



## OFFICIAL RESPONSE TO BIDDERS QUESTIONS

### CARE MANAGEMENT RFP # 12-DHHS-CM-01

Nr.	Section	Page	Question	Answer
294			Can the MCO develop definitions of Medical Necessity and Experimental/Investigational, and seek DHHS approval of them, or are there set DHHS definitions with which MCO must comply?	MCO to comply with He-W 530.01 and He-W 546.01 and NH RSA 420-J3.
295			Appendix C states "None of the Services shall be subcontracted by the Contractor without the prior written consent of the State." By what date must this consent be obtained (e.g., by Readiness Review)? Must the Bidder submit a template agreement to DHHS in order to obtain consent?	Any subcontracting needs to be identified in the proposal, as well as the experience of the subcontractor in the subcontracted area of the proposal.
296			What must be included in the Transition Plan?	This will be specified in the MCO Contract.
297			Does DHHS have a ZIP code standard access table for the designations of rural, urban, and suburban?	Not at this time.
298			Can similar answers to questions be combined into a single response (e.g. Cultural Considerations will be covered in sections 3.5.2 and 3.6)?	Yes with reference.
299			Will the State require Cost Proposals to be certified by an independent certified actuary, or will certifications by an in-house, non-independent actuary be permitted?	Cost Proposals need to include an actuarial certification that the bidder's cost proposal is actuarially sound. Actuary is not required to be independent.
300	3.11.8	61-62	What are differences between questions 63 and 65. They appear to be asking for the same information.	Correct, please answer question 63.
301	3.16	69-70	Should question 81 include appeals as well as grievances? The question only refers to grievances.	Yes
302	1.1	6	This section describes 132,900 current Medicaid covered lives. CMS regulations do not allow certain categories of Medicaid recipients, such as foster care children, from being mandated into managed care. Can you please provide the number you expect will become mandatory to enroll into managed care?	Information on covered populations is provided in the data book.
303	1.1	6	Does DHHS expect that blind, elderly and persons with disabilities will become mandatory into managed care on 7/1/12? If not on 7/1/12, then at a later date? Would DHHS provide the number of blind, elderly and persons with disabilities that are expected to migrate to managed care?	Information on covered populations is provided in the data book.



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304	1.2	9	Can the state provide the list of required provisions for provider contracts that will be in the DHHS contract so that we can include them in our contracts as we put together our network. The following provision is on p. 9 of the RFP: The MCO's contract with health care Providers must be in writing, must be in compliance with applicable federal and state laws and regulations, and must include the minimum requirements that will be specified in the MCO's contract with DHHS.	This will be specified in the MCO Contract.
305	2.1.3	19	Has a final determination been made whether approximately 8500 CHIP members will be included in this contract effective July 1, 2012?	Yes
306	2.4.2	21	The RFP states, that communications between the MCO and DHHS requires seamless transfer of data to/from the MCO and DHHS MIS and includes "DHHS access to all data, which includes all tools required to access the data at no additional cost to the State." Given that these are broad requirements, can the state please clarify the expectations for or further define "access to all data" and the parameters for "at no cost to the state?"	Data requirements will be specified in the MCO contract.
307	2.4.1	21	What is meant by "eligibility verification"? Does this refer the ability for providers to validate eligibility via the provider portal?	MCO is responsible to provide the verification of eligibility to providers.
308	3.1	31	Please clarify when the Step 2 and Step 3 populations would be moved into the managed care program. Also, clarify how the Duals would be moved into the managed care program (e.g., will they be phased in?).	The RFP defines the timeline.
309	3.1	32	Can the state please clarify dental, as page 32 appears to carve out dental while other sections appear to carve services in?	Dental services are not part of this RFP for children or adults. Adult dental benefit is limited to extractions only. However, a Medicaid recipient presenting at an Emergency Room for a dental issue is considered an outpatient hospital visit and therefore will be part of the MCO pmpm. Should an adult require an extraction, that service will be paid outside of the RFP. Additionally pcp's and pediatricians will be expected to do oral exam, risk assessment, anticipatory guidance and application of fluoride varnish (if clinically appropriate) as more particularly described in the service chart in the addendum.
310	3.4.4	36	The auto-assignment methodology seems to say that if 3 plans are awarded contracts, the plan with the highest technical score will get 2 out of every 4 members, with 1 each going to the 2nd and 3rd plan. Can you please describe the auto assignment methodology if 2 plans are awarded?	If the State selects two MCOs then it will develop a new auto assignment algorithm.
311	3.4.3	36	Does the state have a preference or is otherwise leaning towards awarding to either two or three plans?	DHHS will determine whether to select two or three MCOs based on the responses to this RFP. DHHS will at least select two MCOs.
312	3.5.1	37	Does the three attempts for the welcome call requirement have to be telephonically in all three instances?	MCOs should propose their approach to welcome calls.
313	3.8	47	Will the state accept commercial contracts as a proxy for the anticipated Medicaid network supplemented by Medicaid specific provider type letters of intent (LOI)?	Yes
314	3.8	47	Can the State provide blinded claims data by provider?	DHHS will not provide provider level claims data.



