysis prior to the RFP submission?	
	n/a	n/a	Please furnish percentage of generic drug utilization by rate cell.	

Question #	RFP Section #	RFP Page #	Question	Response
	n/a	n/a	Please furnish criteria for calculating the utilization statistics found in the data book - hospital services, outpatient hospital services, etc. For example, statewide infants' Inpatient Hospital Services utilization is 2,395 per 1,000. Is that admissions, days or some other criteria?	
	n/a	n/a	Please furnish distribution of emergency room utilization per rate cell.	
	n/a	n/a	Given that the program is targeting SSI and High Cost Member categories, the broad age band rate categories are not adequate to protect against the potential for adverse selection. One rate fits all approach does not encourage managed care program developments that may attract sicker members. We suggest the risk follow the member with a risk adjustment process for high-cost members based on FFS claims data from the period prior to CCO enrollment. The DOM would adjust premiums between the CCOs based on the specific members assigned to that CCO on a retrospective quarterly basis. Pregnant women and newborns would risk adjust at the end of the first year based on a distribution of DRGs between the CCOs. After the first year, all member categories could risk adjust based on encounter data.	
	n/a	n/a	Recommend the data book be enhanced with 2 more years of data to show FFS trends over the past 3 years.	
	n/a	n/a	FQHC/RHC clinics provide a significant portion of the services for the targeted population. Movement away from their current encounter rates will impose a financial burden to the FQHC/RHC providers. We propose that	

Question #	RFP Section #	RFP Page #	Question	Response
			DOM consider a monthly reconciliation process with a 30-day turn-around for settlement in order to minimize the impact of the new program on FQHC./RHC providers..	
	n/a	n/a	When is age calculated for rate categories - beginning of month vs. end of month?	
	n/a	n/a	What are the completion factors that were used in developing the incurred claims for SFY 2009 and SFY 2008 as well as the additional claims periods used in the rate development?	
	n/a	n/a	Given the fact that this is a new program, there may be increased utilization of services during the initial implementation period when managed care savings that are present in a mature program will not be evident. Will there be consideration of a phased-in approach to calculation of managed care savings during the first year?	
	n/a	n/a	What are the risk-sharing arrangements for NICU services that DOM is exploring? Will there be an opportunity for the CCO's to provide input?	
	n/a	n/a	Will the State provide 2 years of historical claims and eligibility for all CCO enabled members so that members can be risk stratified for care management purposes?	