

**December 21, 2005**

**Request for Applications**

***Medicaid Managed Care Program for Covered Families  
and Children***

**QUESTIONS & ANSWERS**

## GENERAL RFA QUESTIONS

When does the BMHC propose to post the list of all applicants submitting a LOI along with the appropriate regions?

- ANSWER: Potential Applicants are to notify ODJFS of their intent to submit applications by January 6, 2006, and ODJFS will make this information available on the BMHC's website immediately thereafter.

Can participating plans attend the 12/15 PVS session for technical assistance specific to the RFA submission?

- ANSWER: No. The format and content of the December 15, 2005 PVS technical assistance session has been designed specifically for Potential Applicants that do not currently have an agreement with ODJFS to serve Ohio Medicaid members. All currently-contracting MCPs have already participated in the technical assistance session which was specifically designed for them.

Will the publication of electronic. PDF forms include further instructions about the State's desired form or substance of responses to the RFA?

- ANSWER: The complete instructions have been provided and additional instructions will not be forthcoming. NOTE: Although ODJFS has stipulated that the entire application is to be submitted in an electronic format, MCPs should note that ODJFS expects the state agency verification of the Applicant's description on their experience on the form in Appendix C-2 to be manually completed by the state agency representative. The original copy of this form, including the notations by the state agency representative, is to be included in the one hard copy version of the application submitted to ODJFS and is to be scanned for inclusion in the electronic version of the application.

If a current MCP is awarded a regional Agreement, do the changes in the Provider Agreement effective January 1, 2006 apply to those MCPs? Are current MCPs exempt from these changes until they move from their county Provider Agreement to a regional Provider Agreement?

- ANSWER: All currently-contracting MCPs must meet the provisions of their provider agreement, including the changes to that provider

agreement which become effective January 1, 2006. If a currently-contracting MCP is approved for a regional provider agreement they would need to comply with the provisions of that agreement at the time that it becomes effective.

Appendix C, General Provision 7, Page 1: MCP responsibilities include a stipulation that the 'MCP must submit information on the current status of their company's operations not specifically covered under this provider agreement.' Would it be possible to get a more clear definition of 'current status of operations'? Some information is considered proprietary by the SEC and may not be appropriate for disclosure. The ultimate parent's most current financial information is not public information until after quarterly filings with the Securities and Exchange Commission. We could provide the most recent SEC reports to fulfill this requirement.

- ANSWER: Yes, for circumstances where SEC requirements prohibit the release of information, provide the most recent reports permitted by the SEC.

If there are three plans (A, B, and C) entering Region Z and none of the plans has existing enrollment in the region, yet Plan A's statewide enrollment is 40% or more of the statewide CFC eligible population, do plans B and C receive all discretionary auto-assignments (assuming plans have contracts with the same providers) while Plan A receives none, even though all plans are new in terms of Medicaid managed care in the region, and even though plans B and C might have the advantage of having previous provider and consumer relationships in the region from other lines of business (e.g., commercial)?

- ANSWER: Yes unless Plan B and Plan C also become ineligible to receive auto-assignments.

Recognizing the desire to have a viable program while maintaining fair competition between plans, will the department discontinue the use of auto-assignment thresholds following an initial period of program implementation (i.e., once all plans within a region achieve some minimum level of enrollment, will the auto-assignment limitation be discontinued)? If so, what are those minimum enrollment levels?

- ANSWER: The auto-assignment limits were established to assure the long-term viability of the program and ODJFS therefore intends to keep this new requirement in place for the foreseeable future.

The Mercer data book does not breakout mental health or substance abuse data separately. Can data be provided, similar to that shown in Appendix E of the data book, to separately report mental health and substance abuse services in the following levels of care: Inpatient, Outpatient, Specialists, Clinics and Other, with information for paid claims, utilization, Unit Cost and average length of stay, as well as a breakout of costs by rate cohort?

- ANSWER: We do not have this level of detail for the FFS data readily available. However, it should be noted that the behavioral health component of the MCP capitation is quite minimal. In CY04, the MCPs reported that the behavioral health Per Member Per Month (PMPM) generally ranged from \$1.00 - \$3.00.

## SCORING

Section IV B – Selection, Readiness Review, and Implementation: Within section IV.B, has the Bureau determined how the points from the various forms will be allocated among the documentation submitted?

- For example, in section C-2, each applicant could have a different number of states submitted. How will the 280 points be allocated across the various responses?
- In another example of C-7, how will the Bureau allocate points between PCPs, hospitals, and other provider types? How many additional bonus points above 400 are available for panels that exceed the minimums?
  - How will the 280 points be disbursed between experience and compliance?

- ANSWER: ODJFS will not be providing additional specification on the scoring of each of the components of the RFA except where it would assist the Applicant in deciding what strategy to employ in order to receive the highest number of points for that component. With the exception of the provider panel submission outlined in Appendix C-7, however, additional scoring specificity would not assist Applicants in determining how best to complete the forms included in the other Appendices of the RFA. For Applicants who are still working to meet the provider panel requirements specified in Appendix C-7, and who may need to prioritize how to direct their recruitment efforts in the time remaining, Applicants are

advised that ODJFS will give equal weight to the three provider groups reflected in the minimum provider panel charts (hospitals – 140 points, primary care physicians -130 points, and practitioners – 130 points).

Also within section IV.B, if no MCP or if only one MCP is able to score the minimum of 750 points for a given region, would the Bureau consider allowing one or two MCPs earning less than 750 points, to participate in that region to allow the mandatory status?

- ANSWER: Please refer to Page 16 of the RFA which states, “On a regional basis, an Applicant must pass the Mandatory Application Requirements Review and score a minimum of 750 points in order to be considered for selection. If an Applicant does not pass the Mandatory Application Requirements Review and score a minimum of 750 points for a region, then the Applicant will not be selected for that region.”

Page 16, Experience and Compliance History Scoring -- Is a corporate applicant expected to submit a form from section C-2 for every state in which they conduct Medicaid business? What if a state refuses to review and initial the experience and compliance form? What if the state may be willing to comply but cannot meet the indicated time frame?

- ANSWER: Applicants are to use their best judgment in determining how much state experience they wish to describe in response to Appendix C-2 but our expectation is that they will want to receive credit for all states where they have such experience. If a state agency is unwilling/unable to review and respond to Section III of this form, the Applicant should provide information on their attempts to secure the state agency’s cooperation, including contact information for the state agency in question. We designed Section III of this form to require as little effort as possible on the part of the state agency so that it could be completed quite easily and quickly.

Page 16, Performance Improvement and Clinical Management Scoring - How many points will be dedicated individually to the four key areas - case management, clinical performance measures, EDD and PIP? What if there are criteria areas which are conducted by the health plan but not measured by the state and therefore the state is unable to verify a particular question or section?

- ANSWER: In regards to Appendix C-4, the Applicant should indicate a state reference if any of the components of the four key areas can be verified by a state contact. If none of the components of a key area can be verified by a state contact, the Applicant should not complete the state reference section.

Page 16, Provider Panel scoring - please explain the scoring. If an applicant meets all the minimum requirements, would a score of 400 be reached, with any bonus points above and beyond this score?

- ANSWER: The 400 possible points for the provider panel component of the RFA include the points that would be awarded for contracting with preferred providers.

Page 16, Provider Panel scoring - How will bonus points be calculated? Must an applicant meet the full number of preferred providers to obtain bonus points? Are bonus points calculated at an overall region level, or by individual provider types?

- ANSWER: In order to receive points for contracting with Preferred Providers, the Applicant will need to demonstrate that they have met the minimum provider panel requirement for that **specific provider type** within that region. It will not be necessary to meet the **all** minimum provider panel requirements for each specific provider type before the Applicant could receive points for contracting with Preferred Providers.

Page 16, Provider Panel scoring - Will provider submissions be accepted after February 7? Will these be recognized in the scoring?

- ANSWER: If an Applicant is selected by ODJFS to proceed in this procurement process they would at that time be notified to begin submitting their additional providers, however, only those providers submitted with the RFA in February 2006 will be considered in the RFA scoring process.

## MEMBER ENROLLMENT

Can successful bidders provide the State with input on the auto-assignment algorithm?

- ANSWER: MCPs may always provide input to ODJFS.

Does ODJFS have a plan for a minimum number of months for voluntary selection prior to auto assignment in each Region?

- ANSWER: No. Because of the very aggressive time frame in which to enroll all eligibles statewide (May-December 2006), there is no plan to allow a minimum number of months in which consumers can voluntarily choose a plan. Eligible consumers will have a minimum of 30 days in which to make a voluntary selection prior to being auto-assigned to a plan. The time from receipt of the notice that a consumer must select a plan, is eventually assigned to, and is effective with a plan is approximately 60 days.

Will ODJFS consider providing the MCPs with a membership file with the auto assigned members at least two weeks prior to the effective date, or provide a preliminary file of auto assigned members a month in advance, possibly in a CCR format, with the final file as soon as possible after the monthly cut-off date, to allow the Plans ample time to assign PCPs in advance of issuing member ID cards.

- ANSWER: No. The very aggressive time frame in which to enroll all eligibles statewide (May-December 2006) and the process (specified above) that will be utilized to assure that all non MCP-enrolled eligibles are enrolled by December 2006, may not always provide the plans with auto-assignment information at least two weeks in advance of the effective date of coverage. Often assignments are made just prior to state cut-off (eight state working days from the end of a month). Plans do receive Consumer Contact Records (CCRs) for all these assignments the day after state cutoff.

RFA pg. 5: The auto assignment algorithm detailed on page 5 of the RFA states that the first step in auto assignment is to assign a member to the plan with which they have had history. In the case that there is no prior plan relationship, ODJFS will assign the member to a plan that has contracted with the primary care provider of a member of the assistance group. If that primary care provider has

contracts with more than one managed care organization, how will ODJFS select a plan? If the assistance group has relationships with two or more PCPs that have mutually exclusive contracts with managed care organizations, how will ODJFS select a plan?

- ANSWER: Currently a GIS (geographic information system) score is used to decide assignments when there is no clear choice for an assistance group, when two or more members' previous managed care enrollment or fee for service PCP history do not identify a single plan choice.

Provider Agreement Appendix C pg. 9: The Provider Agreement requires MCP submission of newborn notifications in accordance with the ODJFS Newborn Notification File. Where can the MCP access the File and Submission Specifications, as it is not currently located under the Data File Specifications information on the RFA site?

- ANSWER: The newborn notification electronic file specifications will not be available until Fall 2006.
- Section IV A pg. 12: In the 3<sup>rd</sup> paragraph on page 12 of Section IV.A. the submission for the provider panel reads "one hard copy of the full executed

If a member is an inpatient at the time their MCP membership becomes effective, such as a premature infant, does the MCP pick up the liability for the infant on the effective date, or does the previous plan retain liability until discharge?

- ANSWER: The previous (disenrolling) plan would be responsible for the infant through the end of the month in which the infant (newborn) is discharged from the hospital. MCPs still must follow the procedure for inpatient deferment as specified in OAC Rule 5101:3-26-02.

Section II.B, page 4: It states that ODJFS notifies eligible consumers residing in MCP-service counties/regions by mail about managed care membership. Does this mean only "Medicaid" eligible consumers or every household in the counties/regions?

- ANSWER: It means only Medicaid consumers. Non-Medicaid consumers are not eligible to enroll in a plan through this program

Section II.B, pages 4-5: Will there be any way to differentiate auto-assigned members from those voluntarily select a MCP other than the absence of health information on the CCR? Will MCPs get an auto-assigned member's PCP visit history as part of the CCR?

- ANSWER: The consumer contact record (CCR) identifies voluntary enrollments and auto-assigned enrollments by a numerical code located in the field labeled "TYPEOFENROLL". The code for initial voluntary = 01; the code for auto assignment = 02. The code for change from MCP to fee for services (FFS) = 03, and change from one MCP to another MCP = 04.

Where in the contract does it discuss the choice period upon the anniversary of enrollment, or the 90 day choice window upon initial enrollment?

- ANSWER: This information can be found in Ohio Administrative Code (OAC) rules 5101:3-26-02.1. The annual open enrollment month is assigned to each county; it is not automatically the anniversary date of enrollment for each individual.

RFA pg. 4: What is the overall "choice" selection rate for the state?

- ANSWER: Approximately 50 % of eligible individuals actually choose their plan, with the other 50% being auto-assigned to a plan.

RFA pg. 4: How many people gain and lose eligibility per month? What is the disenrollment volume, by reason code, per month?

- ANSWER: Historically, approximately 5-10% of the statewide MCP membership are disenrolled per month. The vast majority of these disenrollments are "automatic" disenrollments due to (often temporary) loss of eligibility or a change in eligibility to a non MCP-eligible category of assistance. In the case of automatic disenrollments, the majority are automatically reenrolled in subsequent months. (Numbers on following example approximate and rounded to nearest 100).

Example:11/30/05	Total Statewide Members	612,000+
Total disenrollments	-34,800	(5.7% of enrollments)
Automatic -29,800		(85.6% of disenrollments)

Voluntary - 4,900		(14.4% of disenrollments)
Total New Members	+38,700	
Auto-reenrolls	+ 8,300	(previous auto-disenrolls)
12/01/05	Total Statewide Members	617,000+

RFA pg. 4: What is the average number of eligibles per household rate?

ANSWER: The average number of eligibles is 2.2 per assistance group.  
(Calculated by assistance group not by household)

Will the current open enrollment month plans be implemented in Jan-May 2006?  
Or wait until region implementation?

- ANSWER: Current counties will maintain the same open enrollment months until such time as the county's region is implemented. Upon implementation the entire region will share an open enrollment month. Some current counties will experience a change in open enrollment months depending on the month assigned to the region.

