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RFP Question and Answer Document

Question #	RFP Section #	RFP Page #	Offeror Questions	The Division's Response
1.	1.2.3; 5.1	8 - 9, 64	RFP Section 1.2.3 requests an original and 10 hard copies plus an electronic copy and redacted version on CD, while RFP Section 5.1 only requests one copy on CD. Please clarify/confirm the required submission format (e.g., hard copy and CDs or one CD only).	Please submit 10 hard copies and one CD copy. A redacted version must be included on the CD.
2.	1.2.3	8	Is it permissible to use smaller font sizes than 12 point, while still ensuring legibility (e.g., 8 point or greater) for exhibits/graphics, tables, diagrams, headers/footers, and RFP requirement text?	Eight (8) point font is allowed for exhibits/graphics, tables, diagrams, headers/footers. It is not allowed for RFP requirement text.
3.	1.2.3	8	Is it permissible to use fonts other than Times New Roman (e.g., Arial or Helvetica) for exhibits/graphics, tables, diagrams, headers/footers, and RFP requirement text?	No.
4.	1.2.3	8	Is it permissible to use 1-inch margins (instead of the required 0.5 inch margins) on the side closest to the binding, to ensure enough spacing for 3-hole punching without impacting the content of the page?	Yes.
5.	1.4.6	17 - 18	Within RFP Section 1.4.6, Provider Network, the Division requires "The Contractor must pay network Providers no less than the rates paid by the Division." Does this apply to pharmacies and ancillary providers managed under an MCO's PBM and ancillary agreements? If so, please provide the Division's reimbursement methodology for both.	The Contractor must pay network Providers no less than the rates paid by the Division. This applies to ancillary providers managed under an entity's PBM and ancillary agreements. Please refer to the Division's website www.medicaid.ms.gov for Pharmacy Information and Fee Schedules and Rates for ancillary providers.

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6.	1.4.11	23	Please clarify which contractual reports are required to be operationally ready by go-live? How will operational readiness for these reports need to be demonstrated by the plan?	Please refer to Exhibit H of the Model Contract for required reports, Contractors will be provided templates for these reports during contract implementation prior to Readiness Review.
7.	1.4.11	23	Please provide the anticipated timing of the readiness review and high-level scope?	As outlined in Section 1. R of Model Contract (Appendix A of the RFP), the Division will allow at least six months for Contractors to prepare for Readiness Reviews, which includes evaluation of all program components including information technology, administrative services, Provider Network management, and medical management. The readiness reviews will include desk reviews of materials the Contractor must develop or provide to the Division and will include onsite visits to the Contractor's administrative offices. The Division may also conduct onsite visits to any Subcontractor's offices. The scope of the readiness review is also explained in Section 10. S of the Model Contract, and includes evaluation of all program components including information technology, administrative services, Provider Network management and medical management. The Division will complete readiness reviews of

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				the Contractor prior to implementation of MississippiCAN Program expansions and contract renewals at its discretion.
8.	3.4, 4.4, 5.5.2	33, 43, 69	The Division references project manager in multiple places in the RFP (e.g., Oral Presentation, Notices, and Resumes), but does not define this role in the RFP or Contract Model as does for other key management positions (e.g., CEO, CFO, etc.). Can the Division please clarify the role and expectations of the project manager? May a contractor deem the CEO and the project manager to be the same person?	References to the Project Manager refer to the person responsible for overseeing the implementation of the contract requirements during the implementation phase. This Individual must possess knowledge of Medicaid programs, particularly with Medicaid managed care programs, with relevant experience navigating similar complex projects. Executive key staff may serve as the Project Manager for purposes of overseeing the Implementation Phase of the Contract.
9.	5.4.2	67	Due to the length of audited financial statements, is it permissible to submit the requested financials in electronic-only format on the required CD?	Yes, electronic copies of the audited financial statements will be accepted.
10.	5.4.3	67 - 68	Within RFP Section 5.4.3, Corporate Experience, the Division asks for corporate reference experience to include the "Direct Contract for client (see Appendix A)." Please confirm that the Division is seeking only the name of the client contract.	Please excuse this typographical error. RFP Section 5.4.3, Corporate Experience, should read "Direct contact for client."As requested in Section 5.4.3, list item #2 requires that the Offeror provides the contact information for corporate references who can speak to quality of the Offeror's work and attest to the Offeror's breadth of experience with the type of service to be provided by this RFP. The required contact information for these

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				corporate references, including the phone number for client contacts, are provided to the Offeror in Appendix E: References. List item #10 should read "Direct Contact for client (see Appendix E)" to reference the appropriate listing of the required client contact information.
11.	5.4.3	67 - 68	Within RFP Section 5.4.3, Corporate Experience, for each reference experience, the Division requires "personnel requirements." Please clarify what the Division means by personnel requirements.	The Division is requesting any personnel requirements, the Contractor agreed to under the referenced experience. (i.e. required number of FTE on the particular project, onsite presence, etc.)
12.	5.6, Question 4	71	Within Question 4, the Division asks for the description of "the job qualifications for Provider Services call center employees" while discussing Member services call center employees. Will the Division please confirm that the language should be "the job qualifications for Member Services call center employees?"	Confirmed. In section 5.6 of the RFP Question 4, the Division is requesting the job qualifications for Member Services call center employees.
13.	5.6, Question 34	75	Within Question 34, in describing the entity's proposed Member Complaint, Grievance, and Appeal process, the Division requests compliance with the Division requirements as described on the Division's Website. Please clarify and define these additional requirements or provide a direct link to where these additional requirements are located on the Division's site.	Requirements regarding State Fair Hearings for beneficiaries can be found at Title 23 of the Mississippi Administrative Code, Part 300 and Part 100, Chapters 4 and 5. https://medicaid.ms.gov/providers/administrative-code/

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14.	5.6, Question 38	76	Within Question 38, the Division asks "how the entity will develop and maintain collaborative relationships with low, medium and high intensity residential treatment facilities." Please define "low", "medium", and "high" as it relates to residential treatment facilities.	ASAM website www.asam.org Level 3 – RESIDENTIAL / INPATIENT SERVICES § III.1 – Clinically – Managed, Low intensity Residential Treatment (Half Way, Supportive living) § III.2 D – Clinically managed, medium intensity Residential Treatment (Social Detox) § III.3 – Clinically – Managed, medium intensity Residential Treatment (Extended Care) § III.5 - Clinically – Managed, medium / High intensity Residential Treatment (Therapeutic Community) § III.7 D – Medically – Monitored Inpatient Detox Services § III.7 - Medically – Monitored Intensive Inpatient Treatment (traditional level 3 ASAM)
15.	5.6, Question 79	82	Please confirm that MMIS refers to the Contractor's information system for its health plan and is not referring to obligations of the Division's MMIS vendor (e.g., Xerox and Conduent).	Yes, Question 79 references the Contractor's information system for its health plan.
16.	5.6, Question 84	82 - 83	Please confirm that, if provided, the copy of the entity's proposed emergency response continuity of operations plan is not included in the 5-page count.	If the plan is greater than five (5) pages, submit a summary including all things requested within the required page limit.
17.	Appendix C	92	Will a data book be released with historical enrollment, unit cost, and utilization data stratified by the rate cell definitions in Appendix C? Providing such information would assist the Contractor in	No further information will be provided other than that provided in Appendix C.

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			understanding the development of the capitation rates and completing Appendix D, Pro Forma Financial Template.	
18.	Appendix C	92	For populations and services that have been covered in the MississippiCAN program, will the capitation rates effective July 1, 2018 assume managed care savings in addition to the experience of the prior Coordinated Care Organization (CCOs)?	Yes.
19.	5.4.2, Appendix D	67, 93	In regard to Appendix D, Pro Forma Financial Template, for entering the Member Months in the P&L, what should the Contractor assume for the total population, the number of Coordinated Care Organization (CCOs) in the program, and the membership split among the CCOs?	Offeror should complete the Pro Forma based on Offeror's estimate of the portion of the market it aims to capture. Pro Forma estimated figures and assumptions will not be evaluated on accuracy of chosen estimates. As stated in Section 1.4.1, the Division will use a time-limited auto assignment methodology to ensure each selected entity reaches a starting threshold of at least twenty (20) percent of the total program enrollment.
20.	5.4.2, Appendix D	67, 93	In regard to Appendix D, Pro Forma Financial Template, for entering the Hospital and Medical benefit costs in the P&L, are there any program or reimbursement changes that took place after the SFY 2017 draft rate development that should be considered?	No.
21.	5.4.2, Appendix D	67, 93	Will estimated enrollment and cost information be provided for the additional covered services in July 2018, IDD Community Support Program, and MS Youth Programs Around the Clock?	The Division appreciates that this would be valuable information and will endeavor to pull this information together.

