Amendment #4 to RFQ 20211210: RFQ Questions and Answers

RFQ #: 20211210 / RFx#3150003991

Date: February 7, 2022

RFQ Name: Mississippi Division of Medicaid Coordinated Care

This document contains all questions submitted by potential offerors by the RFQ Questions Deadline of January 7, 2022. The document is split into two parts:

1. RFQ-Specific Questions and Answers (Blue Table, 120 Questions)
2. Appendix A: Draft Contract-Specific Questions and Answers (Green Table, 56 Questions)

Three additional amendments will be referenced throughout this document that will be published the same day as this Amendment 4 (February 7, 2022):

- Amendment 5: RFQ Corrections and Clarifications
- Amendment 6: Appendix A: Draft Contract Corrections and Clarifications
- Amendment 7: Updates to Certain RFQ forms from Appendix F and H in Word Format
- Amendment 8: Additional MSCAN and CHIP Rate Information in Excel Format

Receipt of Amendment 4 Acknowledged:

_____
(Signature)

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(Printed)

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(Title)

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(Company)

Question#	Section #	Page #	RFQ Question	DOM Response
1.	1.2	6	Can DOM provide an estimated Implementation Period start date in order to enable Offerors to submit the most accurate work plans with their RFQ responses?	The requirement to provide Work Plans and Schedules has been removed from the RFQ. (Corrected in Amendment 5.)
2.	1.2	6	Section 1.2 of the RFQ identifies that "information about the Contract operationalization date will be provided to winning Contractors." As the RFQ requires the submission of a detailed "Work Plan and Schedule" for numerous questions, inclusive of start and end dates, will the Division provide more detail on the assumed readiness period start and end dates, and the contract operationalization dates? If not, what date assumptions should Contractors use when preparing these deliverables?	The requirement to provide Work Plans and Schedules has been removed from the RFQ. (Corrected in Amendment 5.)
3.	1.2.3	8	Please clarify the maximum file size for each submission to the designated SharePoint site.	There is no minimum file size
4.	1.2.3	8	Will Electronic Signatures be accepted by the state?	Yes.
5.	1.2.3.2	8	Will font size smaller than 12 be accepted for headers/footers, captions, graphics, figures, tables, and footnotes?	Tables, graphics, charts, figures, footnotes, callouts, and headers/footers may contain font smaller than 12-point. The font may not be smaller than 9-point font. The font must be in black Times New Roman.
6.	1.2.3.2	8	Will DOM please confirm that tables, graphics, and charts can contain a legible font size smaller than 12 pt?	Tables, graphics, charts, figures, footnotes, callouts, and headers/footers may contain font smaller than 12-point. The font may not be smaller than 9-point font. The font must be in black Times New Roman.
7.	1.2.3.2	8	Will DOM please confirm that reiteration of the question will not count toward page limits?	Reiteration of the question will count towards page limits.
8.	1.2.3.2	8	Will DOM permit other than black font in the Marked/not blind responses?	The Offeror must use black, Times New Roman 12 pt. font for responses, and black, Times New Roman font no smaller than 9 pt. for any tables, graphics, charts, figures, footnotes, callouts, and headers/footers.

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9.	1.2.3.2	8	Will DOM allow for company colors and images in the Marked/not blinded responses?	The Offeror must use black, Times New Roman 12 pt. font for responses, and black, Times New Roman font no smaller than 9 pt. for any tables, graphics, charts, figures, footnotes, callouts, and headers/footers. The Offeror may otherwise use company images and company colors in the Marked/not blind responses.
10.	1.2.3.2	8	Do other elements such as tables, callouts, and graphics have to comply with the Times New Roman 12 pt. requirement?	Tables, graphics, charts, figures, footnotes, callouts, and headers/footers may contain font smaller than 12-point. The font may not be smaller than 9-point font. The font must be in black Times New Roman.
11.	1.2.3.2	8	Would the State prefer offerors paginate sections based on page limits to ensure responses are compliant? Using this model section 4.2.2.1 would be paginated 1-55, section 4.2.2.2 would start over at page 1 and continue through to page 45.	No.
12.	1.2.3.2	8	Section 1.2.3: Qualification Submission Requirements, Figure 1.2: Format of Qualification--Font & Margins states we are required to use black Times New Roman font size 12. Can the State please confirm the following: 1) Offerors may use font colors other than black to distinguish headings, emphasized text, and other specialized text within the narrative, so long as they are not colors that would disclose the bidding entity in the unmarked portion. 2) Offerors may use an easily readable, smaller font for exhibits, graphics, tables, callouts, and headers/footers.	1) No. Only black Times New Roman text should be used. 2) Tables, graphics, charts, figures, footnotes, callouts, and headers/footers may contain font smaller than 12-point. The font may not be smaller than 9-point font. The font must be in black Times New Roman.

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13.	1.2.3.2	8	Section 1.2.3: Qualification Submission Requirements, Figure 1.2: Format of Qualification--Font & Margins states that appendices, as well as samples and templates required of the qualification, must comply with font restrictions, which is black Times New Roman font size 12. Some requested items, such as sample reports, may output in a different font/font size than what is required by the State and cannot be changed. Will these documents be acceptable for submission?	No. The Offeror should reformat the document to conform with RFQ requirements.
14.	1.2.3.2	9	Can the State confirm offerors should include their name within the PDF file and cover page for the Technical Qualification?	Yes, the Offeror should include its name in the PDF file and cover page for the Technical Qualification. These elements will not be accessible by the Evaluation Committee and for the sake of the Office of Procurement's ability to properly organize files and keep records. The Offeror's name should not appear anywhere else in the Technical Qualification.
15.	1.2.3.2	8	Will DOM please confirm that Cover Pages may contain graphics, use a font other than black Times New Roman, and a larger font size than 12 pt?	Cover pages may be formatted however the Offeror desires. The Evaluation Committee will not have access to Cover Pages.
16.	1.2.3.2	10	Can the State clarify if the redacted copy should be submitted to the designated SharePoint site? If not submitted to the SharePoint site, how is the redacted copy to be submitted?	An Offeror's redacted copy should be submitted into the designated subfolder in the Offeror's SharePoint submission folder.
17.	1.2.3.2	10	If the Redacted copy is to be emailed, can the State please clarify if an Adobe cloud link will be accepted and if not is the offeror allowed to break the response into parts for proper submission?	The Reacted copy should not be emailed. An Offeror's redacted copy should be submitted into the designated subfolder in the Offeror's SharePoint submission folder.
18.	1.2.3.3.2	11	Regarding Section 1.2.3.3.2 Definition of Identifying information, can the Division please clarify if Offeror-specific branded or named programs or systems that the Division may be aware	Offeror-specific branded or named programs or systems of any kind would be identifying information, no matter the Offeror's perception of the Division's previous exposure and/or knowledge of them.

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			of based on prior interaction or communication would be considered identifying information?	
19.	1.2.3.3.2	11	Regarding Section 1.2.3.3.2 Definition of Identifying information, can the Division please confirm that Offerors may include awards or accomplishments within the unmarked components of their qualifications, even if the award is unique to the organization as long as the award or accomplishment is not discussed as being unique.	Offerors may not include reference to any awards in their unmarked/Technical responses.
20.	1.2.3.3.2	11	Regarding Section 1.2.3.3.2 Definition of Identifying information, in an effort to "describe our direct experience" requested throughout multiple components of the technical unmarked component, please confirm that Offerors may reference experience, including Offeror's parent company and affiliate companies' experience, outcomes, successes, and other relevant information to support solutions for Mississippi, as long as a specific State or Contract is not included in such justification.	The Offeror may respond in general terms to describe experience in service delivery and payment outside of the State of Mississippi. The Offeror must not indicate the geographical locations of the experience, including but not limited to naming the specific State or Contract with which the experience is related. The Offeror may include to the size of the market served. The Offeror may include the experience of parent and affiliate companies, but the Offeror must not use the names of those companies, as that would violate the rules against Identifying Information.
21.	1.2.3.3.2	11	1.2.3.3.2 states, "if the entity is unique in its function, i.e., the entity is the only or one of the only companies known to perform the function the Offeror is describing, the Offeror may not mention that fact." If the Offeror or a related entity has a characteristic that shows their experience and capacity to provide the service in order to address the experience requirement are they permitted to mention that fact? For example, having the largest foster care membership, holding a sole source foster care contract in another state, or years of experience building Medicaid provider networks.	The Offeror may respond in general terms to describe experience in service delivery and payment outside of the State of Mississippi. The Offeror must not indicate the geographical locations of the experience, including but not limited to naming the specific State or Contract with which the experience is related. The Offeror may include to the size of the market served. The Offeror may include the experience of parent and affiliate companies, but the Offeror must not use the names of those companies, as that would violate the rules against Identifying Information.

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22.	1.2.3.3.2	11	1.2.3.3.2 states, "if the entity is unique in its function, i.e., the entity is the only or one of the only companies known to perform the function the Offeror is describing, the Offeror may not mention that fact." Please provide additional clarification on "known to perform the function".	If the Offeror performs a function that only the Offeror performs, or only a few organizations in the Offeror's industry performs, the Offeror may state that it performs the function, but the Offeror may not state that the Offeror is the only or one of the few organizations that performs this function. This also applies to any organizations associated with the Offeror.
23.	1.2.3.3.2	11	Please confirm that incumbents cannot name staff members or cite known in-state programs, local experience, or local partners.	An Offeror, incumbent or otherwise, cannot name staff members, cite known in-state programs associated with that Offeror, identify local experience, or identify local partners and/or partnerships by name. An Offeror should name potential partnerships in 4.2.3.9, Potential Partnerships.
24.	1.2.3.3.2	11	Section 1.2.3.3.2 states, "the Division of Medicaid defines “any other information” as information including but not limited to names of parent or umbrella companies with which the Offeror is currently associated or has been associated with in prior State Medicaid contracts, the names of subsidiaries of the Offeror, the Offeror’s company and parent company initials, initials of any of the Offeror’s subsidiaries, listing(s) of current and past State Medicaid contracts including dates of service, current or past provider lists in the State of Mississippi." We are concerned that the disclosure of the nature of the organization, such as by referencing that you are a public-private partnership, provider-sponsored, or joint venture, could disclose the identity of the offeror. Please confirm that this information would also be considered identifying information.	The Offeror should not state whether it is a private corporation, publicly-traded corporation, public-private partnership, or make reference to the nature of its corporate structure in the Technical/unmarked proposal.