## **APPENDIX B – NEW PROGRAM REQUIREMENTS**

### **AUTO-ASSIGNMENT LIMITATIONS**

What criteria will be used for discretionary auto assignment? Is the intention to use market share as a primary determinant instead of objective criteria such as panel access, customer satisfaction and clinical performance? Under what circumstances is it likely that ODJFS will not impose auto-assignment limitations?

- ANSWER: ODJFS may use such determinants as plan clinical performance, consumer satisfaction, provider panel, program integrity, as well as market share thresholds, etc., to determine how discretionary auto-assignments are distributed among participating MCPs.

RFA pg 5: The RFA states that auto assignment may be based on the goal of assuring "program stability in the region." What are the targets that ODJFS believes will assure program stability?

- ANSWER: ODJFS has addressed this issue through the enrollment thresholds specified in the auto-assignment limitation specified in Appendix B of the RFA.

What Percentage of auto-assignment is "discretionary" currently? Projected?

- ANSWER: Approximately 50% of auto-assignments are discretionary, and 50% are based on previous MCP or fee for services utilization history. No projections for regions can be made until test assignment utilization files are run prior to implementation of a region(s). This information will be shared with plans that are chosen for regional provider agreements.

## **ON-LINE PROVIDER DIRECTORY**

Appendix B – New Requirements: The on-line provider directory is a strong improvement to the program. Will MCPs be permitted to allow the search to occur upon the most up-to date database in PVS and their provider system for non-PVS providers, or will the search be limited to only the July 1 version of the directory along with any inserts previously approved by the Bureau? We would prefer a more up-to-date search capacity.

- ANSWER: MCPs will be permitted to include all of their ODJFS-approved providers in their on-line directory as well as all contracting providers which are not required to be approved by ODJFS.

On-Line Provider Directory - can the on-line directory be more current than the annual paper directory with inserts or must the on-line directory match the content of the paper directory?

- ANSWER: It is expected that MCPs will continuously update their on-line provider directory to reflect changes in their provider network and they will not need to first revise their paper directory. For ODJFS-required provider types, the MCP may only list ODJFS-approved providers and ODJFS will

perform periodic “spot-checking” of the MCPs’ on-line directories to ensure that unapproved providers are not included.

On-Line Provider Directory - are additional search options, such as specialty, age limitation, languages, acceptable for the online provider directory, or are only the options stated (name, provider type, geographic proximity) permissible?

- ANSWER: The online provider directory must have the capability to be searched by provider name, provider type, and geographic proximity but MCPs will have the discretion to offer additional features and search options.

On-Line Provider Directory - are individualized directories that meet the member's requested criteria able to be provided to members in paper format? (Example: List of OB/GYNs with 10 miles of my work address that speak Spanish)

- ANSWER: MCPs may provide individualized provider directory information to members. However, the provider directory content/format requirements set forth by ODJFS must still be met.

On the searchable provider directory (Appendix B, pg 1), we would like clarification that the providers included can be all specialties and using the most current demographic information we have on those providers. We would also post a PDF version of the ODFJS-approved directory that includes only the required specialists and the ODJFS-approved demographics.

- ANSWER: You are correct.

## **ON-LINE MEMBER WEBSITE**

Appendix B – New Requirements: We also support the interactive member website option for submitting questions, comments, grievances and appeals. Please clarify the Bureau’s expectation surrounding HIPAA concerns with members communicating to the plan. The concern is twofold. First, what validation steps may the plan use to confirm the identity of individuals submitting requests electronically? Second, what is the Bureau’s expectation of security of

responses to members via email? Often, members will not have encryption software on their computers for receipt of emails back to them. Also, please clarify your expectations of the content of the response within one working day of receipt. Does the Bureau expect the full answer to be provided within that response? Does the Bureau expect the initial response to set the expectation for the final response (i.e., when to expect the conclusion of the grievance or the appeal, or when to expect an answer to a question that needs additional research)

- ANSWER: As a health care entity, plans must already be meeting all HIPAA privacy and security standards in its communication with members and the storing of member PHI. ODJFS is not the entity to specify how a plan must meet HIPAA security and privacy standards in communication with its members. It is up to the plan to determine what validation steps to utilize to validate identity of individuals, whether it is by phone, e-mail or letter. In reference to security of response to consumers, it is the responsibility of the plan to specify on the site the security level of the site, and what rules or steps it requests that consumers use when submitting a question containing PHI, or requesting a response that would contain PHI. ODJFS specifies that the question, grievance, appeal, etc., should be acknowledged within one business day. Plans must follow time limits on responses to member questions, appeals, grievances, as stated in the **OAC rules**.

On-Line Member Website - when do we need to have that available for members? Is there a specific date or correlation with the expansion?

- ANSWER: The on-line member website must be fully functional prior to the effective date of the MCP's regional provider agreement.

On-Line Member Website - section refers to "secure internet-based website". Is there a definition of the level of security? Does this require login credentials for each member? 128-bit encryption? SSL? The minimum requirements for the Member Website do not include anything that is member-specific or ePHI; what is the need for anything above normal website security (i.e., virus-free)?

- ANSWER: Consumers may choose to share PHI when using the member website to ask questions, file grievances, etc. That is why it must be secure. ODJFS will not specify the level of security nor encryption.

On-Line Member Website - section refers to members receiving a response within one working day. Does this apply to questions and comments as well as appeals and grievances? What type of response is expected? For appeals and grievance submissions, is confirmation of receipt within one working day and acceptable response?

- ANSWER: Where possible, the BMHC will expect the MCP to treat these on-line member communications the same way, and within the timeframes, that would have been applicable, if the member had contacted them through the member services call center. If this is not possible due to the need to obtain additional information from the member, the MCP would be expected to send an acknowledgement which would include a request for that additional information and set the expectation for the final response. ODJFS will provide additional clarification on the operationalization of this requirement in the regional provider agreement.

Appendix B, Page 2: On-line Member Website. Is the member website expected to be a portal?

- ANSWER: We will require additional information on the Potential Applicant's functional definition of a "portal" in order to answer this question.

## **EXTENDED MEMBER SERVICES**

Provider Agreement Appendix C pg. 5, RFA Appendix B pg. 2: The SFY06 MCP Provider Generic Contract states call center hours are M-F 8:30a-4:30pm and the RFA documents state call center hours are M-F 7am - 7pm. Which document correctly reflects the standard hours required for the MCPs Call Center?

- ANSWER: Appendix C of the MCP-ODJFS county-specific provider agreement specifies the current call center requirements. Appendix B of the RFA specifies the change in the call center requirements that will go in effect when a health plan enters into a regional provider agreement with the ODJFS sometime in 2006.

Appendix B pg. 2 and Appendix C pg 5: In Appendix B of the RFA on page 2 the hours of operation for the call center are 7:00 AM to 7:00 PM, Monday through

Friday. In appendix C on page 5 the hours are listed as 8:30 AM to 4:30 PM. Please clarify which are the correct hours for call center operations.

- ANSWER: Appendix C of the MCP-ODJFS county-specific provider agreement specifies the current call center requirements. Appendix B of the RFA specifies the change in the call center requirements that will go in effect when a health plan enters into a regional provider agreement with the ODJFS sometime in 2006.

Section IV.A., 1.g pg. 14: The statement is that the “Applicant will not use, or propose to use, any offshore programming or call center services in fulfilling the program requirements.” Does call center refer to a member service center or a software support call center? Please clarify.

Appendix B - Can the extended member service requirement be handled by off-site personnel (i.e. 24 hour nurse advice line)?

- ANSWER: If personnel other than the MCP’s member services call center staff are used to meet the additional hours of operation, these personnel would still need to perform all of the same functions as MCP’s member services staff,

Section IV.A., 1.g., Page 14 The statement is that the “Applicant will not use, or propose to use, any offshore programming or call center services in fulfilling the program requirements.” Would ODJFS consider removing the requirement for offshore programming and leave the requirement for the customer call center not using offshore services?

Page 14: A transmittal letter must contain a statement that the Applicant will not use, or propose to use, any offshore programming or call center services in fulfilling the program requirements. Question: Can an Applicant contract with a U.S.-based company for programming services if that company then sends this work offshore?

Section IV.A., 1.g., Page 14: The statement is that the “Applicant will not use, or propose to use, any offshore programming or call center services in fulfilling the program requirements.” Does call center refer to a member service center or a software support call center? Please clarify. Section IV.A., 1.g. Page 14: The statement is that the “Applicant will not use, or propose to use, any offshore programming or call center services in fulfilling the program requirements.” Many of the programs that are used by the MCPs are “off the shelf” and it isn’t possible to verify where the programming was completed. Would ODJFS

consider “grandfathering” for the programming and call center requirements? This would allow plans to continue using software and support centers that may currently utilize offshore services, as of contracting date, but they would not be able to add any new programs or call centers that make use of offshore programming.

- ANSWER: The answer below is in response to the three questions above. The prohibition against the use of offshore programming or call center services only applies to situations where the health plan has employees or contracted staff who are located offshore and who are wholly responsible for the fulfillment of a program requirement(s). For example, it would be permissible for an MCP to utilize offshore programming staff/contractors to obtain software or to development refinements to the MCP's claims processing system. MCPs would not, however, be permitted to have the employees/contractors wholly responsible for the operation and maintenance of the MCP's electronic claims payment system located offshore. The same applies for call centers; an MCP could utilize offshore employees/contractors to provide software or refinements to the call center IT system but the actual call center staff could not be located offshore.

## **NEW MEMBER LETTER**

New Member Letter - What is the specific purpose of the letter or what is the intended benefit to members? Can the letter include the member ID card and then additional be given before the member receives the new member kit?

- ANSWER: The purpose of the member letter is to highlight information which is critical to the smooth transition of a consumer from the Medicaid FFS program to MCP membership. The new member letter may accompany the member ID card. ODJFS will provide additional clarification on the operationalization of this requirement in the regional provider agreement.

New Member Letter - please define "at the same time" - given the content in (1) it would seem that this letter must be in a separate mailing from the new member packet. The content in (1) could be included with the Member ID Cards, if they are mailed separately from the remainder of the new member packet. Is this acceptable to break out the model language to avoid an additional mailing? The remainder of the proposed content of this letter could be included in the new

member packet (Member Handbook, Provider Directory), and thereby reduce the number of mailings to the member.

- ANSWER: The purpose of the member letter is to highlight information which is critical to the smooth transition of a consumer from the Medicaid FFS program to MCP membership. The new member letter may accompany the member ID card. ODJFS will provide additional clarification on the operationalization of this requirement in the regional provider agreement.

## **TRANSITION OF MEMBERS**

Transition of Members - please define "advance" in the sentence "enrollment MCPs will be required to ..."

- ANSWER: "Advance means any time prior to the scheduled service.

Transition of Members - first bullet - "the member has been approved..." Is this approval of the transplant by ODJFS or the transplant facility? If the member/provider does not provide advance notice to the MCP, but the bullets apply, are the MCP obligated to honor that request?

- ANSWER: ODJFS must have approved the procedure. The language in Appendix B specifies that the member must contact the plan prior to (in advance of) the date of service. If not, the plan is not responsible for payment.

Transition of Members - last bullet - "the member is receiving ongoing chemo..." how is ODJFS defining ongoing?

- ANSWER: "Ongoing chemo..." means that the member has already had at least one treatment and is already scheduled for additional treatments.

Appendix B - "Transition of Members" will non-contracted facilities and providers be subject to an MCP's UM and claim processing protocols?

- ANSWER: The specific details of how the new program requirements outlined in Appendix B will be operationalized are still under development. The issue you raise will be considered as part of that process.

Appendix B - "Transition of Members" if the member does not contact the plan prior to the provision of services is the MCP still responsible for payment?

- ANSWER: No, the plan would not have to pay for the service. Appendix B states that the plan is responsible to allow members "...to receive services from out-of-panel providers if they contact the MCP...in advance of the service date....etc". The new member letter (another new requirement included in Appendix B) will inform the member of the need to contact the MCP if they have any health care condition which the MCP needs to be aware of in order to most appropriately/ manage transition their care and if the member does not contact the MCP, the MCP will not be responsible for care received outside of the MCP's panel.

How will deferments be handled for member's inpatient on their effective date as the program goes regional?

- ANSWER: Transition of Members as described in Appendix B does not apply to inpatient deferments. Inpatient deferments will be handled the same way they are now except that required information can be shared via email attachment through the use of TLS.

Appendix B Transition of Members: If a potential MCP member selects a plan but doesn't disclose to a plan, in advance, that they are in a course of treatment, the bills are then sent to FFS (ODJFS) by the provider, how will ODJFS deny the claim? Or, will you pay the claim? If the bill comes into the MCP from a non participating provider can the plan DENY AS MEMBER RESPONSIBILITY?

- ANSWER: ODJFS will not pay claims for MCP members who failed to disclose to the plan in advance out of panel treatment, surgery, office visit, etc. ODJFS will deny the claim as consumer enrolled in MCP. ODJFS will not specify what code the MCP should use. The MCP should use the same code it would use for any situation when a member accesses services out of panel that are not authorized.

## ON-LINE PROVIDER WEBSITE

On-Line Provider Website - When do we need to have that available for providers? Is there a specific date or correlation with the expansion?

- ANSWER: The on-line member website must be fully functional prior to the effective date of the MCP's regional provider agreement.

On-Line Provider Website - section refers to "secure internet-based website" Is there a definition of the level of security? Does this require login credentials for each provider? 128-bit encryption? SSL? Can the non-ePHI items, like the provider manual, contact information and online provider directory be in a non-secure, i.e. public, portion of the website?

Relative to the on-line provider website: "...MCPs will be required to have a secure internet-based website for providers where they will be able to confirm a consumer's MCP enrollment and through this website (or through an e-mail process) allow providers to electronically submit and receive responses to prior authorization requests..." The e-mail through the provider web-site is not secure... we can offer the providers the option to submit authorization requests in this manner, but there will be a warning posted that the Internet connection is not secure. Will this meet the requirement?