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22.	Model Contract Section 2 & Section 5	35, 63	Are Contractors allowed to provide coverage of drugs outside of the PDL as part of a contractor-managed formulary, as long as those drugs do not conflict with PDL requirements? Or alternatively, are the contractors required to use the Division's full formulary in addition to the PDL? If contractors are allowed to manage a drug formulary for products not on the PDL, are they permitted to collect drug rebates for those non-PDL products?	(1)Yes. (2) Yes, contractors are required to use the Division's full formulary in addition to covering drugs found on the PDL. See Administrative Code Part 214, Rule 1.2 at https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-214.pdf which addressess drugs with must be covered as well as drugs subject to exclusion. The contractor has the option to cover more drugs than those covered by the Division. (3)No. The only exception would be on non-drug products , such as diabetic supplies, if they are not listed on the Division's PDL.
23.	Model Contract Section 4	46	Within Model Contract Section 4, Mississippi Enrollment and Disenrollment, sub-section D, the Division states "The Contractor shall provide each Member, prior to the first day of the month in which their Enrollment starts, an information packet indicating the Member's first effective date of Enrollment. The Contractor must ensure the information is provided no later than fourteen (14) Calendar Days after the Contractor receives notice of the Member's Enrollment." Based on timing of enrollment notification by the Contractor, which timeliness requirement supersedes?	The Contractor shall provide each Member, prior to the first day of the month in which their Enrollment starts, an information packet indicating the Member's first effective date of Enrollment. However, subsequent enrollment notices are provided to Contractors, and these packets must be provided no later than 14 Calendar days after receipt.
24.	Model Contract Section 4	46	Do contractors have the option of providing Member Materials in written and/or electronic formats?	No.

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25.	Model Contract Section 5	55	Within the Model Contract Section 5, sub-section F, Prescription Drugs, Physician-Administered Drugs and Implantable Drug System Devices, the Division states "The Contractor is restricted from requiring Members to utilize a pharmacy that ships, mails, or delivers prescription drugs or devices. However, the Contractor may implement a mail-order pharmacy program in accordance with State and Federal law." Please confirm that the aforementioned requirement is not applicable to specialty pharmacies or specialty pharmacy networks, since their preThe Divisioninant way of dispensing is via US mail.	Confirmed; however, MS is an any willing provider state and beneficiaries have the right to choose their specialty pharmacy.
26.	Model Contract Section 5	56	Within the Model Contract Section 5, sub-section F, Prescription Drugs, Physician-Administered Drugs and Implantable Drug System Devices, the Division states "The Contractor is not authorized to negotiate rebates for preferred products. The Division or its Agent will negotiate rebate agreements." Are contractors allowed to contract for rebates on diabetic supplies and administer their own preferred diabetic supplies through pharmacies?	Yes, contractors are allowed to contract for rebates on diabetic supplies covered via the POS benefit if diabetic supplies are not listed on the Division's PDL. However, beneficiaries must be allowed to choose the pharmacy provider from which they obtain said diabetic supplies. Diabetic supplies covered under the medical claim benefit must be covered in accordance with the Division's fee schedule and applicable policies.
27.	Model Contract Section 5	65	Within the Model Contract Section 5, sub-section J, Prior Authorizations #5, the Division states "The Contractor shall create a "smart" electronic authorization request form, customized for each service that requires certification. The form must be standardized for all Contractors and must be prior approved by the Division." Can the Division please provide clarification or guidance to how the form	The form must be standardized to reduce the changes of technical denials due to incorrect or missing information. The form must be customized based on the certification criteria for each service that required certification.

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			should be customized for each service while still remaining standardized?	
28.	Model Contract Section 7	102	Within Section 7, sub-section E Provider Credentialing and Qualifications, #1 and #3.a, the Division requires onsite reviews be performed of all private practitioner offices and other patient care settings conducted in-person. Due to the anticipated large number of sites and burden on providers, would the Division consider focusing onsite visits to PCPs?	No. The Division maintains the applicability of the requirement for site assessments to apply to all private practitioner offices and other patient care settings.
29.	Model Contract Section 11	139	Within the Model Contract Section 11, Reporting Requirements, sub-section F, the Division requires "The Contractor shall submit a monthly report providing information on the Pharmacy Lock-In program in order to monitor services received and reduce unnecessary or inappropriate utilization." The model contract makes no other references to the pharmacy lock-in program. Are there specific requirements? Please also confirm that the contractor can construct its own.	Entities are allowed to have their own policies for pharmacy lock-in, as long as the policies are in accordance with State and Federal Guidelines. Please refer to the Division's Administrative Code, and applicable State and Federal law.
30.	5.6	71	Regarding RFP Section 5.6, Figure 6 Work Statement Questionnaire #4, please confirm that the Division intended to request job qualifications for "Member" services call center employees and not "Provider" services call center employees.	Please see response to Question 12.
31.	5.6	72	Regarding RFP Section 5.6, Figure 6 Work Statement Questionnaire #17, please confirm that the Division intended to request proposed policies and procedures for designating a "specialist as a PCP" rather than "PCP as a specialist."	Confirmed, the RFPs sentence should read "Specialist as a PCP."

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32.	Appendix A - Exhibit F	256	Regarding Appendix A - Draft Contract Exhibit F, please clarify the difference between performance measures 8 and 14 listed in Exhibit F. The measures appear to be very similar: "Percentage of EPSDT eligible members who received a Periodic Health Screening Assessment" vs. "EPSDT eligible Percentage of Members under age 21 who received a periodic Health Screening Assessment."	The measures are duplicative, please disregard number 14.
33.	1.2.3	8	Regarding RFP Section 1.2.3, will the State allow for supplemental information such as attachments?	No.
34.	1.2.3	8	Regarding RFP Section 1.2.3, in order to enhance readability for the reviewer, will the state allow different font styles and sizes for headers, footers, headings, captions, tables, and graphics?	Please see response to Question 2.
35.	1.2.3	8	Regarding RFP Section 1.2.3, may we submit our electronic version of the proposal on a USB drive as opposed to a CD?	Please follow the directions stated in RFP Section 1.2.3.
36.	5.6	70	Regarding RFP Section 5.6, does the required repetition of the statements/questions in the Methodology/Work Statement section count against specified page limits for each question/statement? Can the question text precede the response on a separate uncounted page?	The required repetition of the statements/questions in the Methodology/Work Statement section does not count against the specified page limits.
37.	Appendix A – Section 2(A)(51)	32	Can you confirm that the State is using the terms "medical home" and "health home" interchangeably?	Confirmed.
38.	2.1	26	Given the extensive oversight that state and federal agencies perform over Medicaid Managed care plans and operations, and the federal requirements that all	It was not the Division's intention to exclude an entity that has been sanctioned from submitting a proposal. Neither the federal

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			Medicaid managed care contracts include potential sanctions, it is extremely unlikely that any offeror would qualify to bid as any entity with experience in contractual services providing the type of services described in the RFP would likely have received minor liquidated damages or sanctions over the course of their experience. We believe the intent of this requirement is to prevent offerors with major violations. Therefore, to ensure the State has the opportunity to evaluate bids from the most qualified Offerors with the most relevant experience covering these populations and services, recommend removing this restriction OR revising it to require "Offer has not been debarred by a state or Federal government within the last 10 years."	regulations nor the Division's Contracts equate sanctions with LDs. Transmittal Letter #2 has been amended as follows: The Division requests what all, if any, sanctions Offeror's have received during their operational years in managed care. The Division further requests a statement from all Offeror's that they abide by the prohibited affiliation with individuals debarred, suspended, or otherwise excluded from participation as a director, officer, partner, or person with ownership of more than 5%.
39.	5.6	80	Regarding RFP Section 5.6, Figure 6 Work Statement Questionnaire #9, where may we find a copy of the MississippiCAN Quality Strategy document? It does not seem to appear on the MississippiCAN website.	Question 9 does not relate to Quality Strategy. Question 63 directs vendor to describe supporting the MississippiCAN Quality Strategy. This document will be provided in a link on the Division's Procurement website.
40.	Appendix A – Section 4(G)	47	Is an ICF/IID considered a long term care facility for the purposes of this contract and should members be subsequently disenrolled if a member is placed in an ICF/IID?	Yes, an ICF/IID facility is considered a long term care facility, and residents are not eligible for MississippiCAN. The member should be disenrolled if admitted to an ICF/IID.
41.	1.3.1	9	Can you clarify whether, upon inclusion of the 1915(i) CSP in MississippiCAN, the MCOs will be expected to provide Targeted Case Management (TCM) service directly to eligible members or is it the Division's expectation that the MCOs will contract with the	Entitites will be expected to contract with DMH Regional Centers to provide TCM (T1017).

