COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

Request for Responses from Integrated Care Organizations
RFR # 12CBEHSDUALSICORFR
Responses to Respondent Questions, Group 1 – July 24, 2012

EOHHS has prepared answers to the questions below to clarify the referenced RFR. The questions are grouped into categories for easy reference, and, where practical, the RFR or attachment sections to which they refer are identified.

Amendments to the RFR referenced in some of the answers below are reflected in a separate document posted on Comm-PASS.

Please note: EOHHS may post additional responses to questions from bidders. Any further responses will be posted on Comm-PASS.

.A. GENERAL

1. What is the due date for RFR Responses?
A: EOHHS is amending the due date for RFR Responses. Responses will be due at 4:00 pm (EDT), August 20, 2012. Please see RFR Amendment #1, Item 17.

2. Does the RFR mean that the Massachusetts plan as submitted to CMS was approved and that the program is a definite "go"?
A: Massachusetts and CMS are negotiating and finalizing a Memorandum of Understanding (MOU), which is the CMS approval for the terms and conditions of the Duals Demonstration. Both Massachusetts and CMS are continuing to take operational steps forward, including the release of this RFR, with the intention that eligible MassHealth Members will be able to enroll in ICOs beginning April 1, 2013.

3. When will the EOHHS-CMS MOU be available for review? Where will it be posted?
A: EOHHS and CMS continue to finalize the MOU. When available, it will be posted at www.mass.gov/masshealth/duals.

4. Will there be additional opportunity, after the June 22, 2012, deadline outlined in Sections 1.4 and 10.1, to update the Service Area proposed in the CMS Application to align with the Service Area proposed by the Respondent in its RFR Response?
A: Organizations will be permitted to drop counties or partial counties from the Service Area proposed in their HPMS applications until the due date for the RFR Responses. Please see RFR Amendment #1, Item 1.

B. DEFINITIONS

1. "Contract" is defined as the participation agreement that EOHHS has with an ICO. Shouldn't this also reference CMS as a party to this agreement?
A: Yes. Please see RFR Amendment #1, Item 2.

2. Cultural Competence – Please amend the RFR definition to include sexual orientation and gender identity minorities. There is growing evidence indicating that the adverse life experiences of older LGBTs impedes access to health care and long-term support services,

the two major elements to be coordinated by ICOs. Only through cultural competency training can providers be adequately prepared to affirmatively address the concerns and fears of this growing but still marginalized population.

A: Please see RFR Amendment #1, Item 4.

3. "Material Subcontractor" is defined as any entity to which the Contractor delegates the responsibility to meet all the requirements of any complete, enumerated subsection as allowed under the Contract. Since we don't yet have access to the Contract referenced in this definition, can you provide any guidance on how we define Material Subcontractor for the purpose of responding to the RFR?

A: Please see RFR Amendment #1, Item 5.

C. ENROLLMENT

1. Can a member opt out of the program or change ICOs after the initial 60-day enrollment period?

A: Yes. A member may opt out of the Demonstration, disenroll from an ICO, or change ICOs at any time, effective at the end of the month. These choices are available to ICO enrollees regardless of their enrollment date.

2. Will the state consider a qualitative or technical score based component to the auto-assignment logic?

A: Upon implementation of the Demonstration, EOHHS will not have the qualitative data necessary to inform auto-assignment logic. However, as quality metrics are collected over time, EOHHS may pursue an auto-assignment process that factors in qualitative data.

3. Are duals residing in State residential programs included in the demonstration?

A: Duals residing in State residential programs or facilities are eligible to participate in the Demonstration, with the exception of individuals who reside in an Intermediate Care Facility for the Mentally Retarded or who are enrolled in a Home and Community-based Services Waiver.

4. Can you provide any information on likely intervals and numbers of members projected to be passively enrolled? When this would begin?