- ANSWER: No. Providers should not use a non-secure means to convey confidential member information and therefore a non-secure e-mail system is not a viable option.

Transitions of Members: In that "Continuity of Care Deferments" will no longer be available what guarantee do MCPs have that the non-par providers will accept the Medicaid FFS rate as payment in full?

- ANSWER: As we stated in the December 12, 2005, Applicant Conference, ODJFS intends to only require the use of a non-panel provider when that provider has agreed to accept 100% of the Medicaid FFS rate as payment in full.

On-line Provider Website: Will a Plan's ability to accept and respond to electronic (278) requests (not web-based related) be sufficient for prior auth requests?

- ANSWER: If a health plan provides a mechanism which allows providers to electronically submit and receive responses to prior authorization requests, then they would comply with this requirement.

Appendix B - New Program Requirements/On-line Member Website: What is the purpose for dictating that member handbooks, newsletters/announcements, MCP contact information, Member Service hours, etc. be in a secured environment. These items, as well as the provider directory, are on the public portion of our internet for our commercial business.

- ANSWER: Only confidential information (i.e., your member's status as a Medicaid recipient and their PHI) needs to be in a secure environment.

## **ELECTRONIC COMMUNICATIONS**

The RFA stipulates that MCPs will be required to purchase TLS for all email communication between ODJFS and the MCP. Is SSL acceptable as it provides the same functionality?

- ANSWER: In order to assure approval of/ongoing technical support for a method of communication between the Bureau of Managed Health Care, its Selection Services Contractor and participating plans, the ODJFS Office of Management Information Systems (MIS) specified that all parties must utilize the same software. SSL, though similar in function, will not be recognized as an alternative to Transport Layer Security (TLS).

Electronic Communication - section refers to the ability to enforce sending email via TLS. Does this refer to only PHI? Does it apply to all email communication with ODJFS? By "enforce" does that mean the system is expected to identify secure email based on the criteria (e.g., using the content dictionaries) or is a user-based process sufficient?

- ANSWER: The requirement is to assure that there is a "server to server" utilization of the Transport Layer Security (TLS) technology. The intent is

to assure that all e-commerce between the plans and ODJFS is sent via TLS. This includes but is not limited to: e-mail, newborn notifications, reconciliation inquiries, Just Cause, hospital deferment materials, etc, whether this information appears in the body of the e-mail or as an attachment. “Server to server” will eliminate the need for any additional enforcement with its employees because it will automatically be used whenever information is shared between ODJFS and its business partners.

Appendix B, Page 3: Electronic Communication – Is TLS expected for members as well as ODJFS staff? In addition to the specifications already provided, are there additional specifications available? Does TLS include “PGP”?

- ANSWER: A. As stated in Appendix B, Transport Layer Security (TLS) is to be used for all e-commerce between ODJFS and the plans on a server to server basis. There is no requirement that it be used for the plan’s member website. We are not familiar with the term PGP.

Page 3: MCPs are required to use TLS for email communications between ODJF and the MCP.

Question: Do non-email electronic communications need to use TLS? For instance, is secure FTP with file encryption (e.g., PGP) sufficient for file transfers? Who is the ODJFS contact for coordinating implementation?

- ANSWER: No, non-email electronic communication does not have to use TLS. Secure FTP will continue to be used. If your plan is chosen for a regional provider agreement(s) you will receive contact information at that time.

Page 3: ODJFS will be revising data/information exchange policies and procedures for many functions. Question: How and when will these changes be communicated?

- ANSWER: MCPs that are chosen for regional provider agreements will be provided data formats and policies and procedures in writing. Policies and procedures for these functions are currently under development and are not available at this time.

## **REGIONAL PROVIDER RELATIONS REPRESENTATIVE**

Regional Provider Relations Rep- Per Appendix B, page 3; MCPs are required to have one PR Rep for the region. If MCPs are currently staffed with PR Reps by county, will that be acceptable?

- ANSWER: MCPs must have at least one designated provider relations representative per region but may have designated provider relations representatives by county.

## **REGIONAL PERFORMANCE INCENTIVE SYSTEM**

Section II B – Program Description and Objectives: Of the health plans in operation today, could you share generically how many of the plans retain their at-risk amount of one percent of the monthly premium payments, and how many of the plans qualify for the possible additional incentives?

- ANSWER: The results vary each year. For SFY 2004 and 2005, all MCPs participating in the incentive system were awarded the 1% at-risk amount. None of these plans were awarded the additional incentive amount. In SFY 2003, however, only two of the five participating MCPs were awarded the at-risk incentive amount.

We appreciate the transition plans related to the Performance Incentive System. Will the 24 month transition also apply to the 2005 expansion into Mahoning and Trumbull counties?

- ANSWER: No. A portion of the premium is put at-risk for the existing MCP for these two counties, except for plans that are new to Managed Care in Ohio during the 2005 expansion. These new plans will be put at-risk after 24 months of continuous memberships for those 2005 expansion counties.

Also, regarding the transition of the Performance Incentive System, is it the intention of the BMHC to 'grade' each region based upon that regions performance, irrespective of the number of regions one particular MCO may be doing business in, or will this be an "all or nothing" approach to earning PEIS dollars as a single unit across the state

- ANSWER: We recognize that results of the performance measures may vary across regions and the complication that this may present in setting statewide standards. While we have outlined our general approach to transitioning the incentive system to a statewide program, we have not completed all of the details. Details of the incentive system with a regional system will be released in the regional provider agreement.

Regional Performance Incentive System: Please clarify when the MCO is "at-risk" for premiums received. Example. The MCO was operational in Trumbull and Mahoning Counties as of October 2005. Our understanding is, as of January 1, 2006, the MCO is subject to at-risk premiums for those two counties. Then, assuming Columbiana becomes mandatory as part of the NEC Region in October of 2006, the New Program Requirements state "MCPs will not be put at-risk for any portion of the premiums received for members in new counties, i.e., counties not served prior to January 1, 2006, until the MCP has had continuous membership in a region for 24 months..." In this example, does that mean Columbiana County will not be subject to "at-risk" premiums for the MCO until October of 2008 while Trumbull and Mahoning are subject to "at-risk" premiums as of 1/1/06?

- ANSWER: The example above is incorrect in that, if an MCP is new to Ohio Medicaid with the Trumbull and Mahoning county expansion, then they are not at-risk until their 25<sup>th</sup> month of experience (please refer to Appendix E, page D-6 of the Provider Agreement). The regional approach will function in a similar way as the current county approach in that all MCPs expanding into new counties within a region will not be at-risk for a portion of the premiums for the new counties until the 25<sup>th</sup> month. If an MCP selected for a region is currently contracting with the state for one of the counties in that region, then that MCP will remain at-risk (or will remain on schedule to become at-risk) for that county until the incentive systems is transitioned to a regional approach. In the example above, the MCP, if new to Ohio Medicaid with the expansion of Mahoning and Trumbull counties, will be at-risk for a portion of Mahoning and Trumbull counties starting in their 25<sup>th</sup> month (i.e., October, 2007). If, for example, the same plan is selected for the North East Central region and starts enrolling members in July 2006, then a portion of Columbiana county's premiums will be at-risk starting in the 25<sup>th</sup> month (i.e., July 2008).

Is the plan to have the incentive system at risk for a regional basis vs. statewide?

Appendix B - New Program Requirements, Regional Performance Incentive System: Please confirm that Ohio Medicaid managed care plans that have be

operational for more than 24 months and have membership as of 1/1/06 will continue at risk for a portion of the premiums throughout the regionalization transition period SFY 2006 and SFY 2009. If so, please describe the methodology to be used to track county-based performance under a regional-based system.

- ANSWER: The answer below is in response to the two questions above. The incentive system will be transitioned from a county-based system to a regionally-based system. In order to set performance expectations, sufficient time is required to allow for MCP experience and data collection for the regions. During this transition time, the current county-based system will continue for currently-contracted MCPs. If currently-contracted MCPs are selected in this procurement process, then they will continue to be at-risk for a portion of the premiums they receive for members in counties they are in as of 1/1/06 until the regionally-based incentive system is implemented. The provider agreement specifies the details regarding the initiation of the at-risk amount and the performance measures used in the county-based incentive system. The performance results used to determine the status of this at-risk portion of the premium will be calculated using only the experience of members in the counties for which an MCP has been put at-risk.

Regional Capitation Rates/Regional Performance Incentive System: Currently, the draft regional rates reflect an at-risk amount. Will the at-risk amount be removed as we transition to a regional based system?

- ANSWER: No, the at-risk amount will remain in the rates. ODJFS recognizes that building improvement programs included in the incentive system requires an up-front investment and takes time to develop, implement, and affect change in a measurable way. The at-risk amount is included in the capitation payment as an incentive to develop and implement improvement programs that reach the performance standards.

## **APPENDIX C**

### **C-2: APPLICANT EXPERIENCE / COMPLIANCE HISTORY**

RFA Section I: The RFA contains documents for ABD and Other plan assessments in Section I-Applicant Experience/Compliance History Form? If the CFC RFA is only for the CFC population, will the process require documentation for ABD and Other? If yes, what is considered "Other"?

- ANSWER: Applicants are not required to have experience in providing services to the ABD or some other Medicaid population group (i.e., not CFC) but ODJFS will consider the Applicant's full range of Medicaid managed care experience in scoring this component of the RFA. ODJFS has provided the "Other" option for Applicants who have experience serving Medicaid managed care consumers who are not clearly defined as TANF/SCHIP or ABD.

Please clarify the definition of Medicaid experience. In Section II: PROGRAM DESCRIPTION AND SCOPE OF SERVICE, "A. Definitions/Applicable Regulations"... Applicants may only claim Medicaid managed care experience in another state if the Applicant can document that the non-Ohio health plan and the Applicant are both under the control of the same corporate family. ..."

- ANSWER: Primary Contractor is defined as there being a direct contractual relationship between the Applicant and a state agency, and where the Applicant was the party held accountable by the state agency for meeting the provisions of the contract.

We have affiliate experience acting as a TPA for a MCP in another state. We have serviced this contract for seven years. Will we be permitted to count this experience in Ohio's RFA?

- ANSWER: If the same staff (with only minor differences) and the same administrative support systems will continue to be in place for your new health plan and the only substantive difference is a change in name, this would seem to meet the intent of the requirement that the information to be provided on the form in Appendix C-2 reflect only experience where the Applicant was the party held accountable by the state agency for meeting the provisions of the contract (i.e., Primary Contractor). Under the "Additional Explanation" section on page 2 of the form, explain the difference in health plan names and explain why the Applicant believes that there is no substantive difference between the two health plans.

Appendix C pg. 1: The RFA indicates that all forms in Appendix C will be available in a PDF fillable form no later than December 21, 2005. Appendix C-2, Section III requires Applicants have current state clients complete the State Agency Contract Verifications. Waiting until late December to receive the PDF fillable form will significantly reduce the Applicants' time to obtain clients'

responses. Is it possible for ODJFS to prepare and release Appendix C-2 Forms in PDF fillable format now and distribute the remaining forms later in December as scheduled?

- ANSWER: All of the RFA forms will be posted on our website in the “fillable form” PDF format by no later than December 16, 2005.

Appendix C-2 pg. 3: Section I states the applicant must have the “Applicant Experience/Compliance History Form” completed for “each state where the Applicant has contracted with a state agency to provide managed care services to Medicaid/SCHIP consumers since July 2002.” Does ODJFS intend that statement to be inclusive of any contracts that have been entered into since July 2002 (e.g. the Applicant has been in operations in a particular state since 2003) or is the form only required for contracts that have been in place continuously since at least July 2002?

- ANSWER: Applicants are to include information on any applicable contract that was in effect on July 1, 2002, or for any period of time thereafter.

Appendix C-2: Section I requires Applicants to complete the Applicant Experience/Compliance History Form. For the purposes of completing the Tables in Section II and IV, respectively, should applicants use ODJFS’ contract year as the applicable time periods even if the contract years in other states may differ? (e.g. CYR 2002 = July 1, 2002 – June 30, 2003).

- ANSWER: The forms are to be completed on a state-specific basis and were designed to allow the Applicant to indicate the contract duration dates used by that particular state. We would expect that contract duration dates will vary by state.

For plans currently operational as an MCP in Ohio, Appendix C-2 specifically requests additional state information for all states of operation. For other appendices, such as C-5, would the bureau prefer that applicants respond with Ohio specific information only when we have it, or should we also include information for other states as well? As a related question, within the C-4 Appendices, the Bureau is asking for data from one state for each of the items. Does the Bureau prefer examples of programs that tie closely (or exactly) to specific Ohio requirements, or programs that may vary from Ohio requirements, but have been operational longer?

- ANSWER: Applicants are advised to follow the instructions provided in completing the forms in each of the Appendices:

The instructions for Appendix C-2 stipulate that a separate copy of this form is to be completed for **each state** where the Applicant has contracted with a state agency to provide managed care services to Medicaid/SCHIP consumers since July 2002. This means that Applicants currently contracting with ODJFS should also submit a form which describes their Ohio experience. Ohio-specific forms should be sent to the attention of Eric Jones in the BMHC for the completion of Section III (state agency validation).

For Appendix C-4, Performance Improvement and Clinical Management, it is at the discretion of the Applicant to select the one state which will address the questions outlined in that Appendix. The Applicant should select a state which will adequately address the questions and highlight their program activities

For Appendix C-5 Information Technology: when responding to each question, the Applicant should 1) include its experiences in other states if applicable, and 2) check capability only when the particular experience [or IT feature] will be available to Ohio.

Can experience in a comprehensive management contract of a Medicaid managed care organization be included in C-2? This is a contract in which we perform all health plan functions, including all regulatory requirements, but do not have direct ownership of the plan.