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			DMH Regional Centers to provide TCM?	
42.	N/A	N/A	Will the health plan be required to submit the Mississippi State Department of Health Perinatal High Risk Management/Infant Support System (PHRM/ISS) Referral Form (Form 74) with member signature/release, or will the State establish an alternative referral process for the contract requirement? Will the State provide guidance on referral and coordination of care for high-risk pregnant women to PHRM/ISS, or will the Heath Plans be responsible for developing processes with PHRM/ISS?	The State requires submission of the Mississippi State Department of Health Perinatal High Risk Management/Infant Support System (PHRM/ISS) Referral Form (Form 74) to the MSDH as a part of the referral process. The Contractor shall coordinate with the Mississippi Department of Health (MSDH) for high-risk pregnant women who may be eligible for MSDH's Perinatal High Risk Management/Infant Services System (PHRM/ISS) Program. During contract implementation, the State may provide support in process development.
43.		67	Section 5.4.3 requires Offerors to provide a minimum of three (3) corporate references, and provide for each the following information: 1. The client's name; 2. Client references (including phone numbers); 3. Description of the work performed; 4. Time period of contract; 5. Total number of staff hours expended during time period of contract; 6. Personnel requirements; 7. Geographic and population coverage requirements; 8. Publicly funded contract cost; 9. Any contractual termination within the past five (5)	Please see response to Question 10.

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			years; and, 10. Direct Contract for client (see Appendix A). For Offerors intending to use Medicaid Agencies in other states as client references for this project, is the state, in #2, looking for client reference contact information? Please confirm that by "Direct Contract for client (see Appendix A)," the State is requesting that for each contract the Offeror is providing a reference for, Offerors identify whether it was the direct contract holder with the state or performed the services as a subcontractor?	
44.		14	RFP Section 1.4.5.1 lists call center hours as 7:30 a.m. to 5:30 p.m. Section 6.A.1 of the Draft Contract lists call center hours as 8 am to 5 p.m. Please clarify which hours are correct.	Yes, the time should be the same call center hours in both the RFP and Draft Contract – 7:30 a.m. to 5:30 p.m. The Model Contract will be amended to reflect this change.
45.		83	Appendix A - Draft Contract Section 6 (K) uses both "business day" and "calendar day" in describing the resolution timeframe for Complaints. Would the State please clarify if "business day" or "calendar day" is correct?	Calendar day is correct. This change will be made to the Model Contract.
46.		68	In RFP Section 5.5, the first paragraph refers to "Section I.L" Administration, Management, Facilities and Resources of Appendix A, Draft Contract. Per Appendix A, Draft Contract, please confirm the Section 5.5 is intended to refer to "Section I.M."	Yes, the Division confirms that Section 5.5 intended to refer to "Section I.M."
47.		67	Please confirm that the experience information requested under RFP Section 5.4.3. is for contracts Offerors are providing corporate references for.	The Division confirms that the experience information requested under RFP Section 5.4.3. is for contracts Offerors are providing corporate references for.

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48.		67	RFP Section 5.4.2 requires Offerors to submit financial statements for the past three years for the "contracting entity." For Offerors that are being newly incorporated and licensed in Mississippi specifically to respond to this RFP, historical financial statements for the legal "contracting entity" i.e. Offeror will not be available. RFP Section 5.4.2 does allow Offerors to provide an explanation if the financial statements are not available, which would be the case for newly formed entities; however, "acceptance of the explanation provided is at the discretion of the Division." Will the Division consider accepting parent company financial statements for evaluations of this section?	Yes, the Division will accept parent company financial statements for evaluations in RFP Section 5.4.2.
49.		137	Appendix A - Draft Contract indicates that "All records shall be maintained at one central office in Mississippi designated by the Contractor and approved by the Division." Please confirm that electronic access to records (paper housed elsewhere and electronic records) from the office in Mississippi is acceptable as affirmed in 2013.	The Division accepts electronic access assuming Contractor has access to all information and not limited information.
50.		67	RFP Section 5.4.2 requires Offerors to submit "Documentation of available lines of credit, including maximum credit amount and amount available thirty (30) business days prior to the submission of the proposal." For Offerors that are being newly incorporated and licensed in Mississippi specifically to respond to this RFP, please confirm the Division will accept the Offeror's parent company borrowing capability in response to this requirement. Alternatively, will the Division consider accepting a	Yes, the Division will accept Offeror's parent company borrowing capacity in response to this requirement. The Division will review the appropriate Corporate Guarantees offered for certain provisions under the Contract as being guaranteed by the Parent.

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			Corporate Guarantee from the parent company guaranteeing Offeror's performance of every obligation under the contract?	
51.		57	Appendix A, Draft Contract, Section 5 (F) appears to conflict in part to the provision which states that "this prohibition on the industry practice known as 'spread pricing' is not intended to prohibit the Contractor from paying the PBM reasonable administrative and transactional costs for services." Can the State please clarify if this provision means only that no transaction fees may be charged to a pharmacy?	The Contractor is allowed and expected to pay the PBM an appropriate, market-based administrative/transactional cost. The prohibition relates to the actual drug expense where the costs to the Division must be the "actual" costs paid by the entity to the dispensing pharmacy without any "spread" included. The definition of **"spread pricing"** is that the PBM does not disclose to the plan how much they are actually paying the pharmacy nor that the PBM is pocketing the difference, or spread. The spread price is charged in addition to any agreed-upon maintenance fee between the plan sponsor and the PBM.
52.		65	Can the State provide additional details and expectations of an individual plan's version of a "smart" form given that there is a requirement that the form be standardized across all plans?	Please refer to response in Question 27.
53.		106	The business hours in Appendix A - Draft Contract, Section 7 (H) conflict with those in RFP Section 1.4.7 which states business hours of 7:30am-5:30pm CST. Can the State please clarify the required business hours?	Please refer to response in Question 44.

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54.		92	Please provide member utilization data for the most recent 6-12 months.	Member months for recent period are not presently available; however, enrollment data is available on the Division's website www.medicaid.ms.gov.
55.		92	Regarding Appendix A - Draft Contract, Section 7 (B), Table 6 "Geographic Access Standards," It appears there are replicated categories within this table (PCPs, Hospitals, Dental, and others). Will the Division confirm these are truly duplicative and can be omitted from any geographical analysis, or will it revise Table 6 for clarification?	Yes. The Model Contract will be edited to remove replicated categories within this table.
56.		92	Regarding Appendix A - Draft Contract, Section 7 (B), Table 6 "Geographic Access Standards," please confirm that for the category titled "PCPs - Adult and Pediatric" the intent is to combine all Primary Care Providers into a single measured category for determining adequacy as opposed to breaking out this category by specific specialties (Family Practice, FQHC, RHC, etc. etc.) or by population serviced (Specialists serving Adults vs. Specialists serving Children).	Yes. The Model Contract will be edited to remove replicated categories within this table.
57.		92	Regarding Appendix A - Draft Contract, Section 7 (B), Table 6 "Geographic Access Standards," please confirm the category "Hospitals" are to consist of Acute Care Inpatient Hospitals, Children's Hospitals, and Critical Access Hospitals only and should not consider Psychiatric Inpatient Facilities, Inpatient Long-Term Rehabilitation Facilities, or Specialty Hospitals in measuring Network Adequacy.	This category should include Psychiatric Inpatient Facilities, Inpatient Long-Term Rehabilitation Facilities, and Specialty Hospitals. Please refer to 42 CFR 438.68 and 438.207 for further guidance.

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58.		92	Regarding Appendix A - Draft Contract, Section 7 (B), Table 6 "Geographic Access Standards," please confirm for the category titled "Specialists Adult and Pediatric" the intent here is to combine all Specialist Practitioners into a single measured category for determining adequacy as opposed to breaking out this category by specific specialties (Cardiology, Gastroenterology, etc. etc.) or by population serviced (Specialists serving Adults vs. Specialists serving Children).	Yes. The Model Contract will be edited to remove replicated categories within this table.
59.		92	Regarding Appendix A - Draft Contract, Section 7 (B), Table 6 "Geographic Access Standards," please confirm for the category titled "General Dental Providers Adult and Pediatric" the intent here is to combine all Dental Practitioners into a single measured category for determining adequacy as opposed to breaking out this category by population serviced (Dental serving Adults vs. Dental serving Children).	Yes. The Model Contract will be edited to remove replicated categories within this table.
60.		92	Regarding Appendix A - Draft Contract, Section 7 (B), Table 6 "Geographic Access Standards," please confirm for the category titled "Behavioral Health Providers (Mental Health Providers and Substance Use Disorder) (Adult and Pediatric)" that the intent here is to combine all Behavioral Health Providers into a single measured category for determining adequacy as opposed to breaking out this category by population serviced (Behavioral Health serving Adults vs. Behavioral Health serving Children).	Yes.