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315	3.81	48	Does the policy on trauma on page 48 apply to emergent services? Can emergent services be paid at Medicaid rates without negotiation?	Payment rates are to be negotiated between the MCOs and providers.
316	3.8	48	What assistance or additional information could the State provide to MCOs in efforts to encourage providers to enroll as Medicaid providers. To meet this requirement to encourage providers to enroll as Medicaid providers, MCOs would need to be able to describe enrollment processes, the forms they need to complete, the criteria they need to meet, and understand the time it takes for the enrollment process from beginning to end.	DHHS will discuss how to support enrollment with the selected MCOs.
317	3.82	51	Can the state please confirm that the non-discrimination clause on page 51 means that providers' reimbursement cannot vary based upon degree?	Yes
318	3.9	53	Would you confirm that the 1% withhold in this section is separate and in addition to the 1% performance incentive in section 3.12.4, for a total of 2% at risk?	Yes
319	3.11.8	60	Are memorandums of understanding (MOU) required for the state, local, and community programs that provide related health and social services to members as listed in 3.11.8?	MOUs are not required, but encouraged.
320	3.12.4	66	Can you provide some general description of goals the state is considering employing for the performance incentives? For example, will they be based upon HEDIS measures or some other framework?	The incentive program will be defined in the MCO Contract.
321	3.12.4	66	How will DHHS determine a MCO-specific baseline and measure an MCO-specific improvement?	More detailed information on the incentive payment methodology will be provided in the MCO contract.
322	3.12.4	66	Does the MCO incur an additional penalty of 0.25% per selected measure failed up to 1% of annual capitation premiums?	The MCO could incur a penalty of 0.25% per selected measure failed.
323	3.16	70	Are physician reviews required for all member appeals (e.g., non-covered benefits)?	Yes
324	4.1	84	Will any additional details be provided on the scoring criteria for the technical proposal? For example, how are the 11 topic areas listed weighted?	No further information will be provided.
325	4.1	84	Does Administrative Functions refer to the areas of the SOW associated with questions 80-111 (data reporting, G&A, FWA, TPL, claims QA, delegation of subcontractors)?	Yes
326	4.2	84	Please provide more information on how the Cost Proposals will be scored (understanding there are 30 points possible) and how points will be awarded for the 22 rate cells.	No further information will be provided on scoring methodology.
327	5.18	91	Will DHHS provide an additional detail on its two readiness reviews (site visits), one 90 days prior to program start date and one 30 days prior to program start date. Where in this timeline does the system readiness review described in 2.4.4.8?	The readiness review requirements will be provided in the MCO Contract.
328	6.2	92	We understand that the proposal needs to be in 12 point font. What font is required for tables and graphs? RFPs often allow for 10 point font for tables and graphs.	Text must be readable but font size 12 is not required for all materials.
329	6.10	97	Is the expectation that resumes will be provided for ALL personnel or just key personnel for the administration of the proposed Medicaid program?	Resumes for Key personnel are sufficient.



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330	6.14	98	A challenge to preparing an appropriate cost bid is that the bid amounts should vary dependent upon whether the state awards to either two or three plans. This is true because implementation costs will be incurred largely independent of membership, but must be priced to be recovered over the anticipated membership. Will plans be asked to submit cost bids for both the two and three plans scenarios, or should all respondents assume to respond with a consistent assumption on number of plans awarded?	MCOs will be required to submit a single bid.
331	7.11.3	100	Does the State make any other supplemental payments to providers (like Coos County Hospital kick payment) other than DSH/GME? Will the State continue to make these payments? If not, is the State's expectation that we will make these payments? And, if so, will the State consider these additional monies in our capitation rates? And, can the State provide the providers receiving these supplemental payments and the basis for payment?	See reply to questions # 140 and 141 from November 10, 2011 posting and read addendum to RFP. There are no other relevant supplemental payments. Question for Jim H - re: cat aid payments for kids <6; does this requirement apply on MMC platform as well as FFS? If so, then we think the MCOs should pay that supplemental payment and include that in the rate calculations.
332	7.11	100	Please provide information on the process that will be followed to negotiate capitation rates for the Step 2 and Step 3 populations.	DHHS will establish annual capitation rates for years subsequent to Year 1.
333	7.11.6	101	The example given of a July capitation payment to be paid 5th business day of October, results in an 11 week, or nearly 3 month delay in receipt of capitation from the July 15th midpoint. This proposal requires material negative cash flow to the plans and substantially increases the capital requirements by the DOI to service the contract as nearly 2 months of claims and 3 months of admin costs would have to be funded by the plans at all times. Would the state consider changing this requirement to pay July capitation during July, as in the majority of Medicaid managed care states in which we have experience, or to not more than a one month post pay?	No
334	7.1.	101	Is the 1% withhold on annual capitation payments used to pay the incentive bonuses?	Yes
335	7.11.4	101	Will DHHS compensate the MCO for claims paid when DHHS recovers capitation on deceased or ineligible members?	Settlements are made at six month intervals as described in Section 7.11.4.
336	10.1	115	This section permits the state to terminate the contract at any time and for any reason with 30 days notice. This section supercedes the earlier section which defines a two year contract period with 1 year renewals, effectively making this a month to month agreement for the state and a term agreement for the health plans. Given the substantial implementation costs required to prepare to go live, what if any relief or assurances will the state consider towards reimbursing implementation costs should the state terminate within a brief period of time after go live?	The contract term has been modified in the posted addendum.



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<b>Revision to previously answered question:</b>				
57	3.2	34	Please confirm that for the purposes of responding to RFP questions related to the Bidder's experience (i.e. Q1, Q3, and Q4), a bidder may offer the experience and contracts held by Affiliates of the bidding entity. For example, a new entrant may be in the process of establishing a newly licensed entity in New Hampshire with experience in other states through its parent and affiliate health plans. For the purposes of demonstrating experience and meeting the qualifications of being contracted in another state to provide Medicaid managed care services, such an organization would offer the experience of one of the affiliate health plans currently contracted and operating in other states. Please confirm that this meets the requirements of the bidder's minimum qualifications.	<b>For questions related to the bidder's experience, the bidder should respond with experience related to the bidder, its parent company, and its subsidiaries. Experience of related affiliates and subcontractors may be included in the bid if identified as such, and subject to the requirements of Section 6 of the RFP.</b>