- ANSWER: Applicants may only provide the experience history requested in Appendix C-2 as that experience pertains to situations where the Applicant served as the Primary Contractor. Primary Contractor is defined as there being a direct contractual relationship between the Applicant and a state agency, and where the Applicant was the party held accountable by the state agency for meeting the provisions of the contract.

Should C-2 be completed for Ohio experience? If so, who is the contact for completion of Section III?

- ANSWER: Yes. Eric Jones is the BMHC contact person.

As referenced in C-2, what populations qualify as "other"?

- ANSWER: ODJFS has provided this option for Applicants who have experience serving Medicaid managed care consumers who are not defined as TANF/SCHIP or ABD.

What does the State mean when it asks if a plan's reported regulatory actions imposed on any OTHER contracting health plans?

- ANSWER: ODJFS asks this question in order to receive some context for any regulatory actions which may have been imposed on the Applicant (e.g., if the Applicant was subject to monetary sanctions was this the norm in that state and numerous other plans were similarly fined or was the Applicant more heavily sanctioned than the other contracting plans?)

Appendix C-2 - for the percentage of total eligibles, do you want the total eligibles in the counties where the plan has members, the counties where managed care is present, or the eligibles in all counties?

- ANSWER: The instructions on p. 3 of Appendix C-2 stipulate that the Applicant is to indicate the total eligible population for the entire state.

Page 16, Experience and Compliance History Scoring - Do MCPs currently operating in the state need to get ODJFS to complete this section?

- ANSWER: Yes. The form should be submitted to the ODJFS Bureau of Managed Health Care to the attention of Eric Jones for the state agency validation.

Appendix C-2 - Applicant's Experience/Compliance History, Bullet 2 - Health Plan Name: We formed a separate company to be a provider for Ohio's former enhanced care management (ECM) program. Is it appropriate to submit this experience? If so, would this be an example where we would then need to explain the corporate relationship between our ECM company and our Medicaid company?

- ANSWER: Yes, you can submit this experience but you would need to explain the corporate relationship.

Section C-2: If a plan was sanctioned for noncompliance (fines, membership freeze, etc.) but subsequently returned to a level of compliance and the sanction was lifted (fine returned, membership freeze lifted, etc.), is there a way to indicate that in our submission?

- ANSWER: No. The relevant information here is simply that a sanction was imposed.

Appendix C-2: Please clarify – if we provide full benefits, but if one or more element (e.g. BH) is carved out for one of the populations (e.g. DDD) should that be considered full benefits or full benefits with exceptions?

- ANSWER: The issue here is whether this was a total carve-out of services. In Ohio, payment for the majority of behavioral health services provided to MCP members is covered through the Medicaid FFS program. However, if a member cannot or does not wish to access these services through the Community Mental Health Centers and/or the Ohio Department of Drug and Alcohol Addiction Services, MCPs are responsible for ensuring access to these services through their provider panel and for the payment of these services. As long as the MCP is required to provide at least some portion of a specific service type, we would not consider that to be a carve-out and this would fall under Full Benefits. If, however, there is a complete carve-out of a specific service type the Applicant would check “Full Benefits with Exceptions” and provide clarification on this carve-out on the second page of the form.

Appendix C-2: Some of the states where we operate may not maintain or make available the total # of eligible member throughout the state, especially for past years. In such instances, how should we obtain that info?

- ANSWER: If you cannot obtain this information, provide an estimated number marked with an asterisk and explain that this is an estimated number on the second page of the form **or**, indicate “est.” after the number if there is sufficient space to do so.
- ANSWER: Appendix C-2 Experience/History: For current Ohio Medicaid MCP applicants that created new companies as of 12/1/05 to avoid the franchise fee on commercial lines of business please clarify what is expected/acceptable when reporting experience (i.e., Appendix C-2, C-4, C-5 and C-6).

- ANSWER: If the same staff (with only minor differences) and the same administrative support systems will continue to be in place for the new health plan and the only substantive difference is a change in name, this would seem to meet the intent of the requirement that the information to be provided on the experience forms only experience where the Applicant was the party held accountable by the state agency for meeting the provisions of the contract (i.e., Primary Contractor).

### **C-3: DELEGATION**

Appendix C-3 Delegation - can the member services call center for off hour's coverage, e.g. 7pm-7am Monday through Friday and Saturday and Sunday, be delegated if the MCP offers longer hours of coverage other than 7A-7P M-F?

- ANSWER: ODJFS would require much more information on what the Applicant is proposing in order to respond to this question. If the delegated entity would be performing all of the same functions as the MCP's member services call center staff (which would include the intake and processing of member grievances and appeals) this delegation would not be acceptable.

Appendix C-3 Delegation: 24/7 Call Center Services are provided through an allocation agreement with our parent company. Would this constitute delegation?

- ANSWER: As explained in the instructions for this form, the situation you describe would not constitute delegation.

Appendix C-3: If an MCP delegates case management to a provider, is this the same as an outside entity?

- ANSWER: If the provider is not an employee of the health plan or the health plan's corporate family then the provider would be considered an external entity. If you do not intend to delegate all of your care management responsibilities to your providers you could check the "Other" box and provide clarification on the parameters of this delegation.

Related to Appendix C-3, Delegation: Our MCP does our credentialing and re-credentialing of providers. So on the applicant delegation form we would not check the box that indicates we delegate this activity.

- ANSWER: On this form, the Potential Applicant should only indicate those activities that that it will delegate to an entity outside of the corporate family.

We are aware that some of the potential physician groups that we want to contract with do their own credentialing and that the group would need to sign the Model Medicaid combined addendum. Are we obligated in any other way to disclose this information on the applicant delegation form?

- ANSWER: Yes, however, if you do not intend to delegate all of your credentialing responsibilities to your providers you could check the “Other” box and provide clarification on the parameters of this delegation.

#### **C-4: PERFORMANCE IMPROVEMENT & CLINICAL MANAGEMENT**

For plans currently operational as an MCP in Ohio, Appendix C-2 specifically requests additional state information for all states of operation. For other appendices, such as C-5, would the bureau prefer that applicants respond with Ohio specific information only when we have it, or should we also include information for other states as well? As a related question, within the C-4 Appendices, the Bureau is asking for data from one state for each of the items. Does the Bureau prefer examples of programs that tie closely (or exactly) to specific Ohio requirements, or programs that may vary from Ohio requirements, but have been operational longer?

- ANSWER: Applicant responses for Appendix C-4, Performance Improvement and Clinical Management are based on the following instructions:
- Case Management – Applicant must select one state which will address questions related to a Case Management Program.
- Clinical Performance Measures – Applicant must indicate their experience with three identified clinical performance measures, identifying a state of their choice for each measure. In addition, the Applicant must select a fourth clinical performance measure and state of their choice.

- Emergency Department Diversion - Applicant must identify one program which will address questions related to an Emergency Department Diversion Program.
- Performance Improvement Projects (PIP) – Applicant must identify one state and one clinical PIP which will address questions related to PIP protocol activities.
- It is at the discretion of the Applicant to select the states which will address the questions outlined in Appendix C-4. The Applicant should select states which will adequately address the questions and highlight their program activities.

Throughout the RFA, different references are made to refer to the applying organization as either Primary Contractor or Applicant. The definitions associated with the different terms appear to be inconsistent, as they relate to a multi-state organization's ability to include experience in other states within the RFA response. For example, information required in Appendix C-2 could be provided for plans in other states as long as the corporate relationship is explained. In Appendix C-4, information can only be provided for the Applicant (Ohio-licensed HIC). This implies that data from other plans which are part of the same corporate family could not be included. Please clarify whether the various references are in deed different, or whether the terms are interchangeable, as well as what data from multi-state plans can be included.

- ANSWER: For Appendix C-4, the Applicant can claim other state experiences if the Applicant is the primary contractor with these state agencies. For Appendix C-5 Information Technology, the Applicant can claim other experiences [including Medicare or Commercial] if the Applicant is the primary contractor with these business partners.

Regarding Section C-4-2, Clinical Performance Measures: For each clinical measure, we are asked to provide the "HEDIS Score Relative to the Nationally Reported Results for Medicaid (report as a percentile)." Some of these clinical measures have more than one component to them. Do we report each component or is there a specific component of each measure they would like to see? SPECIFICALLY where do we get the nationally reported rates? I have an NCQA document which lists Medicaid HEDIS Means, Percentiles and Ratios but it does not specify that it is national and it also indicates that these are to be used only for checking reasonability in the HEDIS audit process. I have an NCQA Medicaid Plans Accreditation Thresholds document with national percentiles but it does not include all of the requested

measures. Is there a standard document somewhere that we should all be using for percentile comparisons?

- ANSWER: The *Medications for Asthma Use* rates can be reported in the following categories: Age 5 to 9; Age 10 to 17; Age 18 to 56; and Combined. The applicant should report the “Combined” rate.

The *Frequency of Prenatal Care* rates can be reported in the following categories: <21; 21-40; 41-60; 61-80; and 81+. The applicant should report the “81+” rate.

The *Well Child Visits in the First 15 Months of Life* rates can be reported in the following categories: Zero Visits; One Visit; Two Visits; Three Visits; Four Visits; Five Visits; and Six or More Visits. The applicant should report the “Six or More Visits” rate.

The HEDIS 2004 Means, Percentiles and Ratios should be used for the percentile comparisons. This document is available via the World Wide Web at: <http://www.ncqa.org/Programs/hedis/audit/Medicaid2004MPR.htm>.

Please reference the above link for the document that should be used by all Applicants for percentile comparisons in Section C-4-2.

## C-5: INFORMATION TECHNOLOGY

We have two Information Systems; one is currently used to support our operations where we are the Primary Contractor to a State Medicaid Agency. The other system platform supports an unrelated managed care plan which is a Primary Contractor to a State Medicaid Agency. For purposes of administering the Ohio Medicaid business we intend to use the Information System that supports the unrelated managed care plan. In completing Appendix C-5 can we claim the system features and capabilities of the Systems Platform we intend to use in administering the Ohio Medicaid business?

- ANSWER: Based on the information you have provided, the Applicant does not meet the definition of a primary contractor and cannot claim experience for the system platform support provided to an unrelated MCP. **However**, the Applicant can check capabilities if these system features will be available for their Ohio MCP.

Appendix C-5 pg. 2: The RFA states there are four LOB codes available, however only three are listed on this page. Please clarify.

- ANSWER: This is a typographical error. There are only three LOB codes.

Appendix C-5 pg. 6: Are Applicants to list on the table all of their business partners (i.e., state clients) for which the system capability is currently deployed and then select two as references? Or are we to only show two business partners on the table and then provide their contact information?

- ANSWER: List all business partners [e.g., Medicaid, Medicare, or Commercial], but select no more than two as references.

Appendix C-5, 8 pg. 12: Please provide additional clarification on the meaning of automated tracking of claims and encounters as they move through the processing area. Additional clarification of a utomated tracking of claims and encounters.

- ANSWER: The system must have the capability to automatically track and log claims in and out of processing areas and maintain an accurate inventory of the claims in each processing area at all times – rather than requiring staff to manually count or estimate claim volumes in a processing area -- so claims management relies on system counts to capture the inventory. For example, by tracking the claim number, the system can report the volume of claims in the mail room, in pend status, in medical review, in the cob unit, etc.

Appendix C-5, 10 pg 13: Please clarify what is meant by “immediate electronic notification”. Additional clarification of immediate electronic notification.

- ANSWER: Immediate electronic notification pertains to electronic claim submission where the claim is processed in real time and the status (e.g., rejected, paid, denied, pending) is made available; the system either notifies the provider regarding the status of the claim, or the system posts the status to that provider's account so that it can be accessed by the provider. In this context "immediate" means that as soon as the claim is submitted, it is processed and the status is available.

For plans currently operational as an MCP in Ohio, Appendix C-2 specifically requests additional state information for all states of operation. For other appendices, such as C-5, would the bureau prefer that applicants respond with Ohio specific information only when we have it, or should we also include information for other states as well? As a related question, within the C-4 Appendices, the Bureau is asking for data from one state for each of the items. Does the Bureau prefer examples of programs that tie closely (or exactly) to specific Ohio requirements, or programs that may vary from Ohio requirements, but have been operational longer?

- ANSWER: Applicants are advised to follow the instructions provided in completing the forms in each of the Appendices:

The instructions for Appendix C-2 stipulate that a separate copy of this form is to be completed for **each state** where the Applicant has contracted with a state agency to provide managed care services to Medicaid/SCHIP consumers since July 2002. This means that Applicants currently contracting with ODJFS should also submit a form which describes their Ohio experience. Ohio-specific forms should be sent to the attention of Eric Jones in the BMHC for the completion of Section III (state agency validation).

For Appendix C-4, Performance Improvement and Clinical Management, it is at the discretion of the Applicant to select the one state which will address the questions outlined in that Appendix. The Applicant should select a state which will adequately address the questions and highlight their program activities

For Appendix C-5 Information Technology: when responding to each question, the Applicant should 1) include its experiences in other states if applicable, and 2) check capability only when the particular experience [or IT feature] will be available to Ohio.

Can Ohio references be used for C-5? If so, is there a designated preferred contact for this?

- ANSWER: Yes. Eric Jones is the designated BMHC contact person.

Appendix C-5: If there are various dates when a capability will be available, can the date be included in the relevant section? If so, which date should be used for Page 7 #2? For example, there are items that will be available prior to May,

2006, but some enhanced system functionality will not be available until Q1 2007. How should this type of situation be represented in the chart?

- ANSWER: No. The Applicant can only check capabilities if the feature is available on the date the Applicant's information system will meet 1) all Ohio Medicaid managed care program information system requirements; 2) be fully operational; and 3) have the capacity to serve the membership estimates submitted by the Applicant in the Transmittal Letter accompanying this application.