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61.		92	Regarding Appendix A - Draft Contract, Section 7 (B), Table 6 "Geographic Access Standards," please confirm the category "Behavioral Health Providers (Mental Health Providers and Substance Use Disorder) (Adult and Pediatric)" include all providers in the field of Behavioral Health, both facility and practitioner.	Yes, both facility and practitioner. Please refer to 42 CFR 438.68 and 438.207 for further guidance.
62.		92	Regarding Appendix A - Draft Contract, Section 7 (B), Table 6 "Geographic Access Standards," does the Division consider relative specialties (Neonatal Medicine, Perinatal Medicine, Midwifery, Obstetrics – No Gynecology, Obstetrical Nurse Practitioner, and others) viable specialties for inclusion in the OB/GYN Category?	Yes. Please refer to 42 CFR 438.68 and 438.207 for further guidance.
63.		92	Regarding Appendix A - Draft Contract, Section 7 (B), Table 6 "Geographic Access Standards," please confirm for the category titled "General Dental Providers Adult and Pediatric" the intent here is to combine all Dental Practitioners into a single measured category for determining adequacy as opposed to breaking out this category by population serviced (Dental serving Adults vs. Dental serving Children).	Yes. The Model Contract will be edited to remove replicated categories within this table.
64.		92	Regarding Appendix A - Draft Contract, Section 7 (B), Table 6 "Geographic Access Standards," since Durable Medical Equipment suppliers provide service at the members' home, either via on-site delivery or drop-shipment of the equipment, can the Division provide more guidance on how to exhibit this service for geographical adequacy when the contractor is utilizing out-of-area providers for this service	The distance is measured from the physical location of providers. See Administrative Code Part 209: Durable Medical Equipment and Supplies, Chapter 1, Rule1.9: Documentation, C. 4.provider must have a physical location based on Appendix A - Draft Contract, Section 7 (B), Table 6. Georgraphic Access Standards.

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			category?	
65.		92	Regarding Appendix A - Draft Contract, Section 7 (B), Table 6 "Geographic Access Standards," would the Division be willing to create/release a standard membership file with all PHI redacted for all respondents to use for geographical analysis use? A desired data set would include a unique identifier for each member, a street address, a ZIP code, and if desired for analytical purposes, a gender indicator.	Contractors will be required to demonstrate Provider Network Adequacy given available data; however, specific member information will be provided during Contract Implementation.
66.		92	Regarding Appendix A - Draft Contract, Section 7 (B), Table 6 "Geographic Access Standards," regarding the analysis of geographical adequacy for Obstetrical care, does the Division desire respondents to use a sub-category of membership exhibiting adequacy exclusively to the female population, and if so, is the Division willing to provide that information for all respondents to use?	No. The Division does not desire respondents to use a sub-category of membership.
67.		92	Regarding Appendix A - Draft Contract, Section 7 (B), Table 6 "Geographic Access Standards," would the Division be willing to release a service utilization file for all respondents to use for geographical analysis?	Contractors will be required to demonstrate Provider Network Adequacy utilizing available data; however, specific member information will be provided during the Contract Implementation.
68.		92	Regarding Appendix A - Draft Contract, Section 7 (B), Table 6 "Geographic Access Standards," which category do the IDD CSP providers fall into for geographic access standards/ analysis?	Behavioral Health Providers (Mental Health Providers and Substance Use Disorder) (Adult and Pediatric).

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69.		10	Regarding RFP Section 1.3.3, please provide clarity as to the eligibility category for enrollment of the IDD CSP 1915(i) program and if this program, being a waiver, is exempt from the automatic disenrollment criteria listed on page 11 under Section 1.3.3.	IDD 1915(i) Community Support Program (CSP) is a state plan service. Persons in this program must receive full Medicaid benefits and meet the IDD clinical criteria to participate. This population is not restricted to a specific category of eligibility.
70.		245	Appendix A - Draft Contract Exhibit E indicates that out of network providers must be paid in a manner defined by the State. Section J says out of network providers are to be paid in accordance with the contractor's approved plan for out of network services. Can the State please clarify?	Draft Contract Exhibit E refers to Non-Emergency Transportation (NET) Requirements and does not contain a Section J. The Division was unable to find this discrepancy in Exhibit E.
71.		N/A	Can we see the derivation of the Newborn Enrollment Adjustment Factors from page A-11?	Appendix C MississippiCAN Capitation Rate Development Report provides the information available to Offerors.
72.		N/A	When will we be given SFY 2019 rates? Will it be before we are required to sign the contract?	At this time, the Division does not have a date set for SFY 2019 rate development. Entities will be provided this information during contract implementation.
73.		36	SFY 2017 rates include the MHAP add-on. Will this be included in the SFY 2019 rates? If so, will it be "at-risk" for the MCO's? Will this be implemented in line with the CMS Medicaid Managed Care Mega-Reg?	MHAP will be included in SFY 2019 rates. It is our expectation that MHAP pass-through payments will not be "at-risk". Pass-through payment transitions will be in compliance with the CMS Final Rule of May 6, 2016regulations.
74.		3	Can you describe the calculation for the restated IP savings assumption of 1.013?	The 1.013 represents the removal of the additional savings assumption applied to inpatient services effective December 1, 2016

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				for the Adult and Newborn rate cells. In the December 2015 to June 2016 capitation rates, inpatient savings were assumed for SSI/Disabled Newborn - 5%, Non-SSI Newborn 0-2 Months – 5%, Delivery Kick Payment – 2%, All Other Rate cells – 10%. These assumptions were not applied for the SFY 2017 capitation rates. Inpatient savings assumptions for the child rate cells entering MississippiCAN during 2015 were maintained for SFY 2017 capitation rates.
75.		34	Will rates continue to be adjusted to geographic region for SFY 2019 similar to page A-13?	Yes.
76.		72	Regarding RFP Section 5.6, Figure 6 Work Statement Questionnaire #16, could the Division clarify whether the requirement for new Members to have an appointment scheduled with their selected PCP within 90 days of enrollment is waived for those Members whose claims records indicate they have been seen by this PCP within the clinically recommended timeframe for preventive visits?	No, the Contractor must have documented claims data from the time of enrollment.The requirement for new Members to have an appointment scheduled with their selected PCP within 90 days of enrollment is not waived for those Members whose claims records indicate they have been seen by this PCP within the clinically recommended timeframe for preventive visits.
77.		79	Regarding RFP Section 6.5, will the assignment of children in the child welfare remain the same?	Section 6.5 of the RFP does not exist. Foster Care Children are listed as an optional population, and the custodial guardian, Mississippi Department of Human Services (DHS)/ Child Prection Services (CPS), must choose either initially or annually the

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				Conractor or Medicaid Fee-for-Service.
78.		68	In the beginning of Section 5.5, there are 4 requirements listed for the Offeror to respond to. Where would the State like to see each of these questions addressed within our proposal? As an introduction narrative, an appendix, or broken out amongst subsections? If broken out among subsections, please indicate how.	As stated in Section 5.1 of the RFP all proposals should be "type written… with tabs delineating each section." Please provide all requested information in Section 5.5 of the Offeror's response.
79.		71	The question states: Describe the entity's staffing ratios per enrolled Member, including the number of Member services call center employees and nurse advice line employees, as well as supervisor to staff ratios. Describe the job qualifications for Provider services call center employees. Did you mean to say "member services call center" instead of "Provider services call center"?	Please see response to Question 12.
80.		92	Given that this is not a competitive bid and the Capitation Rates are set by the Division, will any guidance be given regarding the Capitation Rates that should be used for the 3-year Pro Forma that is to be included with the proposal?	The Offeror is expected to know and understand the business requirements and forecast appropriate inflation factors and rates in its Pro Forma. No additional guidance will be provided by the Division.
81.		14	The RFP states "Members have access twenty-four (24) hours, seven (7) days per week to clinical personnel who act within the scope of their licensure to practice a behavioral health/substance use disorder-related profession". Does the clinician credential granted by the Mississippi Department of Mental	Yes.

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			Health including DMH Certified Mental Health Therapist, DMH Certified Intellectual and Developmental Disabilities Therapist, and DMH Certified Addiction Therapist count as "clinical personnel who act within the scope of their licensure" for the purposes of this RFP and contract?	
82.		14; and 20 55	The RFP and Model Contract makes frequent reference to behavioral health/substance use disorder requirements. Is there a change to the substance abuse benefit? Can you please provide us with the benefit coverage/chart and Medicaid fee schedule for SUD services?	Due to the Parity Final Rule, at the time of the contract, the Division plans to reimburse for SUD as a sole diagnosis at a Community/Private Mental Health Center. These centers must be certified by DMH and be a MS Medicaid provider to receive reimbursement. Once approved, services will fall under Administrative Code, Part 206, Chapter 1 at https://medicaid.ms.gov/wp-content/uploads/2014/10/AdminCode-Part_206.pdf. You can also refer to the Rehab Option SPA where these services are covered in Attachment 3.1-A, Exhibit 13.d at https://medicaid.ms.gov/wp-content/uploads/2014/01/Attachment_3.1-A.pdf. Reimbursable services provided to persons with a SUD sole diagnosis are listed below: • Medical Services (Evaluation and Management, Psychiatric Diagnostic Evaluation, Medication Administration, Nursing Assessment)

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				• Psychosocial Assessments and Psychological Evaluations • Therapy Services (Individual, Family, and Group) • Peer Support Services • Targeted Case Management • Community Support Services • Crisis Response and Crisis Residential Services • Acute Partial Hospitalization • Wraparound Facilitation • Treatment Plan Development and Review Please refer to the billing guidelines at https://medicaid.ms.gov/wp-content/uploads/2014/03/CommunityMentalHealthCenter.pdf. For treatment of SUD, pharmacy benefit perspective: Have deleted former lifetime limits for suboxone; naltrexone tablets and suboxone filem are both preferred. Naloxone injection and Narcan nasal spray as preferred products on PDL for treatment of overdose. Methadone is non-preferred for treatment of pain.