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25.	1.2.3.3.2	11	1.2.3.3.2 states "When a response requires reference to a subcontractor, subsidiary, or other related entity, all requirements applicable to the Offeror as discussed in the previous paragraph also apply to that entity." Please confirm that an Offeror may name unrelated entities, such as technology and program vendors, that do not have an ownership relationship with the Offeror.	The Offeror should speak to capabilities only and omit the names of tools, technologies, and application names.
26.	1.2.7	12	Please confirm that the Offeror should include their acknowledged, signed amendments as an attachment to the Transmittal Letter in conjunction with item 14 that identifies the received amendments by name and date.	The Offeror should include their acknowledged, signed amendments as an attachment to the Transmittal Letter.
27.	1.2.9	12	Sections 1.2.9 and 1.4.7 of the RFQ identify that Contractors will be paid an "annual capitated rate". However, Section 1.3.5 identifies that payment will be a "monthly capitation payment". Please confirm that capitation rates are developed annually, however, Contractors will be paid a monthly capitation rate for services provided under the contract.	Capitation rates are developed annually, and Contractors will be paid a monthly capitation rate for services provided under the Contract.
28.	1.3.6	16	Section 1.3.6 identifies that "a time limited auto-assignment methodology will be used to ensure that each selected entity reaches a minimum threshold of twenty (percent of the program." Will the Division consider any additional methodologies to support a more financially sustainable membership level for new entrant Contractors such as proactively assigning all membership of an exiting Contractor to a new Contractor (in the event of one exiting Contractor and one new entrant Contractor)?	The Division's current policies are as stated in Appendix A: Draft Contract, Section 3. See also Appendix A: Draft Contract Questions and Answers, Questions 5-10 (in this document) for additional information.
29.	1.3.6	17	Is the 20% minimum threshold described in the first paragraph for both MSCAN and CHIP combined, or is there a separate 20% threshold for MSCAN and 20% threshold for CHIP?	The threshold is for MSCAN and CHIP combined.

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30.	1.3.6	17	If an incumbent is not chosen, are their members distributed using the time-limited auto-assignment process or is that process only used for newly eligible members?	The Division's current policies are as stated in Appendix A: Draft Contract, Section 3. See also Appendix A: Draft Contract Questions and Answers, Questions 5-10 (in this document) for additional information.
31.	1.3.7	17	Based on information in 1.3.7 in the RFQ regarding use of a PBA, in addition to the definition of PBA in 2.1 as well as section 4.4.4.1 in Appendix A, can the Division clarify what "pharmacy services" the MCOs are anticipated to deliver outside of Physician-Administered Drugs and Implantable Drug Systems (4.4.5), which is covered under Physician Services?	Contractors will not conduct retail pharmacy services. Contractors should maintain pharmacy information and data from the PBA for Care Management purposes and for reimbursement of the PBA for claims.
32.	1.3.7	17	Based on information in 1.3.7 in the RFQ regarding use of a PBA, in addition to the definition of PBA in 2.1 as well as section 4.4.4.1 in Appendix A, can the Division please confirm that the reference to pharmacies does not mean retail pharmacies but medical specialty pharmacies?	NCPDP D.0 type claims for both retail and medical specialty pharmacies will be managed by the PBA.
33.	1.3.7	17	Based on information in 1.3.7 in the RFQ regarding use of a PBA, in addition to the definition of PBA in 2.1 as well as section 4.4.4.1 in Appendix A, can the Division confirm the PBA will manage the pharmacy lock in program and also provide additional information as to what pieces of a pharmacy lock in program the Division expects CCOs to fulfill?	The PBA will manage the lock in program.

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34.	1.3.7	18	It is our understanding based on the language in section 1.3.7 of the RFP as well as in section 4.4.4.2 of the draft contract that pharmacy is carved-out of MississippiCAN/CHIP and will be paid by payments received by the Contractor from the Division and passed through to the PBA. However, in the pro forma template "DOM-CCO-Procurement-4.3.2.6-Pro-Forma-Financial-Template-Referenced-in-Appendix-G.xlsx" on the "P&L" tab there is a line for Prescription Drugs. Is it the expectation of the Division that this line be zero or should we project out the pharmacy costs?	The entry should be zero.
35.	1.5	21	Should Section 1.5 be included in the response to Management Qualification, or is it meant to be an outline of all required documents that are responded to throughout the Response?	Items 3, 4, 5, 7, and 8 can only be provided after award of the Contract by a winning Contractor. These items are included to alert Offerors of the requirement should they be awarded the Contract.
36.	1.5	21	Requirements 1, 2, 6, and 9 are included in the transmittal letter. Where would the State like us to respond to requirements 3, 4, 5, 7, and 8?	Items 3, 4, 5, 7, and 8 can only be provided after award of the Contract by a winning Contractor. These items are included to alert Offerors of the requirement should they be awarded the Contract.
37.	2.3.2	27	Can the Division provide clarification on how the Written Qualification Clarifications included in RFQ Section 2.3.2 will be factored into, or impact the scoring of the Offeror's qualifications.	Written clarifications will be used only in circumstances where the Offeror's response is unclear to the Evaluation Committee. The goal of Written Clarifications is to allow the Evaluation Committee the ability to fully understand the Offeror's proposal. It is not an opportunity for the Offeror to amend its proposal. The Offeror is required to respond only to the request for clarification. The Offeror may not change its proposal through a response to a Written Clarification; the Offeror may only respond to the question asked.
38.	2.6	31	In the post-award debriefing section, is "vendor" equivalent to "offeror"?	Yes.

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39.	4.1.9	41	This requires an Offeror/Contractor to state whether it was terminated prior to the end of the project Contract period. Did the Division intend to limit this statement to the termination of a government programs managed care contract? Further, it is common practice within the industry for a health plan to establish a legal entity (the "Contracting Entity") dedicated solely to holding the managed Medicaid contract with a State Medicaid Agency, while a separate legal entity (the "Administrating Entity") actually administers the day-to-day operations of the plan pursuant to an Administrative Services Agreement with the Contracting Entity. Does the Division intend to consider an Administrating Entity's experience for this response?	The Offeror's response should be limited to a government managed Medicaid contract with a state Medicaid agency. This section applies to both Contracting and Administrating entities.
40.	4.2, 4.3	-	We will submit the forms as PDFs; however, are Offerors allowed to replicate these forms in MS Word to allow for a more complete and thorough answer which may extend the length of the response form?	These forms were made available in Word format to all potential Offerors through Amendment 3 to this RFQ.
41.	4.2.2.1	44	Section 4.2.2.1 requiring the member call center to be in one of the 3 mentioned counties was removed by an Amendment 4 to the prior contract and is not included in the Appendix A CCO contract. Was this intended to be removed from the contract to allow hiring across the state or is this still a preference of the state?	The Member Call Center may be located anywhere within the state. RFQ Question 4.2.2.1.B.1.a. is revised to read as follows: Confirming that the location of the operations will be within the State of Mississippi (provide a yes or no answer; do not include address). (Corrected in Amendment 5.)

Question#	Section #	Page #	RFQ Question	DOM Response
42.	4.2.2.1	45	Section 4.2.2.1 allows Offerors to submit sample member marketing materials. Can the State please confirm if these materials should be submitted outside of the Technical (blind) Submission, or if the materials should be redone to remove all identifying information including branded colors? If the marketing materials should be submitted outside of the Technical Submission, please indicate where in the submission they should be included.	Samples should be reformatted to remove identifying information in conformance with RFQ Section 1.2.3.3 and submitted with the Technical/blind submission.
43.	4.2.2.1	45	Section 4.2.2.1: Member Services and Benefits has a response limit of 55 pages plus 2 marketing samples. Based on the extensive information requested in this section which includes more than 50 question prompts, would the State consider raising the page limit to allow Offerors to fully respond to each prompt included in the Section?	The Response Limit for this section is amended to read as follows: Response Limit: 65 pages, plus two (2) marketing samples, not to exceed five (5) pages each. (Corrected in Amendment 5.)
44.	4.2.2.1	46	Can the State please confirm if there is a question or requirement associated with 4.2.2.1 Question A.4.f.?	There is no question associated with this element. This is a typographical error. (Corrected in Amendment 5.)
45.	4.2.2.1	45	Regarding Section 4.2.2.1: Member Services and Benefits--Response Limit: 55 pages, plus two (2) marketing samples: Can the State please confirm that the two marketing samples will not be counted against the limit of 55 pages for this section?	Yes. The Response Limit for this section is amended to read as follows: Response Limit: 65 pages, plus two (2) marketing samples, not to exceed five (5) pages each. (Corrected in Amendment 5.)
46.	4.2.2.1	46	Section 4.2.2.1: Member Services and Benefits, Item A, Question 4: Chronic Conditions has a letter "f," however there is no associated question listed next to it. Can the State please confirm whether there is a question missing, and if so, provide the question text?	There is no question associated with this element. This is a typographical error. (Corrected in Amendment 5.)
47.	4.2.2.1	46	Please confirm A.4.f is intended to be blank.	There is no question associated with this element. This is a typographical error. (Corrected in Amendment 5.)