Appendix C-5: If the capabilities for a question are in place, but have not been executed, like HEDIS in Ohio for a plan that started in 2005, or have not been in place for the timeframe indicated, like #9 actual performance for the past 12 months of claims timeliness, how should this be represented in the response?

- ANSWER: In this instance, the Applicant will not be able to claim experience, but can check capabilities if applicable.

Enrollment and Disenrollment Data: Ability to accept daily or weekly updates of enrollment and disenrollment transactions (Appendix C-5, pg 18): Please clarify in what format the daily/weekly files would be. 834? CCR? Other?

- ANSWER: Enrollment and disenrollment data is provided to MCPs in the current CCR and HIPAA 834 transaction formats.

Data Warehouse reports (Appendix C-5, pg 25): Please provide examples of the reports that are indicated for: rates of care/access to care, quality and performance measurement, and outcome measures. We are unsure what type of data is included in these descriptions.

- ANSWER: As reporting/measurement requirements may vary by Business Partner, examples of Ohio-specific performance measures methods can be found in the Applicant's Library – Performance Measures Methods [[http://jfs.ohio.gov/OHP/bmhc/RFA\\_CFC/index.stm](http://jfs.ohio.gov/OHP/bmhc/RFA_CFC/index.stm)].

Appendix C-5, page 10, #3: What is the meaning of "notification to providers"? What are the expectations around electronic notification to providers?

- ANSWER: This question references the ODJFS-MCP Provider Agreement, Appendix C (26), requirement that the MCP must notify (e.g., claim payment/remittance advice) providers who have submitted claims of the claim status within one month of submission. Expectations regarding electronic notifications are not specified; the providers must be notified on a routine monthly, or more frequent basis, regardless of the format of the notification.

Appendix C-5, page 13, #10: Please define “immediate”.

- ANSWER: Immediate electronic notification pertains to electronic claim submission where the claim is processed in real time and the status (e.g., reject, paid, denied, pending) is made available; the system either notifies the provider regarding the status of the claim, or the system posts the status to that provider's account so that it can be accessed by the provider. In this context, "immediate" means as soon as the claim is submitted it is processed and the status is available.

Appendix C-5, page 14: Is it acceptable to provide only one contact per category when a MCP's systems are integrated? Throughout the RFA, is it acceptable to provide only one contact per category?

- ANSWER: Yes, if only one business partner can be identified.

Appendix C-5 - Information Technology: The information system we as an applicant use has experience with all lines of business (LOB) listed. From a scoring perspective is it in our best interest to list all LOBs even though the new company formed 12/1/05 will only operate line of business for TANF and SCHIP?

- ANSWER: Applicants are to use their best judgment in determining how much experience they wish to describe in response to Appendix C-5, but our expectation is that they will want to receive credit for all LOBs where they have such experience.

Section C-5, page 21, item 3 & 6: Could you please clarify the meaning of “automated” in these two questions?

- ANSWER: The system has the capability to capture any updates or changes to provider affiliation, location and ownership information, automatically (rather than manually) update all applicable provider records in the database to integrate the changes, track all updates, and provide a history (including effective dates) of the changes.

Appendix C-5, Information Technology, Page 7: The Applicant must provide a date when their Information Systems will meet all ODJFS requirements.

Question: Based on ODJFS responses to prior questions, this appears to be mandated to be when an MCP signs a regional provider agreement with ODJFS. Is this an accurate interpretation of this information request and those responses?

- ANSWER: The purpose of this question is to ascertain when the Applicant believes their information-system will be fully functional, meet all ODJFS requirements and have the capacity to serve the estimated membership submitted by the Applicant. You are correct in your assumption that the information-system capacity must be in place at the time an MCP signs a regional Provider Agreement with ODJFS. However, ODJFS needs to determine if the system capacity is realistically expected to be in place during our projected implementation timeframe.

## **C-6: HIPAA EXPERIENCE & COMPLIANCE**

Appendix C-6 pg. 2: The Appendix requires Applicants to provide the name of the state in which the Applicant has experience with each HIPAA transaction and to record a separate line entry for each HIPAA transaction type. Please clarify that Applicants are to provide this information for every client (for the 3 years indicated).

- ANSWER: In order for plans to receive full credit for HIPAA transaction experience, it is important to list all states and all transactions for each state, even if the transactions are the same in every state.

Appendix C-6: Our health plan has been responsible for production of audited HEDIS measures as the TPA for a plan in Michigan. At the 12/12 vendor's conference, ODJFS officials suggested that for HIPAA-compliant file transfers, our health plan could use our TPA experience in Michigan as an example of applicable experience. Similarly, can we use this experience in Michigan as

applicable experience even though we are not the primary contractor assuming risk in the State?

- ANSWER: If this question is specific to providing the experience information requested in Appendix C-2, the answer is no. As explained in the December 12, 2005, Applicant Conference and in the written Q&A document distributed at that meeting, Potential Applicants are to follow the instructions provided in the applicable Appendix.

Appendix C-6 Information Technology: Please confirm that the State Code and Line of Business code to be used by current Medicaid MCPs that formed new companies as of 12/1/05 as being OH- 1.

- ANSWER: Appendix C-5 is Information Technology: Yes the State Code of "OH" and the Line of Business Code "1" will continue to be used.

If you are a TPA in another state, can you claim that experience in C-6 – when you were totally responsible for the 834 & 820 etc.?

- ANSWER: No. Appendix C-6 instructions for the entry of Health Plan Name as it appears on the contract with the [other] state agency asks for the “corporate relationship” between the Health Plan Name used in another state and the Applicant to the Ohio RFA process when these two entities do not share the same name. Unless the ‘TPA’ is part of the same corporate family as the Health Plan named on the [other] state’s contract, the TPA experience cannot be used by the Ohio Applicant.

## **C-7: REGIONAL PROVIDER PANEL SPECIFICATIONS**

Will we be restricted to sending our electronic PVS Submissions on the 1<sup>st</sup> and 20<sup>th</sup> of the month, when we start building out our Provider Network in preparation for the Regional Expansion? If not, what frequency can we send our electronic PVS Files to ensure we get all of our Providers approved by the February deadline?

- ANSWER: The RFA stipulates that the provider panel submissions for the RFA may only be submitted between February 1, 2006 and February 7, 2006. If an Applicant is selected to proceed in this procurement process

they will receive additional clarification at that time regarding the timeframes and process for the submission of additional providers.

There does not appear to be any placeholders within the new PVS File Structures for our HMO Provider Number. Will ODJFS continue to assign MCOs HMO Provider Numbers by County; or, will this practice be discontinued when we go to the new PVS File format effective 1/1/2006?

- ANSWER: The new Provider Verification System (PVS) will require MCPs to submit provider panel information electronically using a "Submitter ID Number." ODJFS will assign these numbers at a future date.

Will ODJFS discontinue the practice of utilizing Discretionary Providers for adjacent Counties when Ohio goes to Regions? Based upon our understanding, Providers must be willing to see Members throughout the entire Region; but, there will be no cross-over into other Regions, unless the MCO is servicing an adjacent Region (e.g., SW Region and Central Region, etc.).

- ANSWER: The concept of "discretionary providers" is unique to the current ODJFS county-specific minimum provider panel requirements (giving MCPs the option to meet certain minimum provider panel requirements by contracting with providers outside of their service area) but is not an option in the regional provider panel requirements.

Model Medicaid Addendum for each of those providers." Would it be acceptable to submit only one copy of the Model Medicaid Addendum and only the signature pages for each of the providers? This would reduce the size of the binders and paperwork that would need to be handled and still provide the proof of the MCP's provider panel validity

- ANSWER: MCPs must submit the complete Medicaid Addendum in order to ensure that no changes were made to that document by either the MCP or the provider. The submission of signature pages alone will not be sufficient in order for a provider to be counted in the scoring for the RFA.

Will ODJFS discontinue enforcement of the existing hospital privilege rules, which state a provider's hospital privileges must be with a contracted hospital that resides within the same county where the provider's practice site resides?

- ANSWER: See pp. 3 - 6 of Appendix C-7 for clarification on this issue for each of the required specialty provider types.

Appendix C-7 – Regional Provider Panel Specifications: Please clarify the expectation for transportation services for any member that must travel 30 miles or more from their home to receive a medically necessary Medicaid-covered service. Please define what types of transportation are acceptable. (Would gas vouchers/reimbursement be acceptable, prescheduled group van trips, etc?) If an MCP makes a provider available to a member (either through contract or no-par authorization), but the member refuses to use that provider and chooses to travel for the care, must the MCP provide transportation in that case?

- ANSWER: ODJFS appreciates that transportation options may vary substantially across and within regions and this question would therefore need to be addressed subsequent to an Applicant's selection. MCPs are only required to provide transportation to members who **must** travel 30 miles or more to receive services so this requirement would not be applicable if comparable MCP providers are available inside these travel parameters. ODJFS will provide additional clarification on the operationalization of this requirement in the regional provider agreement.

Why is provider capacity minimums set at 55% of eligibles if the state intends to cap any given plan's membership to 40% - 60% of the total regional market?

- ANSWER: The primary care physician (PCP) capacity minimum was set at 55% to ensure that if there were only two MCPs serving a region, both MCPs would have sufficient capacity to serve at least half the consumers in that region. The new auto-assignment limitations specified in Appendix B of the RFA **will not "cap" an MCP's membership at a certain level**. If an MCP meets one of the specified enrollment thresholds, they will continue to receive consumer-initiated enrollments as well as auto-assignments based on prior history with the MCP and providers, and, unless other factors are present, the MCP would continue to see growth in their total enrollment. Regardless of the minimum requirements, MCPs must always have sufficient PCP capacity to serve all of their members.

How does an MCP ascertain applicable "community standards" as applied to non-PCP providers?

- ANSWER: ODJFS expects the health plans to make this determination and provide their findings to ODJFS as part of the Precontracting/Readiness Review process.

Is the 140% of FFS reimbursement rate received by the Holzer Clinic built into the cost experience in the MPC rates projected for the Southeast region by Mercer.

- ANSWER: Yes.

Section IV: Page 12 - The Electronic PVS file due with the application - should it include all signed providers, or just the providers that are the minimum required provider types?

- ANSWER: Pursuant to the instructions in Appendix C-7, Applicants are **only** to submit providers of the types specified in the minimum provider panel charts (included in the Applicant Library). However, because not all submitted providers may be approved by ODJFS, Applicants are advised to submit all of their contracted providers for each of the specified provider types and not just the minimum number that is required.

Clarification on provider submission. The RFA indicates that the MCPs must submit their PVS file between Feb1- Feb 7th. Please clarify the following:

- Are MCPs required to hold all Medicaid Addendums associated with the expansion and submit the entire file with the RFA?
- ANSWER: Yes.
  - If yes, will ODJFS provide a grace period for resubmissions if for any reason ODJFS denies a submission, or determines that a minimum requirement has not been met?
- ANSWER: No. Only the providers submitted with the application will be considered in scoring for the RFA. If an Applicant is selected by ODJFS to proceed in this procurement process they would at that time be notified to begin submitting their additional providers as well as those providers who were not approved in the scoring of the RFA.

If MCPs are able to submit addendums prior to the RFA submission date, will ODJFS tentatively accept providers with hospital privileges at a facility that the MCP has not yet secured an agreement with?

- ANSWER: ODJFS will not accept provider panel submissions specific to the statewide expansion prior to the February 2006 submission date. In the scoring of the provider panel submissions for the RFA, if ODJFS requires a specialty provider to have hospital privileges we will only approve providers that have privileges at a contracting hospital.

Assuming all minimum requirements are met, will MCPs still be required to point providers to a specific county in the region if a provider practices in two counties?

- ANSWER: Under the regional provider panel requirements some provider panel minimums are still county-specific. Further clarification on the situation you describe will be provided if an Applicant is selected by ODJFS to proceed in this procurement process.

Revised Addendums: If a provider signed an addendum with the "any county" language, will that addendum be sufficient for providing services at the regional level?

- ANSWER: Yes.

CNMs- One of the QFPPs employ's CNMs that do not have hospital privileges. They do however have a collaborating agreement with an MD. Are CNMs accepted with this type of arrangement? If so, how does an MCP submit them to the state (i.e. PVS requires HPs, what supporting documents are required). If CNMs with this type of arrangement are not accepted, how does this affect the MCPs relationship with the FQPP?

- ANSWER: CNMs are not among the provider types that are included in the minimum provider panel requirements for the RFA. Currently-contracting MCPs should continue to contact their designated liaisons in the BMHC for clarifications that are not specific to the RFA.

If a plan is unable to contract with a required hospital, and has submitted documentation of all efforts, can the plan still recruit professionals with admitting privileges at that hospital to meet minimum panel requirements?

- ANSWER: No. Where ODJFS requires a specialty provider to have hospital privileges we will only approve providers that have privileges at a contracting hospital.

In the panel exception review process, how will ODJFS consider hospitals requiring a plan to offer a commercial contract to the hospital as a prerequisite to the hospital's participation in the plan's Medicaid network? Is linking the Medicaid product to another product grounds for "deeming" the hospital contracted? Is it considered an "unfair" tactic as it only affects the plans with multiple lines of business? And is inappropriate "linkage"?

- ANSWER: In reviewing provider panel exception requests, ODJFS will focus on the negotiations for Medicaid contracts. If the MCP has made appropriate efforts to contract with a hospital and the hospital refuses to contract solely on based upon an issue related to a commercial contract, ODJFS would not consider this to be a reasonable basis for the hospital's refusal to contract.

Do MCPs that are already contracted with ODJFS need to resubmit previously approved providers via the PVS for consideration in the statewide expansion initiative or will these providers already count toward the minimum panel requirements in their respective regions?

- ANSWER: MCPs that currently have an agreement with ODJFS to serve Ohio Medicaid are not required to resubmit currently-approved providers as these approved providers will automatically be counted toward the minimum provider panel requirements.