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83.		52-57	Section 4.13 requires disclosure and justification of certain transactions between the Contractor and any related party. Is there a standard form that should be used for these disclosures?	Yes. The form will be provided during implementation.
84.		68; and 84	Section 5.5.1 and 5.7 refer to 'phases' of the program. Can you please clarify the phases for which the Division wants to see information (ex: organizational charts, solutions, etc.)?	The phases are implementation, operation, and if necessary turnover.
85.		69	In Section 5.5.2, a 'Project Manager' is referenced. Can you please provide additional details on what this role/position entails?	Please refer to response in Question 27.
86.		92	If available, could additional detail be provided regarding the risk adjustment methodology that is applied to the capitation rates beyond what is included in Milliman's November 2016 report for the SFY 2017 MississippiCAN CCO Rate Calculation and Certification?	The methodology Milliman utilizes was developed by the University of San Diego, California. Additional information regarding this methodology may be obtained from their website at: http://cdps.ucsd.edu/
87.			Please confirm the contract period for the CAN reprocurement. It appears to conflict with the State's verbal communication to extend the current CAN contract until June 30, 2018. Based on the extension, the new contract start date would be July 1, 2018 which only represents an operational period of two years (July 1, 2018-June 30, 2020). The CAN procurement website announcement states, "THE DIVISION seeks competitive written proposals from qualified Offerors for a 3-year period with two, one-year optional renewals beginning July 1, 2017."	The Contract start date for this procurement is July 1, 2017 and will continue through June 30, 2020, with two (2) one (1) year optional renewals. The current MississippiCAN Contract expires June 30, 2017, and will be extended one year.

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88.	1.3.1	9	Please provide additional information about the 1915(i) IDD CSP and MYPAC covered services including: 1) how many individuals are currently served in each program by eligibility category; 2) the list of covered services and provider types for IDD CSP and MYPAC included in MississippiCAN, as well as a list of the registered Medicaid providers of these services; 3) the expenses incurred in the most recent 12-month period under Medicaid Fee for Service for each program.	These individuals do not have specific categories of eligibility but do have specific provider types for services: 1915(i) Provider type: X05 (Members apprx 2,000) U7 – Modifier used for all IDD CSP codes H2023 – Supported Employment, per 15 min T2015 – Habilitation, prevocational, waiver, hr S5100 - Day Care Services, adult, per 15 min T1017 – Targeted Case Management, each 15 min MYPAC Provider type: X04 (Members apprx 1,000) H2022 – Modifier HT See bottom of the document for further guidance.
89.	1.3.1	9	What is the current IDD CM structure and does the Division anticipate CCO's will assume these responsibilities or develop a new level of coordination with the existing system	This section is referencing the IDD Home and Community Based Services (HCBS) waiver program services. There are no specific system requirements needed by the entities.
90.	1.3.1	9	Who currently conducts the Person Centered Support plan and what role does the Division anticipate CCO's to play?	The Contractor will conduct Person –centered planning. Person-centred planning (PCP) is a set of approaches designed to assist someone to plan their life and supports. It is used most often as a life planning model to enable

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				individuals with disabilities or otherwise requiring support to increase their personal self-determination and improve their own independence.
91.	1.3.1	9	Is there an Ombudsman program?	No.
92.	1.3.1	9	Please provide what State assessment tool is used (i.e. The SIS)	The Division works with the Mississippi Department of Mental Health.
93.	1.3.1	9	What expectations does the Division have for CCOs to support programs such as competitive employment and self-direction?	The Division will provide further guidance upon contract award.
94.	5.6, #5	71	In the request for *"the entity's staffing ratio per enrolled Provider, including the number of Provider Services call center employees, as well as supervisor to staff ratios"* please clarify whether the response is to be limited to Provider-related staff functions within the health plan's operations, or whether the response should include other areas of the health plan's operations. Also, please clarify how the state defines the denominator. (e.g., should each individual provider within a contracted practice be counted? Should facilities be counted as one provider? Should providers in networks under subcontracted arrangements be counted in the denominator?)	This includes staff related to Provider support, including the call center, supervisors, provider representatives. The number used as the denominator must be consistent with Network Provider, as defined in the model contract, numbers applied in other reports to remain consistent, which are individual and group providers.
95.	5.6, #7	71	The contract requires that members assigned a medium or high level of risk be assigned a care manager (Contract, p. 117). Please verify that the state expects health plans to set staffing ratios of care	The Division expects health plans to set staffing ratios of care managers to Members for members who are assigned to the medium and high risk levels; however, low risk level

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			managers to Members for members who are assigned to the medium and high risk levels, and not for members assigned to a low risk level.	ratios must be addressed.
96.	5.6, #22	73	Can Enhanced Benefits be limited to a subset of enrollees to address specific chronic conditions? Or must all Enhanced Benefits be made available to all enrollees?	Provision of enhanced benefits to members is at the discretion of the Contractor and must be provided in accordance with 42 CFR 438.3.
97.	5.6, #36	75	Does the state consider Member incentives in its definition of Enhanced Benefits? (Enhanced Benefits are to be described in response to #22)	Enhanced benefits normally refers to covered services. Member incentives are rewards for meeting quality or health measures.
98.	1.4.8.5	20 (p.47 in contract)	Is a new Health Risk Assessment required for members who elect to remain with an incumbent plan and who had one within the last quarter, or the last 6 months?	No – See Model Contract Section 8 A, the Contractor must have documented information from the time of enrollment.It is the responsibility of the offeror to propose a risk assessment schedule tailored to Member needs.
99.	1.4.9, Quality Management	22	This section of the RFP refers to Exhibit F in the contract (p. 254, Performance Measures). The performance measures listed in Exhibit. F are numbered sequentially. However, they skip some numbers. Are any performance measures missing from the Exhibit? These numbers are missing: 1, 2, 3, 5, 12, 16, 17, 23, 24, 25, 27. Also, there are two performance measures assigned to 22.	No, there are no performance measures missing from the Exhibit. The numbering in the list is incorrect and will be corrected in the Model Contract.
100.	1.4.11	23	Please clarify that the second paragraph, which cites 42 CFR 447.45 and 447.46 will hold Contractors responsible for processing 90% of *clean* claims within 30 calendar days…and 99% of *clean* claims within 90 calendar days	Please see Section 18.A. of the Model Contract.

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101.	1.4.5.8	17	When the Division refers to a "web-based reservation system" in RFP 1.4.5.8, is this the same system referred to in Appendix A, Exhibit E, Table 12 in the row: "Standing Order Trip Requests". If not, then please provide an explanation for what web based reservation capabilities should be included in the system referenced in Section 1.4.5.8.	RFP Section 1.4.5.8 was inadvertently included and has been removed.
102.	5.6.37	76	Regarding the use of the word: "GeoAccess" in the RFP in Question 37 of Section 5.6, as well as in Appendix A, Sections 7 and 16, and Appendix A, Exhibit H: we assume that the Division is not referring to a specific software product when it uses the word: "GeoAccess". We assume, rather, that the Division is referring to any software that has the functionality as prescribed in the above RFP citations. Are we correct in our assumption? If not, can you provide a definition for the term "GeoAccess"?	GeoAccess is not a specific software product. GeoAccess means geographic access standards as set forth in Table 6 of the Model Contract.
103.	5.6.88	84	Regarding question 88: we assume that when the Division uses the phrase: "Denials Review and Reporting", it is referring to the functions and requirements prescribed in Appendix A, Section 11.J (Claims Denial Report). Are we correct in our assumption? If not, can you provide further information?	This question correlates to the referenced Section 11.J (Claims Denial Report) of Appendix A, but seeks to receive information beyond that from the Entity regarding its internal program and processes for the handling of denials management.
104.	1.4.1	13	Once the minimum enrollment threshold has been met for each CCO, what is the process for auto assignment of beneficiaries should any CCO's enrollment drop below 20%?	After the initial "time-limited" auto-assignment methodology is utilized to assist each entity in achieving the 20% level, the auto-assignment process outlined in Attachment A of the Contract will be followed, even if one entity falls below the 20% level. It is the responsibility of the Contractor to retain

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				its members.
105.	1.3.3	10	Will vendors for the Mississippi Children's Health Insurance Program (MSCHIP) be procured via a separate RFP?	Yes, vendors for the Mississippi Children's Health Insurance Program (MSCHIP) will be procured via a separate RFP.
106.	1.2	7	Please clarify the contract start date. When will the enrollment start?	Please see response to Question 87.
107.	1.3.5	11	Will the NICU risk sharing program be a risk corridor arrangement or a kick-payment, or something else?	The type of risk sharing arrangement that may be entered into by the Division has not been determined at this time.
108.	1.3.5	11	Please clarify if there are major changes in the methodology and rate development process of SFY2018 rates compared to SFY2017.	The Division does not anticipate any major changes. All Division program and reimbursement changes are included in rate development.
109.	1.3.5	11	Please provide historical information of IDD and MYPAC population including eligibility, benefits and claims, etc.	Please see response to Question 88.
110.	1.3.5	11	Will any risk sharing or risk mitigation program be implemented for these new populations?	The Division reserves the option to enter into risk sharing arrangements with Contractors. Any options for risk sharing arrangements have not been developed at this time.
111.	1.3.5	12	If risk scores are developed more frequently, will they be released monthly or quarterly?	The Division will monitor the population changes along with its actuaries. The current semi-annual development of risk scores will be