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48.	4.2.2.1.A.5.a	46	A.5.a reads ""Describe the Offeror's experience or capacity to manage the care of foster children, and your ability to develop a continuum of care responsive to their needs." Please confirm it should read "experience **and**/or capacity"	The Division confirms that this question should read "and/or" (Corrected in Amendment 5.)
49.	4.2.2.1	48	Given the current reading level for member materials is at a 6th grade reading level, it will take time and collaboration to ensure materials are appropriately revised to be at a 3rd grade reading level to meet contract requirements. Would the Division be willing to discuss the transition process and time period allowed to develop these materials?	The Division will discuss development of materials related to this Contract element during the Implementation period with Contractors.
50.	4.2.2.2	52	With question 4.2.2.2 Provider Network and Services on page 52 of the RFQ, there are 2 section "F", one for Provider Payment and one for Provider Grievances and Appeals. Was it the state's intention to label Provider Payment as "E"? If so, should respondents make that correction in their submission?	Provider Payment should be labeled "E," and Provider Grievance and Appeals should be labeled "F." This is a typographical error. (Corrected in Amendment 5.)
51.	4.2.2.2	52	Can the state clarify that Section 4.2.2.2 - Provider Payment should be labeled as "E. Provider Payment" rather than "F. Provider Payment"?	Provider Payment should be labeled "E," and Provider Grievance and Appeals should be labeled "F." This is a typographical error. (Corrected in Amendment 5.)
52.	4.2.2.2	52	In Section 4.2.2.2: Provider Network and Services, there are two items on RFQ pg. 52 labeled with an "F." Can the State please confirm that "F. Provider Payment" should instead be "E. Provider Payment"?	Provider Payment should be labeled "E," and Provider Grievance and Appeals should be labeled "F." This is a typographical error. (Corrected in Amendment 5.)
53.	4.2.2.3	53	Would the state consider accepting documents as part of Readiness Review to be responsive to Section 4.2.2.3.B.1 & 4.2.2.3.B.2 regarding "including questions" for our Health Risk Screening (HRS) and Comprehensive Health Assessment (CHA) due to the length of such documents or can the state confirm that they would allow as an attachment submission excluded from page limits?	These documents should be included with the Offeror's response to this question. They will be required again as part of the Readiness Review. To accommodate the submission of these documents, the Response Limit for this section is amended to read as follows: Response Limit: 45 pages, plus two (2) appendices: one (1) in response to B.1, and one (1) in response to B.2. Each appendix is limited to five (5) pages. (Corrected in Amendment 5.)

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54.	4.2.2.3	54	The questions below appear to be seeking duplicate information/response. Would the state remove the duplicative question or can the state clarify what specific information it is seeking in these questions: -Section 4.2.2.3.C.3.d. asks for information regarding "The Offeror's Care Management processes and specific communication steps with hospital inpatient Providers to ensure post-discharge care is provided to Members. The Offeror's response should address review of potential Member inpatient readmission by diagnosis and the Offeror's plans for readmission reduction through coordination with hospital providers and other relevant parties." -Section 4.2.2.3.D.2.b asks for information regarding "Coordinating with hospital discharge planners, PCPs/PCMHs, and Behavioral Health staff" related to Transition of Care planning. (p. 54 of RFQ)	C.3.d requests, "Transition planning for Members receiving Covered Services from Out-of-Network Providers at the time of Contract implementation." It appears the Offeror's question is about C.3.e, which is focused on the Offeror's processes post-discharge, as well as how those processes related to the reduction of readmissions. D.2.b is more specific, asking about the relationships the Division expects the Offeror to utilize in Transition of Care services.
55.	4.2.2.3.E	54	Please clarify a case load ratio with an associated care management risk level. Does the ratio pertain to the number of high risk members assigned to a single care manager? A case load of 40:1 could represent an intensive risk stratification level. A ratio of 40:1 for all risk levels deviates greatly from industry standard. If a 40:1 ratio is intended for all risk levels, please clarify how this is factored into the rate setting process.	The 40:1 ratio indicates that no Care Manager for a winning Contractor may have a case load of more than 40 Members. A Contractor may assign fewer than 40 Members to a Care Manager as needed to ensure quality Care Management. Offerors are reminded that medium- and high-risk Members are to be assigned a Care Manager per Section 7.5 of Appendix A: Draft Contract. Low-risk Members are to have access to Care Management teams with a point of contact, and therefore, they are not part of the 1:40 Member count. The ratio will be taken into account in the rate setting process in the same manner that care management is usually taken into account in the rate setting process. More details will be available when the rates are set for the base year of this Contract.

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56.	4.2.2.4	56	Section 4.2.2.4: Quality Management has a 40 page response limit plus a 10-page appendix, but two (2) components of the Quality Management Section request additional information with a 10 page limit (A.2 and C.1). Can the Division please confirm that the Annual Program Evaluation and Annual Program Description Work Plan requested in A.2, and the data analytics and informatics capabilities requested in C.1 each have a 10 page limit that does not count towards the section's 40 page response limit?	The Response Limit for this section is amended to read as follows: Response Limit: 40 pages, plus two (2) appendices: one (1) in response to A.2, and one (1) in response to C.1. Each appendix is limited to ten (10) pages. (Corrected in Amendment 5.)
57.	4.2.2.4	56	In Section 4.2.2.4: Quality Management, the page limit is 40 pages, plus a 10-page appendix. A.2 Quality Management Program asks us to provide models in Appendix A, Draft Contract (no more than 10 pages). C.1 Quality Measurement ask to provide up to 10 pages as an appendix to this response of sample reports that the Offeror proposes to use for this Contract. Can the State please confirm that items A.2 and C.1 each have a 10-page limit, bringing the total additional page count to 20 pages (in addition to the 40 pages allotted)? Can the State please confirm if it would like the model documents requested in A.2 to also be submitted as an appendix, as requested in item C.1?	The Response Limit for this section is amended to read as follows: Response Limit: 40 pages, plus two (2) appendices: one (1) in response to A.2, and one (1) in response to C.1. Each appendix is limited to ten (10) pages. (Corrected in Amendment 5.)
58.	4.2.2.4.A.2	56	Does the State want the models of the Annual Program Evaluation and the Annual Program Description as an appendix to question 4.2.2.4.A.2?	Yes. The Response Limit for this section is amended to read as follows: Response Limit: 40 pages, plus two (2) appendices: one (1) in response to A.2, and one (1) in response to C.1. Each appendix is limited to ten (10) pages. (Corrected in Amendment 5.)

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59.	4.2.2.5.A.	58	The questions below appear to be seeking duplicate information/response. Would the state remove the duplicative question or can the state clarify what specific information it is seeking in these questions: c. Data sources and processes to determine which services require Prior Authorization and how often these requirements will be re-evaluated; f. Process for regularly reviewing Prior Authorization requirements for their effectiveness and potential need for updates;	c. refers application of Prior Authorization requirements to services; f. refers to how the effectiveness of and need for update(s) to the Prior Authorization requirements will be measured.
60.	4.2.2.5.B	58	Will the Contractor have access to real-time pharmacy claims data?	In answering this question, assume that a winning Contractor will have access to real-time pharmacy claim information for all of its Members.
61.	4.2.2.5.B	58	Will the Contractor have access to the pharmacy prior authorization system to review approvals/denials?	In answering this question, assume that a winning Contractor will have access to the pharmacy prior authorization system to review approvals/denials.
62.	4.2.2.5.B	58	Will DOM provide monthly reports to the Contractor similar to the MMR reports that Contractors submit today?	Yes. The Monthly Management Reports (MMR) are the historical name for the Reporting Manual.
63.	4.2.2.5.B	58	Will the Contractor be responsible for handling member and provider calls pertaining to pharmacy claims issues or pharmacy prior authorizations?	No.
64.	4.2.2.6	60	Do systems diagrams count toward the 25 page limit for this section?	The Response Limit for this section is amended to read as follows: Response Limit: 25 pages, plus two (2) appendices: one (1) in response to A.1.a., and one (1) in response to D.1. Each appendix is limited to ten (10) pages. (Corrected in Amendment 5.)
65.	4.2.2.6	60	For Offeror's claims processing systems in Unmarked section 4.2.2.6, please confirm that Offeror is allowed to use names of industry standard tools, technologies and application names or does the State prefer we speak to capabilities only?	The Offeror should speak to capabilities only and omit the names of tools, technologies, and application names.

Question#	Section #	Page #	RFQ Question	DOM Response
66.	4.2.2.6	60	Can the state confirm that the third item listed under Section 4.2.2.6 - Innovation should be labeled #3 as opposed to #2?	The third question should be labeled with a 3. This is a typographical error. (Corrected in Amendment 5.)
67.	4.2.2.6	60	Section 4.2.2.6: Information Technology, Item C. Innovation has two questions numbered with a "2." Can the State please confirm the third question should be numbered with a "3"?	The third question should be labeled with a 3. This is a typographical error. (Corrected in Amendment 5.)
68.	4.2.2.6	60	Regarding Section 4.2.2.6: Information Technology, Question D.1: Can the State please confirm that the attachment with the Offeror's emergency response continuity of operations plan does not count toward the section limit of 25 pages?	The Response Limit for this section is amended to read as follows: Response Limit: 25 pages, plus two (2) appendices: one (1) in response to A.1.a., and one (1) in response to D.1. Each appendix is limited to ten (10) pages. Question D.1. is amended as follows: "In an appendix no longer than ten (1) pages, describe the Offeror's proposed emergency response continuity of operations plan. Address the following aspects of pandemic preparedness and natural disaster recovery, including…." (Corrected in Amendment 5.)
69.	4.2.2.6.D	60	Under D. Continuity of Operations 1b., the RFQ asks the Offeror to address "Essential business functions and responsible key employees." What are the essential business functions as defined by the State of Mississippi?	The essential business functions are the uninterrupted continuity of care of and availability of services to MississippiCAN and CHIP Members.
70.	4.2.2.7.B.1.g	62	Can the state make available a copy of the Annual Quality Management Program report as referenced in section 4.2.2.7.B.1.g.?	The Annual Quality Management Report is a report generated by the Contractor. The Division does not produce this report, and therefore, the Division does not have a copy of the report available for potential Offerors to review.
71.	4.2.2.7.B.1.h	62	The RFQ requires the Offeror/Contractor to describe how it will ensure subcontractor compliance with the Division's policies regarding subcontractor classification of administrative and medical expenses. Will the Division produce such policies?	Subcontractors are required to follow the same polices that apply to the Contractor regarding classification of administrative and medical expenses. It is the Contractor's responsibility to monitor Subcontractors for compliance.