Appendix C-7, Page 7: Provider Panel Exception Form – It is possible that a Provider would finally agree to begin contracting with an MCP in late January, for instance. Therefore, they have not "refused" to contract, but it is unlikely that the contract would be done by February 7<sup>th</sup>. If an MCP does not meet the specified minimum provider panel criteria and at that late date the provider agrees to contract with the MCP, what is the protocol in submitting this information to ODJFS?

- ANSWER: There is no protocol for submitting this information to ODJFS since only contracting providers are to be submitted with the February 2006 application. If a Potential Applicant cannot secure a signed contract prior to the RFA submission deadline then this provider cannot be considered in scoring of the application.

RFA pg 12: When will the most recent ODJFS PVS File be available for bidding MCPs to review prior to the initial PVS file submission to ODJFS?

- ANSWER: Further information on the PVS files will be provided to Potential Applicants that do not currently serve Ohio Medicaid at the PVS training session scheduled on December 15, 2005.

Prior to the Statewide Regional Expansion, ODJFS required specific Providers to have privileges at contracted Hospitals in the counties where they practice. It was not sufficient to list privileges with a Hospital in a neighboring county. The privileges that get submitted on the PVS must list all of the Providers' Privileges for every Practice Site Entry. As a result, any Providers, who have changed their Hospital affiliations and/or dropped their privileges, would need to have these changes reflected on each practice site entry that is affected within PVS. Once Regions are established, there may be Providers, who reside in rural counties that do not have any Hospitals within their county; but, they may have Hospital privileges at a neighboring county within the Region. Will ODJFS allow us to submit Providers, such as described here, via PVS having privileges at Hospitals in neighboring counties – not in the county where their practice site resides?

- ANSWER: See Appendix C-7 for clarification on this issue.

Please confirm that Medicaid MCPs currently operating in Ohio only need to forward Medicaid addendums and fully-executed baseline hospital contracts for newly contracted providers. In other words, are MCPs required to submit addendums and hospital baseline agreements for providers that have been under contract prior to the Sept 20th Vendors Conference and release of the new Medicaid addendums to meet minimum panel requirements?

Section IV.A. Initial Application Page 12-13: A PVS file must be submitted any time between 2/1/2006 and 3:00 pm, 2/7/2006. Question: For an existing OH MCP, should this submission include only those providers added to reach network goals or should it include all existing providers also. Should it include all

new providers contracted with up to and including 2/7/2006 or is there an earlier cut-off date?

- ANSWER: The answer below is in response to the two questions above. As explained at the December 12, 2005, Applicant Conference, currently-contracting MCPs do not need to resubmit their ODJFS-approved providers which are already included in the PVS database. The “cut-off” date is the date of your RFA provider panel submission to ODJFS. If the MCP determines that a provider needs to sign the new Medicaid Addendum **only** to be able to serve all members in the region, the MPC would not submit the newly signed Medicaid Addendum to ODJFS.

If an Applicant has an ODJFS-approved provider with additional practice locations in one of the expansion counties, do we need to submit the additional locations during the 2/1-2/7 window, along with a copy of the already submitted and approved contract documents, or are the additional practice locations already covered under the previously approved contract?

- ANSWER: Information on out-of-network providers was only entered into the PVS for providers located in designated alternate provider areas. If you want ODJFS to consider a provider in the scoring for the RFA and that provider is not listed in the PVS database as you wish them to be, you need to submit this provider with your application pursuant to the PVS instructions you have received.

We have provider contracts that were signed earlier in 2005 using the then current Medicaid Addendum. These contracts have not been submitted to ODJFS because the provider was located in an expansion county. Can these documents be submitted as signed during the 2/1-2/7 window, or must new contracts be signed using the now current Medicaid Addendum?

Existing Plans have participating providers in counties that are outside of their existing service area who are not currently on the PVS. These providers are in expansion counties and the addendums on file for them are not in the new format. Please confirm that the new addendum will not be required for PVS submission of these providers.

As a matter of physician contracting for current providers, are we required to resend ODJFS' new Addenda (the new addenda that MCP's were told to start using upon approval date) to current providers to resign if we want them included/recognized in our network going forward?

- ANSWER: The answer below is in response to the three questions above. If ODJFS has not previously approved an MCP's provider and the MCP wishes to have the provider included in the scoring for the RFA, the MCP must submit the provider with their application. In terms of the addendum to be submitted, previous addendum versions will be accepted so long as the addendum obligated the provider to serve the MPC's members in **all** counties covered under the MCP's provider agreement with ODJFS and not just the county where their practice site is located. MPCs are responsible for making certain that all currently approved by ODJFS have signed add

Will ODJFS consider a panel exception for a new or existing hospital requirement due to hospital demands to hold them harmless with the DRG recalibration effective January 1, 2006 and/or a significant enhanced fee schedule from FFS?

If two plans in a region successfully contract with a large hospital by agreeing to premium fee schedules, but a third plan is unwilling to pay that elevated fee schedule and can document that refusal as the reason that the hospital will not contract with the third plan, is ODJFS likely to approve a panel exception request submitted by the third plan?

- ANSWER: The answer below is in response to the two questions above. Unreasonable reimbursement demands will be considered in ODJFS' determination of whether to grant a provider panel exception request.

Provider Panel Exception Requests: Section II indicates that contacts through mail should not be included. Is e-mail contact acceptable?

- ANSWER: E-mail contact would be acceptable so long as it was a personalized communication specific to the provider in question and not part of a mass e-mailing where the same information was sent to a number of providers in hopes of soliciting a response.

Per the Medicaid addendum item # 6 states that the MCP's compensation is to be considered as payment in full and that the provider will not seek anything additional from ODJFS. The RFA states that FQHCs/RHCs are to be paid what all other providers are paid. Does this preclude the FQHC/RHC from seeking the cost differential adjustment from ODJFS?

- ANSWER: The provision you reference specifically states that by signing the addendum that provider agrees that “the MCP’s payment constitutes payment in full for any covered service and will not charge the member of ODJFS for any **co-payment, cost sharing, down-payment, or similar charge, refundable or otherwise [emphasis added].**” We do not believe that the supplemental payment that ODJFS is federally-required to make to FQHCs/RHCs providing services to MCP members would constitute a co-payment, cost sharing, down-payment or any similar charge and therefore signing this addendum would in no way preclude an FQHC/RHC from requesting the supplemental payment from ODJFS.

For group contracts (i.e., member physicians that choose to opt in or out of a given agreement) will it suffice to submit a signed copy of the master agreement and a roster of those physicians who opted into the Medicaid/S-CHIP contract?

- ANSWER: The instructions provided with the Medicaid Addendum should address all group practice scenarios. The Medicaid Addendum should include only those practitioners that are covered under the agreement.

Regarding the panel provider requirements can an internal medicine doctor be a non-PCP specialist?

- ANSWER: Yes but these providers would not be submitted to ODJFS.

Appendix C, General Provision 7, Page 1: MCP responsibilities include a stipulation that the ‘MCP must submit information on the current status of their company’s operations not specifically covered under this provider agreement.’ Would it be possible to get a more clear definition of ‘current status of operations’? Some information is considered proprietary by the SEC and may not be appropriate for disclosure. The ultimate parent’s most current financial information is not public information until after quarterly filings with the Securities and Exchange Commission. We could provide the most recent SEC reports to fulfill this requirement.

- ANSWER: Yes, for circumstances where SEC requirements prohibit the release of information, provide the most recent reports permitted by the SEC.

In the new PVS technical specifications file layout information there is a field name referred to as COUNTYAPP. The description of this field on the file layout document is as follows: County number pertaining to the county for which the provider information is relevant: See Appendix A. Is this field intended to be used when a provider has more than one office location in more than one county or can the Plan use this field to identify that the provider will be utilized in an alternate area? For example a county that they do not have an office location in but the county is contiguous to.

- ANSWER: Neither. This is a field that should be an exact match for the ADDCOUNTY field. If a provider is practicing at more than one location, each location is a record with its own case track ID#.

If a provider's office is physically located in the East Central region, specifically Carroll County, can the provider be utilized in the Southeast or Northeast Central as a regional provider because his office location is contiguous to these regions? If allowed, how would this be reported on the PVS via the ADDREGION field?

- ANSWER: Though the provider can see members from any region, the provider can only be submitted to PVS for the region where the practice is located. The ADDREGION field is only for the region the site is located.

## **IMPLEMENTATION / ROLL-OUT**

If a current MCP is awarded a regional Agreement in the region they are currently doing business, can we assume they would retain their current membership?

- ANSWER: Yes.

What timeframes does the Bureau intend to set for open enrollment periods after conversion to statewide mandatory enrollment? Will the existing county open enrollment months remain in effect until the region for that county is converted to mandatory enrollment? Will an entire region go through open enrollment during the same month and follow approximately one year later from the point of mandatory conversion for the region?

- ANSWER: ODJFS has not specified the open enrollment months for the regions at this time, but will continue to follow federal requirements which specify that MCP members will have the first three months of MCP enrollment and, annually, one additional month in which to change plans without cause. Since it is not expected that all regions will enter mandatory status at the same time, the open enrollment month for mandatory status counties within regions that have not gone mandatory will remain in effect until the region is specified as mandatory. It is expected that all counties within a region will have the same open enrollment month.

May additional benefits offered by an MCP vary between counties within a region?

- ANSWER: MCPs must offer the same additional benefits to all members within a region.

May additional benefits offered by an MCP vary between regions if the MCP is approved for multiple regions?

- ANSWER: Yes.

When will the draft Provider Agreement (and any related OAC rule revisions) be issued for this RFA? Will selected plans have an opportunity at that time to review new program requirements and submit comments?

- ANSWER: At this time we anticipate that a draft of the ODJFS-MCP Regional Provider Agreement and the proposed revisions to OAC Chapter 5101:3-26 would be distributed to selected health plans for their review and comment by March 2006. The majority of program changes for the statewide expansion will be made through the Provider Agreement. Please be reminded, as stipulated on p.4 of Appendix B, if an Applicant is selected by ODJFS to receive a regional provider agreement they must consider all ODJFS program requirements, including those new program requirements specified in Appendix B, to be nonnegotiable, although they will have the opportunity to provide feedback on how ODJFS proposes to operationalize those requirements.

Will results of this selection process have an impact on the plans selected to offer ABD services?

- ANSWER: ODJFS has not yet drafted the ABD procurement process so we cannot answer this question as this time.

Page 17, Implementation - Will the phase-in occur on an entire region basis, or is it possible that the phase-in could occur at a county(s) level within a particular region?

- ANSWER: Phase-in will occur on a regional basis and include all counties in the region.

If 3 MCPs are selected for a region and 2 are ready to begin enrollment, will they be held up until the 3rd MCP is ready?

- ANSWER: If ODJFS selects three health plans for a region, we believe it is optimum for all parties (ODJFS, the MCPs, consumers, etc.) that these three plans would “go live” in that region at the same time. ODJFS does reserve the right, however, to proceed with only two plans if that becomes necessary.

What is the detailed description for the two character numerical fields for specialty codes in the provider file distributed on CD during the initial bidder’s conference?

- ANSWER: The key to the specialty codes was distributed to all of the Potential Applicants after the September 20, 2005 Applicants’ Conference. If you require an additional copy please email your request to [BMHC@odjfs.state.oh.us](mailto:BMHC@odjfs.state.oh.us).

## **GENERAL PROGRAM REQUIREMENTS**

Provider Agreement Appendix G pg 4-5: Considering members can access Behavioral Health and Alcohol/Drug Addiction Services through FFS CMHCs, what utilization and price assumptions, by type of service, were made in developing the mental health and substance abuse components of the capitation rate?

- ANSWER: Pursuant to ORC Section 5111.16, mental health and alcohol and drug addiction services received through CMHCs and the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) are not considered to be the responsibility of the MCPs and are therefore not included in the MCP capitation rates. However, MCPs are responsible for the payment of Medicaid-covered prescription drugs prescribed by a CMHC or ODADAS-certified provider when obtained through an MCP's panel pharmacy, as well as laboratory services provided by a laboratory on their panel when members are referred by CMHC or ODADAS - certified providers. In developing the MCP capitation rates, the costs and utilization assumptions for these services (pharmacy and laboratory) as well as the behavioral health services provided through the MCP's panel providers are based on historical FFS data, MCP encounter data and MCP cost report data.

Provider Agreement Appendix G pg 5: If the MCPs use the "same fundamental drug formulary as the Ohio Medicaid fee-for-service program, to what degree will ODJFS approve the MCP program or require changes in this program? What criteria determines "fundamental" similarities in the MCP and Ohio Medicaid fee-for-service program formularies?

- ANSWER: MCPs must offer the same baseline formulary as the Medicaid FFS program but MCPs are, subject to approval from ODJFS, able to utilize different utilization management strategies (i.e., there can be differences in the drugs that are prior authorized).

Provider Agreement Appendix C pg. 3: What are the prevalent non-English languages in the CFC population?

- ANSWER: Spanish is the most prevalent non-English language used by the CFC population in Ohio. The non-English primary languages used by the CFC population vary by area within the state and ODJFS expects the MCPs to work with the available resources to identify the prevalent languages in their service area.

Provider Agreement Appendix G pg. 2: What transplants are currently covered in the program?

- ANSWER: The Ohio Medicaid program covers all non-experimental transplants.

Section 5101:3-26-08 (F) states:” No more than fifty per cent of each marketing representative's total annual compensation, including salary, benefits, and bonuses may be paid on a commission basis.” We have been advised that sales are not permitted. Please clarify.

- ANSWER: Although “cold-call” direct marketing is not permitted, MCPs may utilize licensed marketing representatives and MCPs may compensate these marketing representatives for the success of their efforts (e.g., consumer requests for a marketing discussion, consumer calls to the MCP for further information, etc.).