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				adhered to unless population changes warrant otherwise.
112.	1.3.5	12	Please clarify if there are other changes in risk adjustment methodology and process. Will the currently non-risk adjusted populations be risk adjusted?	The Division has no current plans for changes to the risk score methodology utilized or the rate cells it is applied to.
113.	1.3.5	12	Please clarify whether the historical claims will be re-priced to Medicaid FFS fee schedules in the rate development. If so, please provide a narrative of the re-pricing process.	Historical claims are not repriced during rate development.
114.	1.3.5	12	Please clarify whether encounter data or financial statement data, or both from participating health plans will be used in rate development. Please provide a narrative of the encounter and financial data reconciliation process.	The Division plans to utilize both encounter data and financial statement data in its rate setting process. This process is discussed in Appendix C Milliman Rate letter, page A-4, Step 4. The Division also works with its Contractors to reconcile encounter data to Cash Disbursement Joutnals on a bi-monthly basis.
115.	1.3.5	12	Please provide clarification how on the non-medical load components (e.g., administrative, risk contingency) will be developed in the rates. For example, how will the incumbents' financial information be used? If certain administrative costs are capped, what is the criteria?	Historical CCO administrative costs and national benchmarks have been utilized for the development of the administrative load. In addition to the administrative load, consideration for targeted margin (typically 2% of capitation) and premium tax (3% of capitation) have been included in capitation rates.

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116.	1.3.5	12	How will MHAP be treated in the new rate development?	MHAP pass-through payments will have to be transitioned in compliance with CMS regulations. The transition plan has not been developed at this time.
117.	1.3.5	12	Will one year or multi-year historical experience be used as the base data to develop the rates?	The Division anticipates using one year of base data to develop the rates.
118.	1.3.5	12	When does Milliman anticipate using actual MCO IP utilization and cost in the development of the SFY 2018 and/or SFY 2019 rates?	Milliman anticipates using actual 2016 inpatient hospital experience in SFY 2019 rate development.
119.	1.3.5	12	Does the state anticipate any significant changes to the state fee schedule as part of this new contract?	No.
120.			Beyond what is reflected in the RFP documents, does the state anticipate any significant program changes being implemented as part of the new contract?	The Division does not anticipate sweeping changes at the state level; however, the Division is closely monitoring federal Medicaid changes from the new Administration.
121.	4.2	37	For those instances where a prescribed penalty for failure to meet a requirement of the contract is not explicitly valued, please describe the process used by the Division to arrive at a "discretionary" liquidated damage amount (which can range from $1 to $1 Million). In the event the Contractor disputes the penalty, is there an appeals process available to resolve potential disputes?	Disputes are handled in accordance with Section 17.J of the Contract and Section 4.9.5 of the RFP.

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122.	1.2	7	Will a one year extension of the current MSCAN contract be issued to the incumbent Coordinated Care Organizations in order to ensure that services continue to be provided to MSCAN beneficiaries during the 1-year implementation of the Proposed Contract?	Please see response to Question 87.
123.	5.6 Methodology / Work Statement	Page 70 of 98	The RFP states that "The Offeror should repeat each statement/question and then follow with the response." Will this count against the page limit? Can the question text precede the response on a separate page?	Please see response to Question 36.
124.	Appendix A § 7(E)(3)	102 of Appendix A	Can NCQA Credentialing Standards be applied in lieu of requiring an Initial Site Assessment for private practitioner offices & other patient care settings? And requiring a site reassessment if the provider location changes?	Please refer to response in Question 28.
125.	1.4.7	Page 18 of 98	When THE DIVISION references the ability for providers to 'adjudicate' a claim on the web, is the scope of functionality referenced ensuring that all submission edits required for acceptance are met, or is the intent to include clinical edit, FWA, and medical necessity edits along with pricing of the claim?	The Contractor should have functionality in place for the provider to submit claims to the plan via a web portal. The portal should be designed to perform some editing of the submission to ensure appropriate adjudication of the claim.
126.	1.4.11.4	Page 25 of 98	Section 1.4.11.4 requires Contractors to establish a web-based inquiry system for Providers. Item 5 of this section requires web-based screens to conform to the requirements for readability set forth in the Americans with Disabilities Act (ADA). It states that at a minimum the screens must provide: a. Summary of Trips for a Date Range b. Summary of Trips by a beneficiary for a Date	Items a – c were inadvertently included and are not relevant to the RFP. The RFP will be edited to correct this issue.

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			Range c. Details of Trips by Request Tracking number We are unable to identify requirements in the ADA corresponding to the the elements referenced in (a) – (c) above or determine what sort of information they might reference for inclusion in the web-based Provider inquiry system. Please clarify or further elaborate the requirements referenced in (a) – (c) above.	
127.	Business Associate Agreement	Page 5 of BAA	Section III(q) of the Business Associate Agreement requires Contractors to maintain Division data in a separate database from other data and that Division Data not be co-mingled with other trading partners. Can the Division help further clarify the extent and boundaries of these requirements and the degree to which co-mingled data would be found acceptable? This could potentially require considerable resources to be employed by a Contractor and become very inefficient. Example considerations: • Many claims clearinghouses forward claims for all lines of business in a single transmission which MCOs process through their EDI Intake solutions, resulting in co-mingling of data in those databases. Is the expectation that clearinghouses would need to be instructed to send Division data separately, potentially inconveniencing providers as well? • Delegated vendors such as PBMs typically receive and load data into a common platform and do not	The intent of storing the Division's data in a separate database instance without co-mingling of data is to protect PHI/PII data from disclosure to individuals not authorized to see MS Medicaid data but might be authorized to see another trading partner's data. The only acceptable method of co-mingling of stored MS Medicaid data would be if the Division's data is de-identified in the database where other trading partners' data resides. The restriction on co-mingling of data does not apply to the actual EDI and/or PBM process.

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			maintain segregated data sets as they service multiple providers. • Population health analytics and Fraud/Waste/Abuse detection are improved in utility and accuracy when more comprehensive, cross-population data sets are utilized. May Contractors maintain Division data in the same secure database as other data so long as it can be segregated through filters or similar mechanisms?	
128.	Business Associate Agreement	Page 5 of BAA	Section III(r) of the Business Associate Agreement requires that all Division data "be encrypted using industry standard algorithms Triple DESDESK, AES or SSL/TLS." In performing the Contract, however, Offeror will need to be able to share data with others which normally is not encrypted. In addition, encryption isn't possible for data stored temporarily in memory or on disk. Please confirm that these encryption requirements apply to data while in transit over open networks or in storage in high risk locations such as portable device, laptops, etc.	The encryption requirements apply to all PHI/PII data whether in motion or at rest. Clarification of what "data in motion" and "data at rest" includes is stated in 45 CFR Parts 160 and 164 where it states that "data in motion" includes data that is moving through a network, including wireless transmission, whether by e-mail or structured electronic interchange, while "data at rest" includes data that resides in databases, file systems, flash drives, memory, and any other structured storage method. Therefore encryption requirements for data in motion would be for PHI/PII data in transit over any network and encryption for PHI/PII data at rest would be for any structured storage method.
129.	Business Associate Agreement	Page 5 of BAA	Please confirm that the encryption requirements in Section III(r) of the Business Associate Agreement apply only to Protected Health Information and Individually Identifiable Health Information.	The encryption requirements in Section III(r) of the BAA applies to both Protected Health Information (PHI) and Personally Identifiable Information (PII).