Question#	Section #	Page #	RFQ Question	DOM Response
72.	4.2.2.8	64	Section 4.2.2.8, Financial and Data Reporting, item B, Data Reporting, Question 2, Health Information System Data. In describing our approach to maintaining a health information system that collects, analyzes, integrates, validates, and reports data, please provide further detail on what the Division intends Contractors to describe in the first item, i. Utilization. For example, is this referring to Utilization Management data?	This question is in reference to Utilization Management.
73.	4.2.2.11	68	Regarding Section 4.2.2.11: Eligibility, Enrollment, and Disenrollment, Question A, Item 2.c: Can the State please confirm that the Offeror's draft disenrollment survey does not count toward the 15-page limit for this section?	Yes. The Response Limit for the section is amended to read as follows: Response Limit:15 pages, plus two (2) appendices: one (1) in response to A.2.c, and one (1) in response to C.1.e. (optional). Each appendix is limited to five (5) pages each. (Corrected in Amendment 5.)
74.	4.2.3.1 & 4.2.3.2	70	Considering that a "Patient-Centered Medical Home" (“PCMH”) (which is addressed in Section 4.2.3.2) may also be included in the concept of “Value-Based Purchasing” (which addressed in Section 4.2.3.1), should Offerors omit references to PCMHs when responding to Section 4.2.3.1 to avoid redundancy?	No.
75.	4.2.3.3	71	Will a minimum of 0.5% capitation for social determinants of health be provided for in the capitation rates?	No.
76.	4.2.3.3	71	Section 4.2.3.3 of the RFQ identifies that Contractors devote at least 0.5% of their capitation payments to improve SDOH during the contract cycle. Will the Division permit Contractors to categorize these expenses as quality improvement activities for the purposes of calculating medical loss ratio?	The Division will allow Contractors to categorize these expenditures as quality improvements for all expenses meeting the definitions included in Appendix A: Draft Contract, Exhibit C, Section C, Subpart 2.

Question#	Section #	Page #	RFQ Question	DOM Response
77.	4.2.3.3	71	Could DOM provide clarification as to how the required 0.5% of capitated payments for Population Health services will be determined? What costs are included/excluded?	DOM will require that payments for these services be separately identified in the quarterly/annual MLR reporting. The Offeror must refer to 45 C.F.R. § 158.150, as also referred to in Draft Contract Exhibit C, Section C, Subpart 2, to propose services that would conform to this requirement.
78.	4.2.3.4	71	Regarding Section 4.2.3.4: Value-Added Benefits-Prenatal, #3,Dental preventative care during pregnancy and postpartum, as a value add suggestion is the understanding correct this coverage is for pregnant women who are non-EPSDT eligible? Part 200 Chapter 3: Beneficiary Information Rule 3.1: Coverage of Eligibility Groups lists pregnant women as a full coverage category of eligibility.	This is in reference to pregnant women who are non-ESPDT eligible.
79.	4.2.3.4	71	Section 4.2.3.4 of the RFQ identifies that the Division will evaluate any proposed Value Adds as part of the Innovation and Commitment score. It is noted that a list of Division-curated Value-Adds are included with the RFQ. Will the Division please provide additional clarity on the scoring methodology for this section? Are Division-curated Value-Adds scored higher than Contractor-proposed value adds? Is the evaluation based solely on the price per unit, gross value, or net value?	The Division-curated list is provided so that the Offeror has some context for services currently desirable to the Division. Each proposed value-added benefit will be scored based on the information solicited through the form and based on its value, both intrinsic and extrinsic, to the Division, its beneficiaries, and the state. The Division is open to innovative VAB proposals.
80.	4.2.3.4	71	Section 4.2.3.4: Value Added Benefits indicates that Offeror's may describe some of their own value added benefits. Would the State allow Offeror's to include a brief narrative introduction to the value added benefits preceding the requested forms?	No.

Question#	Section #	Page #	RFQ Question	DOM Response
81.	4.2.3.4	71	The state lists in-home respite services in the expanded benefits section of the value-add list. Is there a specific population within MSCAN or CHIP the state wishes to target with this value add? Please define the services and/or codes that the state is asking CCOs to cover as in-home respite services.	As an example, this value-add service could be offered, based on medical necessity, to the following potential participants: • Medically complex children up to age 21 whose caregivers may need additional support • Children up to age 21 with a serious emotional disturbance (SED) whose caregivers may need additional support • Individuals on any of the home and community-based waiver waiting lists whose caregivers may need additional support while waiting for enrollment into a waiver The Division of Medicaid (DOM) recommends adherence to all coding principals and guidelines when determining potential procedure code(s) to use for this value-add which meets the description of the service rendered.
82.	4.2.3.5	71	Section 4.2.3.5: Performance Improvement Projects has a response limit of 4 PIP Proposal Pages. Can the District please clarify if there is a page limit associated with the completed charts required for submission for each proposed PIP?	One (1) page.
83.	4.2.3.5	71	RFQ Section 4.2.3.5 asks for 4 PIP proposals; however, contract section 8.11 - performance improvement plans - indicates the contractor shall perform a minimum of five for MississippiCAN and five for CHIP. Please confirm that Offerors should propose 4 PIPs total in the RFQ response.	This interpretation is correct. Two (2) should be for MSCAN, and two (2) should be for CHIP.
84.	4.2.3.5	71	4.2.3.5 calls for the submission of four (4) Performance Improvement Projects (PIPs). Is the intent to submit (2) MSCAN and two (2) CHIP PIPs?	This interpretation is correct.

Question#	Section #	Page #	RFQ Question	DOM Response
85.	4.2.3.6	71	Section 4.2.3.6 asks Offerors to use the "Health Literacy Campaign Summary Chart on the following page for each PIP the Offeror is including in its response to this section." Can confirmation be provided that the Health Literacy Campaign Summary Chart will be utilized for each Health Literacy Campaign?	This interpretation is correct.
86.	4.2.3.5	72	Please confirm that the response to this section, in its entirety, is to be contained in the forms provided in Appendix E.	Responses to 4.2.3.5 should only be comprised of completed PIP forms included in Appendix E.
87.	4.2.3.6	72	Please confirm that the response to this section, in its entirety, is to be contained in the forms provided in Appendix E.	Responses to 4.2.3.6 should only be comprised of completed Health Literacy Campaign forms included in Appendix E.
88.	4.2.3.9	72	For the summary charts associated with Section 4.2.3.9 Potential Partnerships, please confirm that a total of eight (8) partnerships must be submitted: four (4) community based organization partnerships and four (4) additional care management focused community based organization partnerships.	This interpretation is correct.
89.	4.2.3.9 (Question asked about 4.3.2.9)	72-73	Please confirm that the response to this section, in its entirety, is to be contained in the forms provided in Appendix E.	There is no 4.3.2.9 in the RFQ. This question appears to be in reference to 4.2.3.9. For 4.2.3.9, the response to this section, in its entirety, is to be contained in the forms provided in Appendix E.

Question#	Section #	Page #	RFQ Question	DOM Response
90.	4.2.3.9	73	Please clarify what is meant by "partnerships to be utilized for Care Management closed-loop referrals and warm hand offs." Does DOM intend the Offerors to delegate aspects of Care Management to community based organizations, such as care coordination and disease management?	The Division does not intend for the Contractor to delegate Care Management responsibilities. The Division intends for Contractors to utilize partnerships with community-based organizations to ensure that Members receive holistic Care Management. For example, if a Care Manager becomes aware of a Member who is food insecure, the Care Manager may refer that Member to a food pantry or similar organization local to that Member, and the Care Manager would then be required to ensure that the Member is connected with the food pantry, contacting the food pantry if necessary to ensure an easy process for the Member, and then follow up with the Member to follow-up on whether the Member has utilized the referral.
91.	4.3.1	72	Please confirm that the Offeror is not to provide any narrative for 4.3 and 4.3.1 and that only section 4.3.1.1.2 should be responded to with any narrative.	The Offeror should use the correlating form in Appendix F to reply to 4.3.1.1.1. The Offeror should provide a narrative response to 4.3.1.1.2. The Offeror should provide a narrative response to 4.3.1.2 ONLY if there is no information available that is responsive to the chart provided for 4.3.1.1. (See Question 92, below, for more information.)
92.	4.3.1.2	74	Please confirm that the offerors can provide a narrative response for Section 4.3.1.2 in addition to Appendix F to fully address all components of the requirements.	A narrative response may only be submitted if the Offeror does not have the experience requested through the available form in Appendix F. This narrative should be no longer than three (3) pages. If the Offeror does have the experience requested, submission of the form provided for each applicable experience is the only response the Offeror may submit. Directions for 4.3.1.2 have been updated to clarify the three (3) page narrative limit. (Corrected in Amendment 5.) Directions in Appendix F have also been updated in clarify the three (3) page narrative limit and to remove the requirement for documentation supporting the assertion of unavailability of experience conforming with that requested in 4.3.1.2. (Corrected in Amendment 5.)

Question#	Section #	Page #	RFQ Question	DOM Response
93.	4.3.1.2	74	Section 4.3.1.2 asks Offerors to describe experience from other states. Is the Division asking Offerors to only consider experience from states where an Offeror has served at least 400,000 beneficiaries, or is the Division asking for experience from any state where the total Medicaid enrollment exceeds 400,000 beneficiaries.	The Division is seeking experience for markets totaling 400,000 or more beneficiaries. The Offeror's enrollment in such a market does not have to meet or exceed 400,000 beneficiaries.

Question#	Section #	Page #	RFQ Question	DOM Response
94.	4.3.3	78, 79	The first sentence of 4.3.3 states, in part, that the Organization and Staffing section shall include ... "the Offeror's plan for hiring and management of any subcontractors the Offeror plans to execute the Contract and what economic impact the execution of the Offeror might have on the state." Per 4.3.3.5 and 4.3.3.6, information about subcontractors and our economic impact is to be submitted on the respective forms in Appendix H. Neither of the applicable forms has a field for describing our hiring and management plan for subcontractors or for the impact that will have on the economy in the State. Can the State please provide additional guidance on where in the RFQ response it would like Offerors to describe these elements?	The directions for 4.3.3 are amended as follows for clarity: "The Organization and Staffing Section shall include team organization, charts of proposed positions, number of FTEs associated with each position for key staff, and job descriptions of key management personnel and care managers listed in Section 1.13, Administration, Management, Facilities, and Resources of Appendix A, Draft Contract, as well as the Offeror's plan for hiring and management of any subcontractors the Offeror plans to execute the Contract, and what economic impact the selection of the Offeror might have on the state." (Corrected in Amendment 5.) Directions for 4.3.3.5 are amended to allow for a brief narrative explaining the Offeror's overall philosophy and strategy for subcontractor hiring and management. (See Amendment 5 for this addition in the body of the RFQ; see Amendment 7 for this addition in the directions included in Appendix H). Additionally, there is a field on the first Subcontractor form for 4.3.3.5 that asks how the Offeror will monitor and manage that specific subcontractor. Responses to this element of the form are to be used to understand the Offeror's approach to management of specific subcontractors. It was not the Division's intention that the Offeror include information about potential subcontractors' economic impact. Directions for 4.3.3.6 are amended to clarify this point. (Corrected in Amendment 5.)
95.	4.3.3.1	78	Can the state confirm whether the offeror is allowed to list name of staff within the requested org charts requested in Section 4.3.3.1?	The Offeror is not allowed to list the name of staff in its response.