Can the MCP coordinate/manage the prescribing of medications written by any of the self-referred provider agencies (FQHC, RHC, QFPP, etc.) to ensure appropriate prescribing patterns and coordination with additional member medications?

- ANSWER: Subject to ODJFS approval, MCPs may require prior authorization of certain drugs/drug classes.

Provider Agreement Appendix G pg. 4-3: Will the CMHC’s be expected to provide current data regarding members receiving mental health services to allow for the MCP’s to coordinate services?

- ANSWER: CMHCs are not required to provide this data but MCPs are encouraged to work with the CMHCs to coordinate the care of their members.

Provider Agreement Appendix G page 4-4: Will CMHC’s be authorized to provide all levels of care, inpatient, outpatient, group home, partial, IOP, community and school-based services, etc?

- ANSWER: Each CMHC differs in the services that they provide.

Provider Agreement Appendix G pg. 4-5: While members may self refer to the CMHC’s and certified Medicaid ODADAS providers, is it also expected that

members may self refer into the MCP network? Can the MCP directly coordinate for behavioral health referrals and ongoing care management?

- ANSWER: MCPs must, through their panel providers, provide access to any Medicaid-covered behavioral health service that a member is unable or unwilling to access through the traditional community providers although the MCPs are not required to allow members to self-refer to their behavioral health providers.

Section II.B: Is ODJFS willing to sponsor at least quarterly meetings between participating plans and the vendor administering the State's SSC?

- ANSWER: There will be ongoing opportunities for dialogue among the participating plans, ODJFS and the SSC with the rollout of mandatory status in each region.

Will the historical provider directory timeframes and guidelines still be applicable for existing plans and then new guidelines and timeframes be applicable as plans are approved according to the regional approach?

- ANSWER: The existing provider directory requirements and timeframes are currently under revision to reflect the addition of the on-line directory and the move to regional provider agreements. Currently-contacting MCPs will be notified of these changes as soon as they are finalized.

What is meant by subrogation within Ohio given that MCPs currently do not perform that function?

- ANSWER: See Ohio Revised Code section 5101.58 and Ohio Administrative Code rule 5101:3-26-09.9.

Will MCP provider numbers be assigned for each county or each region?

- ANSWER:

Rules section 5101:3-26-08 C-1 prohibits unlicensed marketing. What license is sufficient to permit an individual to market an MCP?

- ANSWER: Individuals who solicit enrollment in a specific health insurer in Ohio must be licensed by the Ohio Department of Insurance.

Section II.A. Definitions, Page 3: Assistance Group is defined as family members receiving the same category of covered families and children Medicaid. Question: Is this information represented in the 834 and/or CCR data? If so, is it the same as a case id? If not, can it be included in this data?

- ANSWER: Yes. An example of case id information as it appears on the 834 is: 9999999999MA C01. It appears as one field. On the consumer contact Record (CCR) the example information appears as 9999999999/MA C/01. Referred to as CASE/CAT/SEQ, the information is broken down as follows: CASE = case number: a series of 10 numbers which is unique to the entire household at a particular address; CAT = category: the type of Medicaid the assistance group is receiving (in the examples: MA C); SEQ = sequence: a two-digit number that differentiates assistance groups with the same category of assistance in the same household or CASE (in the examples: 01). The information is helpful in identifying those individuals within a household that are in the same assistance group.

Are their limitations to psychology services for adults twenty-one year years or older when services are provided by an independent psychologist and independent group psychologist practices? Is this limited to any other provider disciplines (MD's, MSW's, etc.) or provider types (facilities, clinics, etc)?

- ANSWER: As stated Appendix G of the SFY06 Provider Agreement, refer to OAC rule 5101:3-8-05 for covered psychology services and limitations. Appendix G (1) also states that independent psychologist services are no longer covered for adults age twenty-one and older as of January 1, 2004. This would also cover MD's, clinics etc.

The document titled GenericPA\_SFY\_06-ProviderAgreement, outlines the covered services in Appendix G, with Section 2.b.iii listing the covered mental health and substance abuse services. Please confirm whether there are any limitations to any of the services listed. Administrative code section 5101:3-8-05, covered psychology services and limitations, states that for dates of service

beginning on and after January 1, 2004, psychology services specified in paragraphs (C) to (F) (psychological testing, therapeutic services and diagnostic interview examinations) of this rule will no longer be covered Medicaid services for adults twenty-one years of age and older when services are provided by an independent psychologist and independent group psychologist practices, however this is not mentioned in the document titled GenericPA\_SFY\_06-ProviderAgreement document.

- ANSWER: What Appendix G, Section 2.b.iii is stating are the exclusions, limitations and clarifications to the basic benefit package (G -1). We did not repeat all the covered services in the exclusions, limitations and clarifications section. In the behavioral health services (B iii) is just coordination services with CMHCs, ODADAS, and MH providers and again we do not repeat all the covered services as stated in Appendix G (1).

## **FINANCIAL**

Provider Agreement Appendix J pg. 5: Is Medicare PDP considered other healthcare lines of business for reinsurance coverage requirements?

- ANSWER: If the PDP is covering the full range of health care services and is a Medicare Advantage PDP, this would be considered another health care line of business. If the PDP is only covering prescription drugs, this would not be considered another health care line of business.

Appendix J, 2.b. pg. 3: Does the 15% limit on administrative expenses include the 4.5% franchise permit fee, which is properly reported on the administrative expense line of the financial statements submitted to ODI? Clarify whether the 15% limit on administrative limits includes or excludes the 4.5% franchise permit fee. If the 15% limit includes the franchise permit fee, then the actual administrative expense limit is 11.5% of revenue.

- ANSWER: The 15% limit does not include the 4.5% franchise fee.

Appendix J, 2.c. pg. 3: This financial indicator is another way of saying that ODJFS expects revenues to meet or exceed expenses. Would ODJFS consider waiving this requirement during the first period in consideration that plans would likely expect to report a loss due to un-reimbursed start-up costs during the 1<sup>st</sup>

half of the year? Alternatively, would ODJFS add clarification that justifiable exceptions include operating losses resulting from start-up phase losses? Eliminate risk of membership freeze for new plans that are likely to incur a loss in the first operating period due to start-up costs and only six months of operations.

- ANSWER: Appendix J of the ODJFS-MCP Provider Agreement, under *Penalty for noncompliance*, states: “Justifiable reasons for noncompliance may include one-time events.” The first year start-up costs may be a justifiable reason. The MCP will have to demonstrate that the deficiency does not potentially jeopardize access to or quality of care or affect the MCP’s ability to meet the administrative requirements (e.g., prompt pay requirements).

Appendix J, 3 pg. 4-5: Reinsurance with this low deductible is expensive, resulting in several dollars administrative costs PMPM or several percent increase in administrative cost ratio). The resulting increase in the administrative cost ratio is significant enough to cause concern with the 15% administrative ceiling described in Appendix J, 2.b. Would ODJFS consider increasing the deductible to a more cost effective level such as \$200,000 for very well capitalized companies or allow an effective but much less expensive insolvency protection of an irrevocable letter of credit, performance bond or guarantee from a very large and very well capitalized affiliate? Increase deductible to \$200,000 or allow substitution of guarantee from a credit worth affiliate or accept an irrevocable bank letter of credit. Note that CMS regulations require insolvency protections that include these options but do not require reinsurance.

- ANSWER: In the regional ODJFS-MCP Provider Agreements, ODJFS will modify the reinsurance requirements outlined in Appendix J to address this concern. ODJFS will insert the following language:

If the Medicaid MCP does not have more than 75,000 members in Ohio, but does have more than 75,000 members between Ohio and other states, ODJFS may consider alternate reinsurance arrangements. However, depending on the corporate structure of the Medicaid MCP, other forms of security tools may be required in addition to reinsurance. These other security tools may include parental guarantees, letters of credit, or performance bonds.

Some rural Ohio hospitals are concerned that once a Member signs on to be part of an MCO that they will not be included in the pure Medicaid statistics and will therefore hurt the hospital in its calculation of DSH payments (Disproportionate Share payments). In other states a Medicaid Member is a

Medicaid Member regardless if they are in an MCO or not and it does count towards DSH. We have been told that ODJFS has been asked this question by hospitals and has yet to respond and some hospitals are unwilling to move forward unless this is clarified.

- ANSWER: Yes, hospital costs for treating MCP members, and any applicable Medicaid Managed Care shortfall, are included in the calculation of Ohio's DSH payments to Hospitals, as indicated in OAC rule 5101:3-2-07.5 and 5101:3-2-09.

The Mercer databook member months by region is inconsistent with the membership numbers provided in Appendix A of the RFA. Please see the following comparison:

	Eligibles by Region - RFP Appendix A			Mercer Databook			
	HF	HS	Total	Appendix E		Appendix J	
				Member Months	Average Members	Member Months	Average Members
Northwest	98,916	30,932	129,848	1,425,606	118,801	823,327	68,611
West Central	84,145	24,843	108,988	831,011	69,251	928,534	77,378
Central	198,064	60,010	258,074	2,493,346	207,779	1,753,638	146,137
Northeast	206,155	55,038	261,193	1,140,628	95,052	2,473,846	206,154
Northeast Central	54,143	155,772	209,915	1,626,165	135,514	673,892	56,158
East Central	109,160	35,728	144,888	1,549,954	129,163	1,092,103	91,009
Southeast	73,298	21,402	94,700	2,159,591	179,966	172,456	14,371
Southwest	117,893	37,725	155,618	965,509	80,459	1,368,440	114,037
Total	941,774	421,450	1,363,224	12,191,810	1,015,984	9,286,236	773,853

Why is there such a variance in the numbers? Should the numbers be compared (are they representing the same eligible groups, etc?)

- ANSWER: The eligibles and member month information included in the RFA Appendix A, the Data book Appendix E and the Data book Appendix J differ for a number of reasons. The information included in Appendix A of the RFA is based on actual November 2005 eligibles. The member month information included in Appendix E is based on actual Fee For Service member months during State Fiscal Years 2003 and 2004. The member months listed in Appendix J, have been calculated based on March 2005 eligibles and penetration assumptions assuming an average start date for the regions of September 1st, 2006. For these reasons, it is not appropriate to directly compare these numbers.

Please provide data points, similar to that shown in Appendix E of the Mercer databook, to separately report mental health and substance abuse services in the following levels of care: Inpatient, Outpatient, Specialists, Clinics and Other, with information for paid claims, utilization, Unit Cost and average length of stay, as well as a breakout of costs by rate cohort.

- ANSWER: We do not have this level of detail for the FFS data readily available. However, it should be noted that the behavioral health component of the MPC capitation is quite minimal. In CY04, the MCPs reported that the behavioral health per member per month (PMPM) generally ranged between \$1.00-\$3.00.

We have encountered a number of hospitals concerned about losing Supplemental Upper Payment Limit (UPL) and HCAP reimbursement with the MCP expansion. These hospitals get UPL and HCAP payments in addition to their normal Medicaid payment per claim. The UPL and HCAP amounts are paid to the hospital based on filed cost report information. How does the state plan to make whole those facilities that will lose UPL dollars due to the expansion of the Medicaid Program? Please provide specific details on the formula, mechanics, etc. that will be used. The providers are concerned ODJFS will stop paying UPL and HCAP allocations in 2006, and have asked Paramount to absorb those amounts via contract negotiations. We need to clarify if ODJFS intends to continue UPL and HCAP payments directly to hospitals. If not, it adds to the complexity of MCP contract efforts.

- ANSWER: ODJFS anticipates that the upper payment limit payments to hospitals will continue to be consistent with our approved state plan and Federal policy. We are analyzing data to determine the probable effects of managed care expansion on UPL access on an individual public hospital basis. This analysis should be finished in early January. At that point we will share the data with the individual hospitals as well as with OHA. In the interim, individual hospitals and/or OHA will run their own analyses and share the results with ODJFS for further discussion and decision making.

In regard to HCAP, hospitals costs for treating Medicaid Managed Care enrollees, and any applicable Medicaid Managed Care shortfall, are included in the calculation of Ohio's DSH payments to Hospitals, as evidenced in OAC rule 5101:3-2-07.5 and 5101:3-2-09.

What contract compliance and performance penalties were paid in FY2004 (reported by each MCP and specific penalty)?

- ANSWER: See Chart below:

RE: SFY2004 (July 1, 2003 - June 30, 2004)

<u>MCP</u>	<u>Amount</u>	<u>Explanation</u>
Plan A	\$1,014,185.43	"At Risk" incentive amount returned to ODJFS based on plan's performance
Plan A	\$1,000.00	Noncompliance with CLIA requirements
Plan A (total)	\$1,015,185.43	
Plan B	\$16,985.52	Noncompliance with clinical performance standards (composite scores)
Plan B	\$111,446.00	"At Risk" incentive amount returned to ODJFS based on plan's performance
Plan B (total)	\$128,431.52	
Plan C	\$18,020.21	Noncompliance with minimum data quality standard for encounter data
Plan D	\$251,915.83	"At Risk" incentive amount returned to ODJFS based on plan's performance
Plan E	\$81,457.28	"At Risk" incentive amount returned to ODJFS based on plan's performance
<b>Total for all MCPs</b>	<b>\$1,495,010.27</b>	

How much did the MCPs receive in incentive payment for SFY2004 and YTD2005 (reported as a % of cap and straight dollars)?

- ANSWER: In SFY 2004, all of the MCPs received a 1% incentive payment as part of their rates. Only four of those plans were at-risk for the incentive payment. These four MCPs each qualified to retain 100% of the at-risk incentive monies paid to them. None of them qualified to receive any additional incentive payments.