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130.	1.4.11.3	Page 25 of 98	Section 1.4.11.3 of the RFP states: "Contractor shall provide the Division access to the Contractor's data systems for auditing and monitoring purposes. Access shall include, but is not limited to, all equipment, systems, and communications software necessary for the Division to obtain utilization information." Please confirm that Contractors would be required to provide this access upon notice and related to a requested audit; Contractors would not be required to provide ongoing (permanent) operational access.	Access is needed for auditing and monitoring purposes. Auditing access will be limited to notice, and monitoring access may be ongoing for certain functions.
131.	2	Page 26 of 98	Section 2 of the RFP states that the CHIP program is administered by the Division as a separate program. However, CHIP data is included in the databook and "Quasi-CHIP" is noted as a population to be enrolled in MississippiCAN under the contracts awarded by the RFP. How will CHIP population be administered alongside MississippiCAN?	Quasi-CHIP members were either formerly enrolled in CHIP or new enrollees under the MAGI income requirement. The CHIP population and administration is separate from MississippiCAN.
132.	2.1(1) & 5.2(5) and Appendix A § 1(F)(6)	26 & 65 of the RFP and 11 of Appendix A	The Division's Sanctioned Provider List is a list of individuals and entities whose participation in the Mississippi Medicaid program has been terminated for cause. We therefore understand "sanctioned" to mean an entity that has been terminated or otherwise excluded from participation in a federal or state health care program for the purposes of sections 2.1.1 and 5.2(5) of the RFP and section 1(F)(6) of Appendix A to the RFP. Please confirm this understanding.	"Sanctioned" as referenced in sections 2.1.1 and 5.2(5) of the RFP and section 1(F)(6) of Appendix A to the RFP are not related to the Sanctioned Provider List. Please see response to Question 38.
133.	4.7.3 & 4.15.2	Page 45 & 59 of 98	Pursuant to the requirements of the RFP Offerors will have to disclose Social Security Numbers and dates of birth of their officers and directors. Please confirm that the unredacted version of any proposal (not just a	The unredacted version of any proposal will not be provided to any third party without providing the Offeror notice of the request and the opportunity to file for a protective order.

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			proposal submitted by a party to an executed Contract) will not be provided to any third party without providing the Offeror notice of the request and the opportunity to file for a protective order.	
134.	4.13.1 & 5.1(4)	Page 52 & 64 of 98	Does the Division have a particular form Offerors should use for making the ownership and financial disclosures required by section 4.13 of the RFP?	See response to Question 83.
135.	4.16.3 & 5.2(14)	Page 60 & 65 of 98	The Data Use Agreement (DUA) posted on the Procurement Website indicates that the following documents are part of the DUA: Attachment A: The Division Data Attachment B: SSA Computer Matching and Privacy Protection Act Agreement Attachment C: Security Controls Attachment D: Notification of Breach Attachment E: Certificate of Return or Destruction/ Sanitization of Confidential Data Attachment F: Service Agreement In the Transmittal Letter, Offerors are required to agree to the language of the DUA without revision. Please advise where Offerors might find these attachments so that they can review and provide the required agreement in the Transmittal Letter.	The Division will provide attachements on its website.
136.	5.2	Page 64 – 66 of 98	Please confirm that the documentation requested within the Transmittal Letter items (such as a copy of the Offeror's license) should be attached immediately behind the Transmittal Letter in the response.	Confirmed.
137.	5.2(9)	Page 65 of 98	Please clarify the lookback period for identifying prior projects that were terminated prior to the end of the	The lookback period is five (5) years.

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			Contract period.	
138.	5.4.3	Page 68 of 98	Section 5.4.3 requests, among other things, that an Offeror indicate for each experience the "Total number of staff hours expended during time period of contract" and "Publicly funded contract cost". Our organization has been serving several Medicaid programs for more than 10 years, including one for more than 20 years. Compiling this type of information for older time periods may not be possible and is unlikely to be useful for evaluation purposes. Please confirm that Offerors may report information for the most recently completed year with respect to these elements of experience.	Offerors must report information for the current contract period.
139.	5.4.3	Page 68 of 98	Section 5.4.3 requests, among other things, that an Offeror provide for each experience, "Direct Contract for client (see Appendix A)". Please clarify this requirement. Is this requesting the name of the contract with the client? Appendix A is the Draft Contract with the Division. Is this cross-reference an error?	Please see response to question ten (10). As requested in Section 5.4.3, list item #2 requires that the Offeror provides the contact information for corporate references who can speak to quality of the Offeror's work and attest to the Offeror's breadth of experience with the type of service to be provided by this RFP. The required contact information for these corporate references, including the phone number for client contacts, are provided to the Offeror in Appendix E: References. List item #10 should read "Direct Contact for client (see Appendix E)" to reference the appropriate listing of the required client contact information.

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				This list will be updated in the RFP.
140.	5.4.3	Page 68 of 98	Section 5.4.3 states that "Offerors must submit appropriate documentation to support information provided." Please clarify the scope of this requirement. Read literally, this could require submission of hundreds of pages of material. For example, would this require submission of copies of each of the Offeror's current contracts?	The Division is only requesting the Offeror submit appropriate documentation to support information provided in the case the information requested (1-10) is not available. Complete contracts should not be submitted. Only relevant information in lieu of the unavailable information should be submitted.
141.	5.5(4)	Page 68 of 98	Section 5.5(4) requires Offerors to submit "biographies of any Subcontractor staff proposed to work on this program." Please confirm that this requirement applies to individual Subcontractors, for example where the Offeror proposes to subcontract with a physician to act as medical director. It would not apply to employees of subcontracted entities such as the Offeror's pharmacy benefit manager.	The Offeror should submit this information on any subcontractors that will be fulfilling any of the key Executive or Administrative positions laid out in Section 1.M of the contract (Administration, Management, Facilities and Resources), or information on any subcontractors that will be working on the contract in any capacity and their key personnel.
142.	5.6(40)	Page 76 of 98	Please confirm that the Provider Agreement templates submitted with the response do not need to contain compensation terms.	The Provider Agreement templates submitted with the response do not need to contain compensation terms.
143.	6.2.2.3	Page 88 of 98	Section 6.2.2.3 indicates that the evaluation criteria for the Methodology/Work Statement will include the Offeror's data management plan and its processes for maintaining confidentiality of PHI. We did not	The Division requires that the offeror abide by provisions of the Health Insurance Portability and Accountability Act of 1996, including EDI, code sets, identifiers, security, and

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			identify any portion of the Methodology/Work Statement requesting this information. Please: (1) Confirm that the Offeror may attach a copy of its data management plan as an attachment to Question 76 and that it will not count toward page limits; and (2) Add a question to the RFP regarding the Offeror's processes for maintaining confidentiality of PHI.	privacy provisions as may be applicable to the services furnished through this RFP. The Offeror, if awarded a contract, will be required to comply with the data management and confidentiality provisions as outlined in Appendix A: Model Contract.
144.	Appendix A § 5(J)(1)	59 of Appendix A	Section 5(J)(1) of the model contract states that "Decisions to deny a Service Authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by a physician pursuant to Miss. Code Ann. § 41-83-31." That statute indicates that "No determination adverse to a patient or to any affected health-care provider shall be made ***on any question relating to the necessity or justification*** for any form of hospital, medical or other health-care services without prior evaluation and concurrence in the adverse determination by a physician licensed to practice in Mississippi" (emphasis added). Please confirm that section 5(J)(1) requires a determination from a physician only where the issue relates to medical necessity and non-licensed personnel may deny a Service Authorization for administrative reasons, such as the requested service is not a Covered Service or exceeds maximum limits.	Confirmed.
145.	Appendix A § 10(B)	126 of Appendix A	NCQA requires a plan to have operational data in order to perform its accreditation activities. Please confirm that a Contractor will have 18 months after	Question 8 in the work statement asks the Offeror to describe their process toward achieving NCQA accreditation. The Offeror

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			services begin under the Contract to achieve accreditation.	must also demonstrate how the design of their program aligns with NCQA standards to prepare for successful accreditation.
146.	Appendix A § 11(S)(2)	153 of Appendix A	Section 11(S)(2) of Appendix A provides that "The Division may impose liquidated damages or other available remedies under Section 16, Default and Termination, of this Contract for non-compliance with ***these*** requirements" (emphasis added). Please confirm that the requirements referenced in Section 11(S)(2) as subject to liquidated damages or other available remedies are the requirements relating to the processing of submitted claims by the Contractor and not to the submission of claims by Providers within 180 days. We are concerned about the administrative costs to Providers and the willingness of Providers to serve MississippiCAN members if Providers were to be subject to such liquidated damages.	The Division may impose liquidated damages or other available remedies upon the Contractor under Section 16, Default and Termination, of the Contract for non-compliance with the stated requirements.
147.	Appendix A § 13(A)(2)	167 of Appendix A	Section 13(A)(2) of Appendix A requires the Contractor to enroll members with diabetes, asthma, cardiovascular disease and chronic kidney disease in high risk Care Management. Many people with these conditions are stable and comfortable with self-care. Automatic assignment to high risk based on these conditions is not consistent with general Care Management principles which involve assigning members into risk categories based on their individual situations. This person-centered approach is contemplated by the model Contract itself, which provides that "the severity of the Member's conditions / disease state" and an "evaluation of co-morbidities, or multiple complex health care conditions" should be	The Contractor shall enroll members with diabetes, asthma, cardiovascular disease and chronic kidney disease in high risk Care Management in addition to complying with the requirements of section 9(A)(1).