Question#	Section #	Page #	RFQ Question	DOM Response
96.	4.3.3.2	78	Is it the intent of the State for Offerors to provide job descriptions for positions listed in 1.13.2 Additional Staff Requirements in addition to Key Personnel listed in sections 1.13.1.1 Executive Positions and 1.13.1.2 Administrative Positions?	Yes.
97.	4.3.3.4	78	Section 4.3.3.4 requires staffing ratios per enrolled member and/or provider as well as total staffing numbers. For consistency in comparison across responses, what membership assumption should Offeror's use when developing this response?	The Offeror should assume an enrollment of 125,000 Members per Contractor for the purposes of preparing its Qualification.
98.	4.3.3.5	79	The definition of "Subcontract" in the draft contract includes not only direct subcontracts, but also downstream contracts "between a third party and fourth party, or between any subsequent parties". Given how extensive this list may be, please confirm that for the purposes for RFQ responses, including, but not limited to the Subcontractor information required in RFQ Section 4.3.3.5, that Offerors are only required to submit information for direct Subcontractors, and not an exhaustive list of downstream entities.	For the purposes of RFQ responses, the Offeror need only submit first-level subcontractors, i.e., subcontractors with which the Offeror expects to directly subcontract with for services. This does not relieve the Contractor of any responsibilities stated within Exhibit A, Draft Contract, regarding Subcontractors as defined in that document.
99.	4.3.3.5	79	For Section 4.3.3.5 Subcontractors, in the summary table that must be completed for each subcontractor would the Division considering adding an additional category for entity type? Currently the options are "The entity is a: subcontractor or wholly-owned subsidiary". Would the Division consider adding "The entity is a: affiliate under the same common ownership"?	Yes, that addition to the form in Appendix H: Organization and Staffing for 4.3.3.5 Subcontractors is appropriate. (Use updated form included in Amendment 7.)
100.	4.3.3.6	79	Please confirm that Section 4.3.3.6 Economic Impact is intended to be MARKED.	Section 4.3.3.6 Economic Impact is intended to be Marked. (Corrected in Amendment 5.)

Question#	Section #	Page #	RFQ Question	DOM Response
101.	4.3.3.6	79	In Section 4.3.3.6, Economic Impact, are Offerors permitted to also include any positions that they will locate in Mississippi that are not dedicated to the Mississippi Medicaid contract, but would nonetheless provide a positive economic impact to the state (e.g. call center representatives for other state Medicaid programs that would be located in Mississippi if awarded a contract).	The Offeror may include a two (2) page narrative of other investments, if applicable. (Corrected in Amendment 5.)
102.	4.3.3.6	79, 80	This section outlines completion of Wage Charts. The last sentence allows for a "Narrative of other investments." Is this to be submitted as an attachment or part of the Appendix? Is there a page limit for this narrative?	The Offeror may include a two (2) page narrative of other investments, if applicable. (Corrected in Amendment 5.)
103.	Appendix C	15 of Appendix C	This page states, "There are no withholds associated with the CHIP capitation rate." Will this remain the same once CHIP is combined with MSCAN or will the CHIP rate cell be subject to the 1% withhold applied to the MSCAN rate cells?	CHIP will be subject to the 1% withhold as a new Rate Cell in the new Coordinated Care contract.
104.	Appendix C	23 of Appendix C	The CHIP population is currently priced at a statewide level. Once combined with MSCAN will the CHIP capitation rates be developed at a regional level like the MSCAN rates?	Milliman will evaluate the necessity of splitting CHIP rates by region at the time of rate setting under the new contract.
105.	Appendix C, Contract 1.13.1.1	40 of Appendix C	Please confirm that the Chief Medical Director may also serve as the Perinatal Medical Director or Behavioral Health Medical Director if they meet the contractual requirements of those roles.	They may not. These are three separate and distinct roles.
106.	Appendix C	Capitation Rate Exhibit 1-8	PDF tables for rate buildup are not formatted to fit within page and therefore do not contain complete data. Please provide complete data set files.	This information is supplied in Excel format via Amendment 8.
107.	Appendix E		Additionally, Appendix E identifies that "to the extent that some or all of the desired value-added services may be covered through the Offeror's care management strategy, that should be made evident in the Offeror's Care Management answers in its	This interpretation is correct.

Question#	Section #	Page #	RFQ Question	DOM Response
			qualification." Please confirm that even if some value-added services are provided through the Care Management strategy, they should also be incorporated into the Proposed Value Added Benefit: Summary Chart and Proposed Value-Added Benefit: Staffing sections?	
108.	Appendix E, 4.2.3.4	97	Will over-the-counter medications continue to be a PDL managed category?	Yes, OTC medications that fall within therapeutic classes reviewed under PDL.
109.	Appendix E, 4.2.3.4; Contract 8.9	97	Will the state please confirm that any proposed and implemented VABs the state has recommended under the Social Determinants of Health section are allowed to be included in the 0.5% Capitation Payment requirement for SDOH projects.	Expenditures made on Value-Added Benefits will not be allowed to be included in the 0.5% Capitation Payment requirement for SDOH projects.
110.	Appendix E, 4.2.3.6	103	Section 4.2.3.6 instructs the Offeror to "Use the Health Literacy Campaign: Summary Chart on the following page for each ***PIP*** the Offeror is including in its response to this section." Please confirm that the instructions should read "for each ***campaign*** the offeror is including" and not "for each ***PIP***".	This was a typographical error and was corrected in Amendment 3.
111.	Appendix F		Can the State clarify the proper heading in Appendix F form referencing Corporate Experience should be 4.3.1.2 and not 4.3.1.1?	This was a typographical error and was corrected in Amendment 3.
112.	Appendix F, 4.3.1.1	111	The biographical information form asks the Offeror/Contractor to disclose any "Contractual terminations" within the last 5 years. Are these disclosures limited to managed care contracts with government entities?	The Offeror's response should be limited to a government managed Medicaid contract with a state Medicaid agency. This section applies to both Contracting and Administrating entities.
113.	Appendix F, 4.3.1	113	The form titled "Corporate Experience: Current and/or Recent Client" on RFQ page 113 of 140 lists the same line item asking for "Geographic and population coverage requirements:" twice. Please confirm that one of these lines will be removed.	This is a typographical error. This document has been corrected in Amendment 7 to remove the duplicative "Geographic and population coverage requirements:" field.

Question#	Section #	Page #	RFQ Question	DOM Response
114.	Appendix H, 4.3.3.3	132	Question #2 of 4.3.3.3 states "The Offeror will Describe how and where administrative records and data will be maintained and the process and time frame for retrieving records requested by the Division or other State or external review representatives." Appendix H 4.3.3.3 has the same statement. Does the signature on Appendix H suffice, or do we need a narrative of how we will address the question in #2? If so, is there a page limit or other formatting requirements for this narrative?	Use of the form included Appendix H 4.3.3.3 will satisfy 1. of this section. (See Amendments 5 and 7.) 2. has been amended to allow for a narrative no longer than two (2) pages. (See Amendments 5 and 7.)
115.	Appendix H, 4.3.3.5	135	Form 4.3.3.5 "Prior Experiences with Subcontractor" has two (2) sections titled "Geographic and population coverage requirements." What is the difference between the two sections or will the State confirm this is a duplication?	This was a typographical error and was corrected in Amendment 3.
116.	General		Can the State please confirm that testimonials or quotes from community organizations or other stakeholders may be included in the response to the Technical Qualifications and would not be in violation of the blind/unmarked requirement as long as the quote speaks to future partnerships that will be contemplated for this RFQ?	Quotes may not be included in the Offeror's qualification.
117.	General	N/A	Several questions in the RFQ require a work plan and schedule to be submitted. These work plans and schedules will naturally differentiate a new entrant versus an incumbent. Can the State please provide additional guidance on how Offerors should navigate this work plan and schedule requirement given the "unmarked" requirement for this portion of the RFQ?	The Division is amending the RFQ to remove these subparts from the Methodology Work Questionnaire section. (Corrected in Amendment 5.) Additionally, the following is stricken from 4.2.2.: "For each of the subsections below, responses to Work Plan and Schedule are not subject to the page response limits listed for that section. Work Plans and Schedule response are limited to 15 additional pages for each section." (Corrected in Amendment 5.)
118.	General		The RFQ uses interchangeably "Offeror" and "Contractor," are these considered the same?	Yes.