A: EOHHS and CMS will widely publicize and provide information about the Demonstration to eligible members before April 1 so that members have sufficient information and time to make a choice to enroll in an ICO or opt out of the Demonstration. Dual eligible members who are eligible to enroll in the Demonstration and meet the criteria for subsequent auto-assignment will be included in the auto-assignment process. The number of members who will be auto-assigned to an ICO will be based on the number of members that have selected an ICO or opted out of the Demonstration. EOHHS expects batch auto-assignments to occur in two or more phases. A member will always be given at least 60 days after notification of their auto-assignment to make a different choice. EOHHS is considering targeting July 1, 2013, for the effective date for the first group of batch auto-assignments. It is currently anticipated that batch auto-assignments would occur at 90-day intervals thereafter, until all eligible individuals are contacted and choose an ICO, are auto-assigned, or opt out of the Demonstration. Once all existing eligible members are reached, EOHHS will develop a monthly auto-assignment process for newly accreting dual eligible individuals that provides a 60-day notification and selection timeframe.

D. SERVICES, CARE DELIVERY, AUTHORIZATIONS

1. At the meeting on June 1, it was stated that ICO enrollees would have a choice of at least two IL-LTSS Coordinators. Is that per county or just that the ICO must have a minimum of two in total?
A: Per the RFR, the ICO must offer a choice of at least two IL-LTSS Coordinators for each enrollee who needs IL-LTSS coordination.

2. What if an ILC will not contract with an ICO? Would the State assist in these instances?
A: During the readiness review period, if a Respondent has been unable to contract with at least one ILC as required by the RFR, the Respondent should notify EOHHS and provide information about its efforts to contract with ILCs.

3. If a CBO provides PCA management or FI services, can that CBO also be contracted to provide IL-LTSS Coordinators?
A: Yes. Please see Section 4.6.D.1 of the RFR.

4. Will MassHealth be adding any required elements to the CMS Model of Care (MOC)?
A: No. Please review the April 27 FAQ document found on Comm-PASS at 12CBEHSDUALSDEMOORGANIZATIONS for additional guidance on completing the MOC for CMS.

5. Does the Care Coordinator have to be employed by or contracted with the primary care practice, or can it be provided by the ICO?
A: In keeping with the RFR definition, the Care Coordinator should be employed by the primary care practice. One important goal of this Demonstration is to give Enrollees access to a medical home that provides integrated primary and behavioral health care and care coordination. While ICOs may contract with primary care practices that do not *currently* have the capacity to perform these functions, ICOs are required to support such practices to help them build that capacity. The ICO may employ staff or contractors to ensure that this function is provided for all Enrollees as primary care practices gain capacity.

6. Please clarify the roles of Care Coordinator and Clinical Care Manager. When is it appropriate to include a Clinical Care Manager on the Individualized Care Team (ICT), versus a Care Coordinator? How is this need identified?
A: The Clinical Care Manager should be included on the Enrollee's ICT in lieu of a Care Coordinator when it is determined for a given Enrollee that the services of a Clinical Care Manager are appropriate. As stated in Section 4.6.C of the RFR, "each ICO (or Primary Care Provider, working in partnership with the ICO as needed), shall determine a mechanism to identify, offer, and provide Clinical Care Management services to Enrollees with complex care needs. Such Enrollees may be identified through several mechanisms, including but not limited to analysis of service utilization data, referral by the Primary Care Provider or ICT, and Enrollee self-referral. These Enrollees may include individuals who require multiple prescription medications, have one or more chronic health conditions, or are assessed to be at high risk of hospital or nursing facility admissions, emergency department use, or loss of independence."

7. Clinical Care Manager – The RFR definition allows for this individual to be employed by PCP or the ICO. Could the Clinical Care Manager also be employed or contracted by another organization that may have care management responsibilities for which the ICO contracts, e.g., behavioral health agency?

A: Yes. A Clinical Care Manager could be employed or contracted by a subcontractor to the ICO. Any such arrangement should be thoroughly described in the RFR response.

8. Most of the language throughout the RFR seems to point to the Primary Care Provider (PCP) practice as being accountable for organizing the assessments, establishing/managing the Interdisciplinary Care Teams (ICTs), etc. What is the state's expectation in terms of whether it sees Integrated Care Organizations (ICOs) taking primary responsibility at first, but moving towards more delegation to practices as they become able to do so? Do ICOs have the leeway to establish their own criteria for readiness for delegation, either formal or informal, of these activities to practices?