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			included in the predictive modeling used to assign risk levels to Members (see section 9(A)(1) of Appendix A). Automatically assigning Members with these conditions to a high risk category is not consistent with these principles and is not the best use of Care Management resources. Please confirm that Members with diabetes, asthma, cardiovascular disease and chronic kidney disease are to be assigned a risk level in accordance with section 9(A)(1) of Appendix A rather than automatically assigned to a high risk category regardless of their individual circumstances.	
148.	Appendix A – Draft Contract; Section 2(A)	Page 38-39 of 283	The requirements applicable to subcontractors in the Contract suggest a more narrow definition of "subcontract" and "subcontractor" than is currently provided. For example, the RFP requires that Offerors provide for each subcontractor a signed Drug Free Workplace certificate, a signed work statement, references and a description of each subcontractor and its experience, among other things. Further, Contractors are required to obtain advance approval of any subcontractor, with liquidated damages in the amount of one month's capitation for each day a subcontract is in place without approval. Given the amount and detail of the information to be provided in the bid and the amount of liquidated damages that the Contract states are a "reasonable estimate of the loss which will be incurred," a "subcontractor" would seem to be an entity with which a Contractor has contracted to provide financially significant, critical and substantial services under the Contract. However, the definitions of "Subcontract" and "subcontractor"	Appendix A, Section 2.A is amended as follows: 96. **Subcontract:** An agreement between the Contractor and a Subcontractor to provide any function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to the Division under the terms of this Contract. Subcontracts must be approved in writing by the Division prior to the start date of the agreement. 97. **Subcontractor:** Any individual, firm, corporation, business, university, governmental entity, affiliate, subsidiary, nonprofit organization, delegated vendor, or any other entity with which the Contractor enters into an agreement to provide any function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to the Division under the terms of this Contract. A

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			in Section 2(A) of the draft Contract are far more broad and would seem to include print vendors and similar entities whose services are not critical to the performance of the Contract. Would the Division consider revising these definitions to be better aligned with the subcontractor requirements? We propose the following: **Subcontract**: An agreement between the Contractor and any individual firm, corporation, business, university, governmental entity, affiliate, subsidiary, nonprofit organization, or any other entity (a) to administer any covered benefits under the Contract, such as dental, vision and Non-Emergency transportation, and/or (b) to which Contractor pays (or reasonably anticipates it will pay) an amount equal to [$500,000] or more annually to perform part or all of the Contractor's responsibilities under this Contract. Subcontracts must be approved in writing by the Division prior to the start date of the agreement. **Subcontractor**: An entity with which the Contractor enters into Subcontract. A network provider is not a Subcontractor by virtue of the network provider agreement with the Contractor.	network provider is not a Subcontractor by virtue of the network provider agreement with the Contractor.
149.	5.6 Methodology / Work Statement	Page 74 of 98	Member Services Q28 does not list a page limit. Please provide a page limit if applicable.	There is a five (5) page limit.
150.	Section 1.2.3 5. Proposal	page 8 of 98	Section 1.2.3 requires an original and ten (10) copies of the proposal under sealed cover must be received	Please see response to Question 1.

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	5.1 Introduction		by the Division no later than 5:00 p.m. CDT, on April 7, 2017. Also to submit one (1) full copy of the Proposal and one (1) redacted version on CD in a single document in a searchable Microsoft Word or Adobe Acrobat (PDF) format. Section 5.1 indicates one copy of the proposal shall be submitted on CD in a single searchable document in Microsoft Word or Adobe Acrobat (PDF) format. Please confirm the proposal requirements to include: a) one (1) original hard copy; b) ten (10) hard copies; c) one (1) full copy of the proposal on CD; and d) one (1) redacted version of the proposal on CD. (CD contents should be a single searchable document in MS Word or PDF format.).	
151.	Section 1.2.3	page 8 of 98	May Offerors use font size 10 in diagrams, graphs, charts and tables?"	Please see response to Question 2.
152.	RFP §§ 1.4.5 & 1.4.7 and Appendix A §§ 6(A)(1) & 7(H)(1)	RFP 14 & 18 and 68 & 106 of Appendix A	The RFP indicates that the Member and Provider call centers should operate from 7:30am to 5:30pm CST. However, the draft Contract requires they operate from 8:00am to 5:00pm CST. Please confirm that consistent with section 1(B) of the draft Contract that the terms of the draft Contract would govern this requirement.	Please refer to response to Question 44.
153.	1.4.5.8	Page 17 of 98	Please clarify the purpose and use of the Web-Based Reservation System.	This requirement will be removed from the RFP.

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154.	5.6 Methodology / Work Statement	Page 71 of 98	Question #4 states: Describe the entity's staffing ratios per enrolled Member; including the number of **Member services call center** employees and nurse advice line employees, as well as supervisor to staff ratios. Describe the job qualifications for **Provider services call center** employees. Please confirm that "Provider services call center" in the last sentence should be "Member services call center."	Please refer to response to Question 12.
155.	Appendix A - Draft Contract Section 4 J	Page 49 of 283	Please confirm that the only members who can be retroactively enrolled to Contractors are newborns.	Confirmed. Newborns are enrolled from the date of birth, if born to a mother enrolled in Medicaid.
156.	Appendix C 0 MississippiCAN Capitation Rate Development Report	N/A	Appendix C contains the capitation rates for SFY 2017. When will capitation rates for 7/1/2018 be available?	SFY 2019 rates will be available during Contract Implementation.
157.	Appendix D - Pro Forma Financial Template	N/A	Please confirm that in filling out Appendix D, the pro forma, Offerors should use the SFY 2017 expected member months as presented in Table Appendix C3 of 5,930,508 member months per year divided by the assumed number of awarded Contractors. Are three Contractors anticipated?	Three Contractors are anticipated, though not guaranteed.

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158.	Appendix D – Pro Forma Financial Template	N/A	We note that the MLR Reporting Year is July 1 – June 30. Should we therefore assume that the years in the column headings in Appendix D are State Fiscal Years rather than calendar years?	Yes.
159.	Appendix D – Pro Forma Financial Template	N/A	Please provide clarification regarding lines 5 and 6 on the MLR tab of Appendix D. Do these inputs refer to credibility adjustments?	Lines 5 and 6 refer to an adjustment for Newer Experience. This provision is no longer included in the Model Contract, Exhibit C and will be deleted from the MLR Reporting Form in a future revision. These inputs do not relate to credibility adjustments.
160.	Appendix C - MississippiCAN Capitation Rate Development Report; Appendix B	B-4	There is a 15% CCO savings assumption on Prescription Drugs for the Non-Newborn Children population. Please comment on the source of this savings if Contractors must use the Division's PDL and cannot negotiate rebates with manufacturers.	Prescription drug utilization patterns for this population are highly seasonal. This may indicate there is unnecessary utilization that could be mitigated under managed care. It may also indicate there are opportunities for enhanced drug compliance to reduce non-pharmacy costs. In either situation, we are comfortable with the overall level of savings estimated relative to the FFS delivery system assumed in rate development.
161.	Appendix A-Draft Contract; Section 7 J 1	Page 113 of 283	Will the Division or Contractors be responsible for expenses related to medical education (Graduate, Indirect, and Direct)?	Contractors will be responsible for additional medical education payments. Graduate Medical Education (GME) payments are made by the Contractors as an add-on payment per case to hospitals applicable to Medicaid APR-DRG payment methodology at the same rate of payments for FFS paid by the Division.

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162.	Appendix C - MississippiCAN Capitation Rate Development Report; IV Data Sources	13	There appears to be a disconnect in the following two quotes from Appendix C. Please clarify. Were the eligibility and claims excluded for members in a PTRF or just the PTRF claims? Or are these referencing different services? Page 7: "MississippiCAN continues to exclude costs for inpatient residential psychiatric stays, though members are not disenrolled from MississippiCAN." Page 13: "…any individuals receiving services for category of service (COS) 26 – Inpatient Residential Psych were also removed from the data."	The "costs" for inpatient residential psychiatric stays have been removed for purposes of rate setting purposes as these services are not currently covered under the Contract with the CCOs. However, the beneficiaries receiving these services are considered for statistical purposes as the Contractors are responsible for case management review and discharge planning of patients during and after their inpatient residential stay.

Table in response to Question 88.

MYPAC Providers

Brentwood Behavioral health	00223531
Catholic Charities	05205339
Life Help	09581272
Methodist Children's Homes	00078516
Millcreek*	02436246
Mississippi Children's Home	07152543
Region 12 Commission on MH MR	05731359
Youth Villages, Inc.	00759838

**Not providing any services.*

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1915(i) CSP Providers

Providers of Targeted Case Management (T1017)	
North Mississippi Regional Center	04580504
Hudspeth Regional Center	08582577
Ellisville Regional Center	05850722
Boswell Regional Center	08339029
South MS Regional Center	09555710

Providers of CSP Services (S5100, H2023, and T2015)	
Life Help 1915I	05534383
Willowood Developmental Center	04428750
Mississippi Christian Family Ser	04428750
Midd West	07376861
Son Valley	02909271
Millcreek	07475367
Region 8 Mental Health Services	02222751
Communicare	04629718
Timberhills	05839877
Warren Yazoo Mental Health	05157868
Gulf Coast Mental Health Center	01403744
Life Help 1915I	01253876
REM Mississippi	01288246
Saint Francis Community Serv	04879736
Singing River Services	06738328
Community Counseling Services	03658575
Pine Belt Mental Healthcare	07977264