Question#	Section #	Page #	RFQ Question	DOM Response
119.	Multiple	Multiple	For the staffing attachments for SDOH, Value Added Benefits, PIPs, etc., the instructions seem to indicate that only "additional and/or dedicated" staff should be included. If an Offeror engages other staff member who may not be dedicated or "additional" in its programming for these respective areas, should they be included in this attachment?	No.
120.	Multiple	Multiple	A number of questions within the Unmarked Methodology/Work Statement, such as Question 4.2.2.1.A.2, ask for the Offeror's "direct experience in service delivery and payment". Can DOM confirm that specification of experience and success outside of Mississippi will not be considered in violation of 1.2.3.3.2? If that would be a violation, can DOM provide additional guidance for how to express experience without violating 1.2.3.3.2?	The Offeror may respond in general terms to describe experience in service delivery and payment outside of the State of Mississippi. The Offeror must not indicate the geographical locations of the experience, including but not limited to naming the specific State or Contract with which the experience is related, but it may include to the size of the market served. The Offeror may include the experience of parent and affiliate companies, but the Offeror may not use the names of those companies, as that would violate the rules against Identifying Information

[End of 1. RFQ Questions and Answers]

Question#	Section #	Page #	Draft Contract Question	DOM Response
1.	1.12	39	The 10th item in the data exchange section states, "any files related to pharmacy and/or drug benefits and/or services as directed by and in a timeframe determined by the Division." Is this still a requirement for the CCOs or will this be the responsibility of the PBA?	As the PBA continues to evolve, the Division may need certain data transfers from a Contracted CCO regarding pharmacy and/or drug benefits. DOM will inform Contractors of the specifics of this need if it should arise.
2.	1.12.10	39	The Contract in 4.4.4.1 states that the PBA will share the claims with the Contractor for the purposes of Care Management and payment. Within the Data Exchange Requirements section, 1.12.10, the Contractual Agreement states the Contractor must utilize data extract from the Division and/or its Agents and that data extract files will include any files related to pharmacy and/or drug benefits and/or services. Can the Division provide clarity around the files the MCOs will receive related to pharmacy including file format and frequency?	Contractors will be able to view claims through a web portal application.
3.	1.17.1.4, 11.1.7	46	It appears that Contract Section 11.1.7 - Reinsurance and Section 1.17.1.4 - Financial Insurance have duplicative language. Would the division confirm that the two are the same requirement and that only reinsurance coverage is required. Otherwise, please provide additional detail on Financial insurance requirements as we have not encountered this type of insurance in other Medicaid contracts.	These sections refer to the same requirement. Only one policy is required.
4.	2.1.98	63	To ensure there are clear lines of responsibility between the PBA and the CCOs, what process will be used to decide how a drug will be administered for those that can be administered in either a retail pharmacy setting or a medical setting?	The Division will provide additional information to winning Contractors on this topic.
5.	3	72	Section 3 states, "the Contractor will be responsible for assessing eligibility and conducting enrollment for members of MississippiCAN and CHIP." Please confirm that this is the Division's responsibility and not the Contractor's.	This is the Division's responsibility, not the Contractor's. The sentence is amended to read, "The Division will be responsible for assessing eligibility and conducting enrollment for Members of MississippiCAN and CHIP." (Corrected in Amendment 6.)

6.	3	72	Contract Section 3. Eligibility, Enrollment, and Disenrollment, states, "The Contractor will be responsible for assessing eligibility and conducting enrollment for members of MississippiCAN and CHIP." Can the State please confirm that "Contractor" should instead read "the Division?" If the State is in fact looking for Contractors to take on this function, can the State please provide additional information on what the process and expectation is, so Offerors may adequately address this in their RFQ response?	This is the Division's responsibility, not the Contractor's. The sentence is amended to read, "The Division will be responsible for assessing eligibility and conducting enrollment for Members of MississippiCAN and CHIP." (Corrected in Amendment 6.)
7.	3.2	75	The passive auto enrollment rules under section 3.2 of Contract include - "Special Open Enrollment: If passive auto assignment is needed during that the Special Open Enrollment period, assignment will be made using a random process." Does the 20% minimum threshold referenced in 3.2.2.1 take precedence in order of operations for passive enrollment during the special open enrollment period over the above random process?	Yes.
8.	3.2	75	The passive auto enrollment rules under section 3.2 of the contract include: "Value-Based Purchasing: If multiple Contractors meet the Proximity standard, then assignment will occur based on Value-Based Purchasing (VBP) performance measures as defined by the Division." Please provide additional clarification on how the auto assignments will be made, including a description of the type of VBPs that will be used to determine these assignments. Since VBPs often require at least 1 year of provider experience, please also provide clarification on how this process will be implemented if a new entrant is awarded a contract.	The VBP process will be developed prior to the operationalization of the Contract, based on input from winning Contractors through the RFQ and during the implementation period. There will be a least one measurement year before any VBP-driven auto assignments are made.

9.	3.2.1	75	In section 3.2.1 the contract contains the following language - "The Division may, at its discretion, set and make subsequent changes to a threshold for the percentage of Members who can be enrolled with a single Contractor" The language appears to a maximum threshold verse the minimum threshold language of 20% provided under section 3.2.2.1. Please provide if the Division has set a maximum threshold of members who can be enrolled with a single contractor, and the details.	There is no maximum threshold.
10.	3.2.2.1	76	The following language is in Contract Section 3.2.2.1 - "Beneficiaries already enrolled with an incumbent contractor, should one exist, are allowed to continue their enrollment with that entity or change to another entity. Following Special Open enrollment, a time-limited auto-assignment methodology will be used to ensure that each selected entity reaches a minimum threshold of twenty (20) percent of the program. Once such threshold has been reached, the Division will revert to the passive auto enrollment methodology outlined in Section 3.2 of the Contract" The above section addresses beneficiaries enrolled with an incumbent, and how they will continue with that entity unless they make a change. If an incumbent is not awarded would it be correct to assume that those displaced members will go through the following process. First, In the special open enrollment the displaced members will be given a 60 day window to select one of the awarded CCOs. Second, After the special open enrollment any displaced members that have not made a selection will be assigned to the new entrant(s) until they reach 20% of the program. Third, if any additional members are remaining from step 2 they will be equally distributed among the awarded CCOs. If the above assumption is not correct please provide how the division intends to handle beneficiaries that are with an incumbent that is not awarded a contract.	After the 20% threshold is met, the Division will utilize the passive auto enrollment methodology as stated in Section 3.2 of Appendix A, Draft Contract. If no incumbent was awarded a Contract, that process would necessarily start at the third step, Prior Claims History, to ensure continuity of care for the Member. If there is a mix of new and incumbent plans, then the process would start at the first step of Section 3.2, again to prioritize continuity of care for the Member.

11.	4	87	The Contractor must submit reports related to covered services and benefits in accordance with Section 16, Reporting Requirements, of this Contract, and the MississippiCAN and CHIP Reporting Manuals, which are incorporated into this Contract via reference. Can the State please provide these Reporting Manuals or a link to the manuals referenced here and also throughout Appendix A.	Downloadable links for both Reporting Manuals will be provided on the dedicated DOM CCO Procurement Website no later than Friday, February 11, 2022.
12.	4.3.1.1	102	Will DOM consider reviewing/approving pre-emptive policies prior to FDA approval for new drug therapies (j codes) to allow the Contractor to have policies in place when drugs receive FDA approval?	The Division will not review/approve policies prior to FDA approval for new drug therapies (j codes). In accordance with Administrative Code, Part 200, Chapter 2: Benefits, Rule 2.2 Non-Covered Services, A.6., DOM does not cover "Procedures, products and services for conditions and indications not approved by the Federal Drug Administration (FDA) and/or that do not follow medically accepted indications and dosing limits supported by one (1) or more of the official compendia as designated by the Centers for Medicare and Medicaid Services (CMS)…"
13.	4.3.1.6	103	Please confirm that a Mississippi license is not needed for all authorization reviews. Section 4.3.1.6 states, "nurses, physicians, and other licensed health professionals conducting reviews of medical services, and other clinical reviewers conducting specialized reviews in their area of specialty shall be currently licensed or certified by the Mississippi state licensing agency or hold a multi-state license with Mississippi privilege." We received previous clarification from DOM that this was only applicable to authorizations resulting in the reviewer making the denial, in compliance with 42 C.F.R. § 438.210 (b)(3).	Section 4.3.1.6 refers to Denials. Denial of authorization must be made in compliance with Miss. Code Ann. § 41-83-31.

14.	4.4.4	113	Section 4.4.4 of the draft contracts identifies that the Pharmacy Benefits Administrator (PBA) will be responsible for claims management and payment and prior authorization for all covered outpatient drugs for Members. It goes on to identify that the PBA will "share all Member claims with the Contractor for the purposes of Care Management and payment". Please confirm that the Contractors are expected to reimburse the PBA for claims paid? As pharmacy expenses can represent a significant portion of a Member's medical expense (for which the Contractor is at risk for), will Contractors have input into the PBA's prior authorization policies and processes?	The Contractor will reimburse the PBA for claims as described in Section 4.4.4.2 of exhibit A, Draft Contract. The Contractor will serve as a pass-through payer to the PBA; funds for PBA claims will be transferred to the Contractor by the Divisions. The PBA and the Division will develop Prior Authorization policies and processes.
15.	4.4.4.1	114	Question in regards to section 4.4.4.1 "The Contractor is expected to cooperate with the PBA fully in all aspects of pharmacy administration. The PBA will share all Member claims with the Contractor for the purposes of Care Management and payment." For care coordination and clinical interventions, will pharmacy claims files be provided on a daily basis and in an industry standard format? Will there also be access to a PBA reporting portal/system for MCO access?	Contractors will be able to view claims through a web portal application.
16.	4.4.4.2	114	Will the Contractor be required to pay additional funds, outside of the funds the Division provides, to the PBA?	No.
17.	4.4.4.2	114	Contract Section 4.4.4.2 states "The PBA will submit a weekly invoice to the Contractor that the Contractor will pay with funds provided by the Division. The Contractor must make payments as directed by the Division to the PBA. The Contractor will establish a dedicated bank account for the purpose of receiving the funds and managing the payment of PBA invoices." Can the Division provide more detail on how they will be paying the CCO for the PBA invoices?	Like the Contractors, the Division will receive weekly invoices from the PBA. The Division will allocate the funds necessary to pay those invoices to the Contractors, directing those funds to each Contractor's dedicated PBA bank accounts. Each Contractor must then use those funds to pay their invoice from the PBA.

18.	4.4.4.2	114	Regarding the weekly invoice mentioned in Section 4.4.4.2: a. Will this be a pass thru item? b. Will all pharmacy payments be outside the capitation payment? c. Will there be administrative costs included in the rates for processing these payments?	a. Yes. b. Yes. c. Milliman will evaluate the expected administration costs associated with the pharmacy services under the new contract and build it into the capitation rates, as appropriate.
19.	4.4.4.3	114	How will the capitation rates be adjusted to account for the administration? Currently rates have an admin percent applied to the total expected medical/rx dollars. If Rx dollars are removed from the rate, the admin dollars needed for administering the pharmacy benefit will not be accounted for in the rates according to the current methodology.	Milliman will evaluate the administration costs associated with the pharmacy services under the new contract and build that into the capitation rates, as appropriate.
20.	5.1	116	Regarding Contract Section 5.1, can the state confirm that when you speak to a toll-free dedicated Member services call center, that it is the toll-free line that needs to be dedicated to this contract?	Yes.
21.	5.1.6	119	The requirement in Contract Section 5.1.6 that “the average monthly speed to answer after the initial automatic voice response is forty (40) seconds or less” appears to conflict with the requirement in 5.1.1 that “the average hold time for a member before speaking with a live representative must not exceed 2 minutes”. This 2 minute requirement is also specified for the provider calls. Can you confirm that the 40 second requirement should be removed and both member and provider should operate under the 2 minute requirement?	The second item in the list of 5.1.6 should read, "The average monthly speed to answer after the initial automatic voice response is one hundred and twenty (120) seconds or less;". (Corrected in Amendment 6.)
22.	6.1	155	Will pharmacy network contracts be the responsibility of the PBA?	Yes.
23.	6.2.5	158	In order to broaden member access to highly qualified PCMH programs, will DOM permit PCMH recognition / certification from other respected organizations such as URAC and Joint Commission?	The Division prefers NCQA certification. The Division may discuss other strategies for certification with winning Contractors.