The total at-risk amounts paid to MCPs in SFY 2004:

Plan A = \$608,893

Plan B = \$6,193,253

Plan C = \$1,150,803

Plan D = \$772,977

In SFY 2005, all of the MCPs received a 1% incentive payment as part of their rates. The incentive analysis has not yet been completed for this time period.

## **MEDICAID FFS REIMBURSEMENT QUESTIONS**

*We received a number of questions specific to how the Ohio Medicaid FFS program reimburses providers for certain services. Although ODJFS does require MCPs in certain situations to reimburse some non-panel providers at 100% of the Medicaid FFS reimbursement rate (see OAC rules 5101:3-26-03 and 5101:3-26-11), ODJFS does not expect or recommend that health plans attempt to reimburse all of their providers using the Medicaid FFS fee schedules. These fee schedules are unique to the FFS program and in many cases the logic which determines whether a claim will be paid and/or the specific reimbursement amount is solely a facet of the programming behind the FFS claims processing system and not captured in the OAC rules or any other written document. While the BMHC will assist MCPs in determining how to properly reimburse providers when they are required to reimburse those providers using the Medicaid FFS rate, ODJFS will not otherwise provide such technical support. ODJFS will provide newly-contracting MCPs with a technical assistance session on how to access the appropriate resources to obtain information on the Medicaid FFS payment schedules but after that, MCPs will be responsible for utilizing these resources to obtain this information. Responses are provided to the FFS payment questions listed below in that this information might be critical to helping a Potential Applicant determine if they wish to continue in this procurement process.*

In the FFS program, how does the state currently reimburse for short stay and Emergency Room observation?

- ANSWER: FFS defines short term stay as an inpatient hospital stay where the patient stays past in the hospital past midnight on the first day of the admission. If the patient does not stay in the hospital past midnight on the first day of admission, FFS would require this to be submitted as an outpatient claim.

Emergency Room observation is addressed in OAC rule 5101:3-2-21 (L).

Provider Agreement, Appendix G, pg 1: Please clarify the Home Health Services that are covered for the CFC population.

- ANSWER: MCPs are required to provide all services covered by the Ohio Medicaid program for home health services.

In what format will the MCP receive the fee schedule? It is currently in PDF format on the website? <http://emanuals.odjfs.state.oh.us/library/pdf/3160apxDD.pdf>

- ANSWER: It is currently in PDF format on the website but you can also buy a print-out of all the codes used by the department through production control. The request would go through Provider Relations (614-752-9551). There is no expectation that the fee schedule will be available in any other formats.

Does Ohio Medicaid still utilize local-use codes? The fee schedule has local codes with current rates for "W", "Y" and "Z" codes.

<http://emanuals.odjfs.state.oh.us/library/pdf/3160apxDD.pdf>

- ANSWER: Most local level codes were changed due to HIPAA. We do have a crosswalk on our website from local level codes to HIPAA codes. <http://jfs.ohio.gov/ohp/> Click on HIPAA codes sets, trading partner EDI – then click on HIPAA Compliant codes – then click on crosswalk.

Will a list of Level 1 ASC providers be supplied by the state?

<http://emanuals.odjfs.state.oh.us/library/pdf/3-2-21appxc.pdf>

- ANSWER: You can find information on the ASC program on our e-manuals website <http://jfs.ohio.gov/ohp/>

When is the Clinic Facility Fee Schedule used?

<http://emanuals.odjfs.state.oh.us/library/pdf/3-2-21appxd.pdf>

- ANSWER: This fee schedule is used when a provider meets the requirements outlined in OAC rule 5101:3-13 or when an outpatient hospital bills for a clinic facility fee as outlined in Appendix D of OAC rule 5101:3-2-21.

What version of DRG is used? If it is state defined, will MCPs be provided a manual?

- ANSWER: ODJFS uses DRG Grouper version 15 and maps upward toward Medicare. Although a complete manual is not available, additional information is available in Appendix A of OAC 5101:3-2-07.11.

When is the Ancillary Fee Schedule used?

<http://emanuals.odjfs.state.oh.us/library/pdf/3-2-21appxf.pdf>

- ANSWER: Outpatient hospitals would use the Ancillary Fee Schedule specified in Appendix F whenever they bill ODJFS using a code that does not appear in Appendices A, B, C, D, E, or G.

Will a list of Level 1, 2 and 3 ER providers be supplied by the state?

<http://emanuals.odjfs.state.oh.us/library/pdf/3-2-21appxe.pdf>

- ANSWER:
  - Level 1 = Teaching hospitals
  - Level 2 = Children's hospitals
  - Level 3 = All other hospitals

What does "SFY2005 Charge High Trim" refer to for DRG relative weights?

<http://jfs.ohio.gov/ohp/bhpp/RW010106.pdf>

- ANSWER: This is outlined in OAC rule 5101:3-2-07.3 (Methodology for determining relative weights.)

### **QUESTIONS NOT RELATED TO THE RFA**

*ODJFS received a number of questions that are not related to the completion of the RFA but instead request clarification regarding how current operational specifications might be revised, how new program requirements will be implemented, the timeframes for specific components of the pre-contracting/readiness review phase, and the roll-out of the regional expansion. As we explained in the December 12, 2005, Applicant Conference and in the written Q&A document distributed at that meeting, many of these operational details are still under development but they will be*

*shared with the health plans we select to proceed in this procurement process in March 2006 as soon as they are available. These questions are listed below and except where some clarification of the RFA language seems indicated, we are not responding to these questions at this time.*

Attachment B, on line provider directory: The current approved paper directory format requires (this is a small list of the 10 page RRT Provider Directory requirements given to current health plans in 2005.) Disclaimer language on each page, information related to interpreter services, a women's health section, office hours disclaimer, language, etc. Will all of the same information requirements that are proscribed on paper, need to be put into production on the on line provider directory? This is very crucial information to have answered so that we can identify what type of resources to devote to this project.

- ANSWER: ODJFS can provide the following clarification at this time: MCPs will be required to have a copy of their ODJFS-approved provider directory literally posted on their member website and in addition will be required to have a “searchable” feature consistent with that commonly used by commercial health plans. When a member receives the results of their provider “search,” the MCP will need to ensure that the provider-specific clarifying information the member would have seen in the provider directory (e.g., address and phone number, proficiency in languages other than English, practice limitations, etc.) is displayed with those provider names. General provisions (e.g., the right to a women’s health specialist, interpreter services notification, etc.) could be listed prior to the steps used to search for a specific provider or provider type and would not need to be included with the results of each specific search.

We understand from the December 12, 2005 applicant conference, ODJFS does not want additional benefits to vary by county within a region. We are concerned however, that adequate providers/vendors of additional benefits may not exist in all counties in the region or may become cost-prohibitive in some counties. For example, one of the additional benefits that may be offered is routine cab transportation in metropolitan areas. Could routine transportation be retained as an additional benefit for a region, but be provided under different arrangements based upon a member’s residence? (e.g., taxi within a city, gas voucher for transportation from a rural setting, etc.) Or would that type of variation negate the additional benefit as being considered for the entire region?

- ANSWER: ODJFS appreciates that non-emergency travel options may vary considerably within a region and will be open to discussion on how this might be addressed if an MCP wants to offer this service as an additional benefit.

GenericPA\_SF06-ProviderAgreement, Appendix G Section 2.b.iii states that there are Medicaid covered services available through CMHC's and through ODADAS-certified Medicaid providers, but then it states that MCPs are not responsible for paying for behavioral health services provided through CMHCs and ODADAS-certified Medicaid providers. Please clarify: What responsibilities does the MCP have in regard to members accessing services through CMHC's and ODADAS-certified Medicaid providers? What are the guidelines/requirements for when a member should access the CMHC vs. the MCP for behavioral health services? Are there any services provided by the CMHC's or ODADAS-certified Medicaid providers that the MCP has financial responsibility?

- ANSWER: For clarification on an MCP's financial responsibility for behavioral health services see Appendix G of the ODJFS-MCP provider agreement.

In the RFA and at the recent vendor's conference, ODJFS indicated they had no plans to revise the non-contracting rule in relation to the new transitional care request. We would like ODJFS to reconsider this in light of the many member rights and UM issues this will impact. For example, how will this impact information requested or the study methodology in the yearly EQR studies in which plans are required to participate?

- ANSWER: As we indicated during the December 12, 2005, Applicant Conference, we are considering these issues in developing the OAC rule and ODJFS-MCP provider agreement changes for the regional expansion.

As outlined by ODJFS, annual provider directory timelines currently take approximately 6 months to complete from beginning to end. To anticipate the enrollment deadlines outlined in the RFA (May 1/June 1 2006), our directory process will begin in January to be complete by the June 1 enrollment period. This timeline overlaps with the timeframe relevant to our existing provider agreement. Question: When will the plans receive a defined approach and timeline(s) to produce the Provider Directory? Does the State anticipate revising the timelines associated with the existing provider agreement to take into consideration the regional phase in?

- ANSWER: Yes. Currently-contracting MCPs will be notified of the revised deadlines regarding the annual provider directory submission.

Will the State allow a state wide printed provider directory or will the plans be required to publish individual provider directories to coincide with each individual region's approval-or will the State allow plans to utilize the on-line directory in lieu of establishing a new hard copy directory for each regional roll out?

- ANSWER: No response at this time.

The plans will be submitting all of their expansion providers on the PVS by 2/7/06. However, because of the varying timeframes in which the regions will be going "live", is it possible for a plan to have PVS approved providers in many of the expansion counties and regions? Also, will the state allow the plan to print PVS approved providers that are not included in the first region that goes live?

- ANSWER: No response at this time.

New Member Letter: Would it be acceptable to send the new member letter with member ID cards? ID cards are mailed separately from the new member packet containing the handbook and directory?

- ANSWER: No response at this time.

Will there be model language for the new member letter? Will it be acceptable to send the new member letter with the ID card & meet the requirement to be received by the eligible date – with the new member packet to follow? (Allowing non-priority cost mailing of packet)

- ANSWER: No response at this time.

Will ODJFS forward to the plans all prior authorization requests they receive to ensure the plans are aware of any and all prior auth activity?

- ANSWER: No response at this time.

Appendix B: On-Line Member Web Site, On-Line Provider Directory The requirement for an internet-based provider directory "available in the same format as the ODJFS approved provided directory" leads us to have many, many questions, some of which we may not even know to ask prior to the black out question period that starts 12/16/05. Will the Plans have access to any technical support for these types of questions, during December through February as we begin to work on this project?

➤ ANSWER: No response at this time.

OAC 5101:3-2-05 (B)(2) indicates the following: "When any provider of the designated provider types are to be added to the MCP's provider panel, the MCP must submit evidence of the following within thirty days of the execution of the subcontract for prior approval of the provider's addition to the panel: . . ." Is this guideline going to remain the same moving forward?

➤ ANSWER: No response at this time.

In Appendix C-7, 1. General Provisions, please provide clarification around the following provision as discussed in that section: MCPs must ensure access to appropriate provider types on an as needed basis. The MCP will be required to SECURE an appointment from a panel pediatrician/MD or ARRANGE for an out of panel referral to a pediatrician. Will this require the plans to be available to our members and providers to assist with appointments to ensure access standards are met? Will we be required to promote this to our members and providers, and if so, how will ODJFS measure our compliance to this?

➤ ANSWER: No response at this time.

Will plans continue to be allowed to distribute targeted mailings on a yearly basis to all eligibles as the regions go live?

➤ ANSWER: No response at this time.

We would like more information on the time lines surrounding the member letter and new member kit. If the member letter and ID card arrive by the first of the month, how long after that does the state expect the member to receive the new

member kit? And, when will this requirement become effective as the regions go live?

- ANSWER: No response at this time.

Section IV.B. Selection, Readiness Review, Implementation, Page 17: ODJFS will enter into provider agreements and start the enrollment process on a regional basis, phased-in based on ODJFS, MCP, and/or community readiness.

Question: How will this phased-in approach impact reporting to the state (i.e., encounters)? For instance, for an existing OH MCP, would existing members in counties not yet migrated need to be reported based on counties and new/existing members in regions that have migrated need to be reported based on region? Would 820 data received from ODJFS be partially regional and partially county-based?

- ANSWER: No response at this time.

Appendix B, New Program Requirements Page 1-3: Online provider and member website functionality is required. Based on ODJFS responses to previously asked questions, the expectation is that this functionality must be available at the time the MCP signs a regional provider agreement with ODJFS. Question: Would ODJFS expect this functionality to be available for assessment during the Readiness Review? Can an estimated timeframe be provided? For example, will this be mid-April, mid-March, etc.? What are the consequences if functionality is not delivered according to this schedule?

- ANSWER: No response at this time.

Provider Agreement, Appendix C, Item 22, pg 5, Paragraph 2 states "MCP member services closure days must be specified in the MCP's member handbook, member newsletter, or other some general issuance to the MCP's members at least 30 days in advance of the closure." Should this be listed as the Holiday (i.e. New Year's Day) or the specific date (Jan 1, 2005)?

- ANSWER: No response at this time.

Provider Agreement, Appendix C, pg 8, Item 25.a Section states "The MCP shall provide to the selection services contractor (SSC) ODJFS prior-approved MCP

materials and directories for the distribution to eligible individuals who request additional information about the MCP." How far in advance do materials and directories need to be sent to the SSC?

- ANSWER: No response at this time.

Provider Agreement, Appendix K, Item 1, pg 1 Beginning in 2004, MCPs were required to initiate 2 PIPs and in 2005 an additional PIPs. Will new MCPs be required to initiate 3 PIPs in the first operational year?

- ANSWER: No response at this time.

OAC 5101:3-2-05 (B)(2) indicates the following: "When any provider of the designated provider types are to be added to the MCP's provider panel, the MCP must submit evidence of the following within thirty days of the execution of the subcontract for prior approval of the provider's addition to the panel: . . ." Is this guideline going to remain the same moving forward?

- ANSWER: No response at this time.