24.	6.5	169	Will Centralized Credentialing be in place upon award? If not, is the state willing to deem active, Medicaid enrolled providers state credentialed, so CCOs can contract with them/include them in CCO network without direct credentialing?	Centralized Credentialing is scheduled to be in place upon reward.
25.	6.9.3.2	184	Section 6.9.3.2 states "In order to effectively train Providers, the Contractor shall have a working knowledge of the Contractor tool and web portal and be able to communicate about the basic functionality of the tool and how it can be used to meet Provider Clinical Transformation goals." Can the Division provide further definition of "Contractor tool" in this context?	This is in reference to the Provider Portal, as described in Draft Contract, Section 5.8.4.
26.	6.9.3.3	185	Please define "Provider Network Representatives" in the context of the requirement to have at least 30 Representatives.	The Draft Contract states, "The Contractor shall implement policies to monitor and ensure compliance of Providers with the requirements of this Contract. The Contractor shall retain a proportional number of Provider Representatives to assist Providers. This number shall not be fewer than thirty (30), including Subcontractors. These Provider Representatives shall have appropriate training by the Contractor. These Provider Representatives shall assist Providers with claims, enrollment, credentialing, and all areas required for assistance. Provider Representatives are required to develop relationships with Providers located in their coverage area through regular contact. The Division shall reserve the right to modify or change the provider representative requirements during the term of the Contract." The Division expects the Contractor to have Provider Representatives adequately staffed across the state and dedicated proportionately to each provider population (MSCAN v. CHIP, higher percentage of representatives for PCPs v. practice types with fewer members, etc.).

27.	7.3	190	Section 7.3 states, "the number of Care Managers hired must equal at least a 40:1 ratio of Members for each Care Manager." If the intent is for each CCO to have a CM ratio of 1 CM for every 40 members enrolled with the CCO, that would result in a need for 3,000-4,000 case managers per CCO. a. If this is correct, can you please clarify how this will be accounted for in the rates? b. If this is incorrect, can more clarity be provided on how this ratio should be calculated? c. Please confirm that "care manager" is inclusive of non-clinical member-facing staff such as community health workers and care coordinators.	a. The ratio will be taken into account in the rate setting process in the same manner that care management is usually taken into account in the rate setting process. More details will be available when the rates are set for the base year of this Contract. b. The 40:1 ratio indicates that no Care Manager for a winning Contractor may have a case load of more than 40 Members. There may be fewer than 40 Members assigned to a Care Manager as needed due to stratification of Members and to ensure that Members are receiving the best Care Management. Offerors are reminded that medium- and high-risk Members are to be assigned a Care Manager per Section 7.5 of Appendix A: Draft Contract. Low-risk Members are to have access to Care Management teams with a point of contact, and therefore, they are not part of the 1:40 Member count. c. As stated in Draft Contract, Section 7.3, “Care Managers must have appropriate skills and training to engage with Members of different acuity levels, including training and experience in healthcare delivery, health education and coaching, supporting access to needed resources, and assisting in adherence to treatment plans. Care Managers must additionally receive Cultural Competency training. Additionally, the Contractor must hire at least one Care Manager with special training and knowledge of Care Management practices relevant to Mississippi’s Native American community.” The Offeror may hire qualified individuals who fit this definition. Clinicians are not required.

28.	7.3	190	Contract Section 7.3: Care Managers states that the "number of Care Managers hired must equal at least a 40:1 ratio of Members for each Care Manager." Is the 40:1 ratio applicable when Care Manager caseloads include a mix of acuity/risk levels (i.e., Low, Medium, High)? For example, is the 40:1 ratio the same for a Care Manager with a case mix of 60% medium-risk and 40% high-risk members and a Care Manager with a case mix of 70% high-risk or 30% medium-risk members?	Members assigned may be stratified across risk levels or not; that is at the Offeror's discretion in its qualification. 40:1 is the highest ratio the Division expects; Contractors can assign fewer Members per Care Manager as appropriate.
29.	7.4.1	191	Can the state clarify what constitutes a "Closed-loop Referrals and Warm Handoff" as indicated in Contract Section 7.4.1? For example, if a referral is made by an individual members or provider, is the expectation that Care Managers follow-up on these referrals or is the requirement limited to referrals that the Contractor makes?	The requirement applies to referrals made by a provider and referrals made by the Care Manager.
30.	7.4.2, 6.2.5, 3.2.4, RFQ 4.2.3.2	191, 158, 77	Can the state clarify what the intention is regarding mandatory enrollment of medium and high risk members with a PCMH. Section 7.4.2 states "the Contractor is required to utilize a PCMH as the PCP for higher acuity (medium- and high-risk) Members" and 6.2.5 states that we are to "develop an NCQA-recognized Patient-Centered Medical Home (PCMH).... for each medium- and high-risk Member." The RFQ Question 4.2.3.2 includes the language "PCMHs should be made available to all medium- and high-risk Members." Understanding that while PCMHs are available in MS currently, there is limitations of the network at present. Is the intent for the respondent to build this network and to offer or make available a PCMH to all medium and high risk members (retaining their choice of providers per Section 3.2.4)? Also, should PCMHs be made available to all members, including low risk members?	The Contractor should work to build a robust PCMH network within the state. PCMHs are required for medium- and high-risk Members; PCMHs are desirable for low-risk Members but are not required.

31.	7.4.1, 7.5.1, 7.8.4	191, 199, 204	Can the state please clarify the appropriate time frames for closed-loop referral follow-up once a CM has made a referral to an external entity or provider: Section 7.5.1 and Table 7.1 of the contract references a 30 day time frame, Section 7.4.1 references a 7 day time frame, and 7.8.4 references a 48 hour time frame.	Table 7.1 and Section 7.5.1 should include a 7-day time frame as stated in Section 7.4.1, not a 30-day time frame. (Corrected in Amendment 6.) Section 7.8.4 is in reference to Transitions of Care only, and in this circumstance, a 48-hour time frame is required.
32.	7.4.3.3	194	Contract Section 7.4.3.3, Risk-level Assignment identifies multiple subpopulations to be assigned to a medium- or high-risk care management category, while 7.4.3.3.1, Mandatory Assignment, includes a list of those same subpopulations as required to be automatically enrolled into a high-risk category. Can the State please confirm that the requirement for those subpopulations to be enrolled into a medium- or a high-risk category, as indicated in 7.4.3.3, is the accurate one? For example, if a member with diabetes or SPMI has completed the CHA and is determined to be at medium risk, is this allowable?	7.4.3.3.1 speaks to automatic assignment at the time of a Member's enrollment and/or at the time the condition is first detected. The language referring to medium- or high-risk care management assignment in 7.4.3.3 is indicating that if, during the life of the Member's enrollment with the Contractor, after a follow-up assessment is conducted, the Contractor has information about the Member that placement in medium-risk care management is more appropriate, then the Member may be reassigned.
33.	7.4.3.3	194	Will the state provide guidance on how it defines "Serious SDOH challenges" referenced in contract section 7.4.3.3.	Serious SDOH challenges are SDOH issues identified by the Contractor through its Assignment of Risk Levels process. Given the nature of SDOH, these determinations are based on a holistic view of the Member and may change on a case-by-case basis. In making answers about its Care Management strategy, the Offeror is encouraged to highlight SDOH challenges it believes may be applicable to the MississippiCAN and CHIP populations in Mississippi.

34.	7.4.3.3.1	194	Contract Section 7.4.3.3.1 of the draft contract identifies that "all members identified as having one of the following conditions" should be enrolled into the "high-risk" Care Management category. The conditions listed include: pregnancy, diabetes, asthma, cardiovascular diseases, and/or chronic kidney disease, substance use disorder, and Foster Children. Section 7.4.3.4 identifies that the "Contractor will provide Medium- or High-Risk care Management to all Members identified with the following conditions: diabetes, pre diabetes, asthma, hypertension, obesity, attention deficit disorder, congestive heart disease, organ transplants, behavioral health conditions, foster children, substance use disorders, perinatal conditions." Please confirm that the reference in 7.4.3.4 is correct, and that members in these categories may be assigned to Medium or High Risk care management depending on their full Comprehensive Health Assessment, and do not all automatically default to High Risk care management.	7.4.3.3.1 speaks to automatic assignment at the time of a Member's enrollment and/or at the time the condition is first detected. The language referring to medium- or high-risk care management assignment in 7.4.3.3 is indicating that if, during the life of the Member's enrollment with the contractor, after a follow-up assessment is conducted, the Contractor has information about the Member that placement in medium-risk care management is more appropriate, then the Member may be reassigned.

35.	7.4.3.3, 7.4.3.4	194-195	Can the state please clarify the mandatory populations for medium and high risk assignment as there appears to be some discrepancy across contract sections. Contract Section 7.4.3.3 states that Members who have high costs or potentially high costs or otherwise qualify, include but are not limited to Members with persistent and/or preventable inpatient readmissions, pregnant women under twenty-one (21), high risk pregnancies, serious and persistent behavioral health conditions, Substance Use Disorder, Members with serious SDOH challenges, foster children, and infants and toddlers with established risk for developmental delays, shall be assigned to the medium or high risk level. Members being discharged from an acute inpatient psychiatric stay or PRTF shall be assigned to the high-risk level and receive Care Management services. *Subsequently, Section 7.4.3.3.1 states that many of the conditions or situations addressed above should enroll in high risk (vs. medium and high) including ALL pregnant members (vs. high risk pregnant members and pregnant members under 21). *Subsequent section 7.4.3.4 states that "the Contractor will provide Medium- or High-Risk Care Management services to all Members identified with the following conditions: diabetes, prediabetes, asthma, hypertension, obesity, attention deficit disorder, congestive heart disease, organ transplants, behavioral health conditions, foster children, substance use disorders, perinatal conditions." This language seems to revert to the CCOs capability to assign members to one of two risk levels (medium or high) based on their needs despite the fact that many conditions (diabetes, asthma, cardiovascular disease, etc.) are included in the mandatory high enrollment conditions.	7.4.3.3.1 speaks to automatic assignment at the time of a Member's enrollment and/or at the time the condition is first detected. The language referring to medium- or high-risk care management assignment in 7.4.3.3 is indicating that if, during the life of the Member's enrollment with the contractor, after a follow-up assessment is conducted, the Contractor has information about the Member that placement in medium-risk care management is more appropriate, then the Member may be reassigned. 7.4.3.4 refers again to a Contractor's ability to reassign as stated in 7.4.3.3.
36.	7.8.8	206, 207	Please clarify how the PPHR described in this section will be used.	The PPHR will be used as one quality metric for measuring each Contractor's efforts to improve the quality of care for Members. This quality metric may be used in association with the Contractor's annual incentive withhold.

37.	8.5	213	Please provide a copy of the Mississippi Division of Medicaid Value-Based Payment Work Plan.	This document is under development and will be further developed based on responses from Offerors and with winning Contractors during implementation.
38.	8.9	215	Contract Section 8.9 states the Division reserves the right to raise the 0.5% SDOH capitation payment rate during the life of the contract. Will the state provide a threshold or range for any potential increase?	The Division will not require more than 1% of the capitation payment to be devoted to SDOH projects.
39.	8.9	215	The contract (section 8.9) specifies that 0.5% of Capitation Payments received be devoted to Social Determinants of Health projects with community-based organizations. Will the state please confirm that Contractors may implement SDOH projects (upon state review and approval) that partner with entities, subcontractors, or vendors in lieu of or in addition to projects with community-based organizations. If so, will the state also confirm these projects (upon state review and approval) may be included in the 0.5% Capitation Payment.	Contractors may partner with other entities in projects designed with community-based organization. Contractors may not partner with other entities in lieu of partnership with community-based organization. The 0.5% must be devoted to SDOH projects and initiatives built in partnership with community-based organizations. As stated in Exhibit A, Draft Contract, projects are subject to Division approval.
40.	8.9	215	Regarding the commitment of at least 0.5% of Capitation Payments to Social Determinants of Health: a. How should these costs be shown in the Pro Forma? b. Please confirm that these expenses will count in the numerator of the MLR for minimum MLR calculation purposes. c. Please clarify if this is for both the MSCAN and CHIP programs.	a. Show these costs separately so the Division can track these expenditures. b. Yes, these expenses will count in the numerator of the MLR for minimum MLR calculation purposes. c. Yes, because under the new procurement/contract, CHIP will be combined into MSCAN as a separate Rate Cell.

41.	8.20	226, 227	Please confirm that table 8.1 contains the rate targets we must meet. Also in Table 8.1 EPSDT Screening Rates, the second measure is immunizations and the rate targets show 85% of enrolled members under age one (1) had required immunizations; and 75% of enrolled members between the ages of one (1) and 21 had screenings. Should the 85% measure for members between ages of one and 21 be for immunizations instead of screenings?	Section 8.20 should reference Table 8.1 in the second paragraph of the section. Table 8.1 contains the rate targets a Contractor must meet for EPSDT Screening and Immunization Rates. Table 8.1 should be named "Table 8.1 EPSDT Screening and Immunization Rates." Under the Measure "Immunizations" in Table 8.1, the requirement should read as follows: "Eighty-five percent (85%) of enrolled Members under age one (1) had required immunizations; Seventy-five percent (75%) of enrolled Members between the ages of one (1) and twenty-one (21) had required immunizations." (Corrected in Amendment 6.)
42.	8.21	227	Table 8.2 Well-Care Child Assessments and Immunization Screening Rates follows this statement. Please clarify that the Screening rates requirement for 8.21 are contained in Table 8.2.	8.21 should reference Table 8.2 in the second paragraph of the section. Table 8.3 does not exist. Table 8.2 contains the rate targets a Contractor must meet for CHIP Well-Care Child Assessments and Screening Rates, in compliance with Section 8.21. (Corrected in Amendment 6.)
43.	9.1.6	231	Section 9.1.6 states "the Contractor shall not employ off-system adjustments when processing corrections to payment errors unless it requests and receives prior written authorization from the Division." Can the Division define and provide more information about "off-system adjustments?"	Off-system adjustments are defined as any payments or adjustments that the Contractor would expect to include in its financial template but would not be included in Encounter reporting.
44.	11.1.2	250, 251	In Section 11.1.2 Payment in Full of Appendix A - CCO Contract, the contract contains the following language: • Failure to provide Care Management services as required under Section 7, Care Management will result in Capitation Payment reduction. • Failure to enroll the Members identified in Section 7.4.3.3.1, Care Management: Assignment of Risk Levels: Mandatory Assignments into the Contractor will result in Capitation Payment reduction. Please provide additional clarification on the process to	The Division will evaluate the level and quality of care management provided by each CCO against standards of care for each beneficiary level as described in Appendix A, Draft Contract. The determination that either a pattern of inappropriate provision of care management or delays in the provision of care management exist is at the sole discretion of the Division. A corrective action plan (CAP) will be required from the Contractor upon the Division's finding of a failure to meet requirements as appropriate. The timing and amount of any associated Capitation Payment reduction will be dependent upon the failure found by the Division, the ability

			determine a failure on the part of a Coordinated Care Organization to meet these requirements and how the Division will assess the reduction in capitation payment, including the timing and amount.	of the Contractor to resolve the issue, and the impact on the Member community. At all times, the well-being of the Member community will be tantamount in the Division's application of the Capitation Payment reduction.
45.	16	302	Please provide a copy of the MississippiCAN and CHIP Reporting Manuals.	Downloadable links for both Reporting Manuals will be provided on the dedicated DOM CCO Procurement Website no later than Friday, February 11, 2022.
46.	16.2.4	305	The numbered list of claims denials by category in Section 16.2.4 begins at #15, rather than #1. Will the Division please confirm that this list of denials is comprehensive and there are not missing denial types the Contractor is responsible for reporting on?	The list is comprehensive, and there are no missing denial types. This list should begin with 1 and be numbered through 8. This is a typographical error. (Corrected in Amendment 6.)
47.	16.5	311	Section 16.5 states "it is a Division requirement that the Contractor integrates with any future Division Government-to-Constituent (G2C) CIAM with Federation." Can the Division provide more information on any planned or potential G2C CIAM initiatives?	The Division will provide additional information to winning Contractors regarding this requirement as it becomes available during the life of the Contract.
48.	16.7.1	314	Will the PBA be responsible for pharmacy encounter data submissions?	Yes.
49.	16.8	320	This section states, "For any pharmacy and/or drug delivery services and/or benefits the Contractor is directed to deliver by the Division, the Contractor shall report drug (i.e., j-code) utilization data to the Division's Agent." Will the Contractors be required to submit drug data to the Division or will this be the responsibility of the PBA?	For Physician-Administered Drugs and Implantable Devices, this would be the responsibility of the Contractor. For retail pharmaceuticals, this would be the responsibility of the PBA. If the Division requires additional information from the Contractor regarding this issue, the Division reserves the right to make that request during the life of the Contract.
50.	Exhibit C, B.2.b	331	Please confirm that rebates received by the PBA would not be excluded from the minimum MLR calculation.	Rebates will not be included in the MLR calculation.

51.	Exhibit C	331	As a PBA will be utilized for pharmacy claims management, can the Division confirm the PBA will manage "prescription drug rebates received and accrued by the Contractor, as well as rebates available and retained by the pharmacy benefits manager;"? Can the Division also confirm the language relating to "pharmacy benefits manager" should be updated to "pharmacy benefits administrator"?	The PBA will be responsible for management of prescription drug rebates received and accrued, as well as rebates available and retained. (Corrected in Amendment 6.)
52.	Exhibit C	332	Can the Division confirm this requirement will be updated as a PBA will be utilized for pharmacy claims management? Can the Division also confirm the language relating to "pharmacy benefits manager" should be updated to "pharmacy benefits administrator"?	This requirement will be updated to account for PBA claims management. The language relating to "pharmacy benefits manager" should be updated to "pharmacy benefits administrator."
53.	Exhibit C	335	As a PBA will be utilized for pharmacy claims management, can the Division confirm the PBA will perform "Prospective prescription drug utilization review aimed at identifying potential adverse drug interactions"?	Yes. (Corrected in Amendment 6.)
54.	Exhibit C, L.2.a	348	Will MSCAN and CHIP be combined for the minimum MLR requirement, or will they have separate minimum MLR calculations? If separate, will CHIP have an 85% minimum MLR threshold like pg. 14 of Appendix C? The difference between the 87.5% and 85% minimum MLRs are due to the MHAP/MAPs payments being included in the MSCAN calculation, while they are not in the CHIP program because CHIP does not have MHAP/MAPs payments. If combined, will there be an update to minimum MLR amount to blend the two minimum thresholds of 87.5% and 85% for MSCAN and CHIP respectively?	Yes, these will be combined. The Division will calculate a revised Minimum MLR Ratio to be effective with the first reporting year of the Contract.

55.	Exhibit D	352	Please confirm that the intent is for the Contractors to respond within five (5) business days of the receipt of Grievance and Appeals.	The intent is for the Offeror to respond within five (5) calendar days of receipt of the Grievance or Appeal. Inclusion of "business" in this requirement is a typographical error. (Corrected in Amendment 6.) The requirement is reiterated in Table 5.1 Summary of MississippiCAN Member Grievances and Appeals Requirements and Table 5.1 Summary of CHIP Member Grievances and Appeals Requirements.
56.	Exhibit G	404	Is this is reference to the quality withholds referenced in 11.1.1.5 or a separate set of measures? Additionally, is PM#1 duplicative of GEN#1 or a different set of performance measures?	GEN#1 is duplicative of PM #1. GEN #1 will be removed. (Corrected in Amendment 6.) This Liquidated Damage does not apply to the quality withhold described in 11.1.1.5.

[End of 2. Draft Contract Questions and Answers]

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