A: The ICO is ultimately accountable and responsible for carrying out all the obligations and providing all services as described in the RFR and the Contract. As described in the RFR, ICOs also are required to support primary care practices to develop the competencies to operate as patient-centered medical homes and/or Health Homes (see Section 4.6.A). Primary care practices with which an ICO contracts may be at varying levels of readiness to take on specific roles required by the RFR, including providing Care Coordinators, organizing Interdisciplinary Care Teams, and providing integrated primary care and behavioral health. Respondents to the RFR should provide detailed information on how they propose to work with practices to achieve medical home/health home competencies and fully meet the requirements of the RFR. This information may be provided within several different RFR responses, including, but not limited to, Sections 10.4.C.4, 10.5.F.1, 10.6.B.1, and 10.8.

9. Section 4.6.A.3 states that "ICOs must provide incentive structures to support PCPs to accomplish these requirements and to adopt additional medical home and/or Health Home principles and practices." Does this mean all PCPs/practices in network or only those with enough volume to support shared savings or alternative payment models?

A: ICOs must develop and implement strategies for supporting contracted primary care providers to adopt medical home and/or Health Homes principles and practices. These strategies may vary from practice to practice, depending on the practice size, location, volume of enrollees, current capabilities, and other factors. An alternative payment model such as shared savings is one possible approach. Other strategies may include providing other types of support, including payments, technical assistance, training or infrastructure, or facilitating shared resources (e.g., Care Coordinators) between several practices.

10. Section 4.9.C.1 states that all team members for Behavioral Health Utilization Management shall have "at least two or more years of experience in managed care or peer review activities." Does working as a provider count toward the required experience?

A: Yes. If a BH utilization manager has prior experience as a BH provider, that experience would meet the requirement.

11. Do ICOs have the leeway to determine when referrals for authorization/UM are required? (Several MCOs currently don't require referrals authorizations.)

A: Yes. An ICO may develop UM protocols that do not require referrals. EOHHS will review and approve the UM protocols of all selected ICOs during readiness review activities.

12. Sections 4.7.C, 4.7.D and 10.5.D.3: The RFR states that "The Enrollee will be at the center of the care planning process. Each ICP must reflect the Enrollee's preferences and needs. The ICO will ensure that the Enrollee receives any necessary assistance and accommodations to prepare for and fully participate in the care planning process…" The RFR also asks the Respondent to "Describe the process for transitioning Enrollees to new

providers, if needed, once the ICP is completed and signed." Do we need written (signature) approval from members on care plans, or can the member give verbal approval?

A: ICOs should have policies and procedures in place to secure the signature (or electronic authorization) of the Enrollee or the Enrollee's representative on the ICP, or have other identified processes for documenting that the ICP has been discussed with and agreed to by the Enrollee.

13. What happens with abortion services? Does the Hyde amendment apply?

A: All selected ICOs will be required to execute a separate Abortion Services contract with EOHHS. EOHHS will pay ICOs separately for providing this service. A model ICO Abortion Services contract will be posted on Comm-PASS as Appendix I to the RFR. Please see RFR Amendment #1, Item 6 and Item 18.

E. PROVIDER NETWORKS

1. What kind of outreach is expected from the ICOs to ILCs and RLCs prior to implementation? How will these interactions be measured by EOHHS in terms of quality during the evaluation process?

A: Potential ICOs should be in contact with community-based organizations (CBOs) in order to meet the requirements of the RFR. Respondents should describe their intention to contract with and establish working relationships with CBOs. The establishment of relationships with CBOs will also be explored during the readiness review.

2. What kind of commitment from providers must ICOs secure to satisfy the provider network requirements? The RFR says "Name and Address."

A: For purposes of responding to the RFR, ICOs should provide at least the information about provider networks requested in the RFR, including, but not limited to, in Sections 10.1 and 10.4. Evidence of contracts with providers or other documentation will be required as part of the readiness review process for selected ICOs.

3. Section 4.5.C: Can the state make available existing contract templates used with Personal Care Management (PCM) Agencies and Fiscal Intermediaries (FIs)?

A: A copy of EOHHS's model contract with PCM Agencies is available on Comm-PASS (www.comm-pass.com) under Document Number DMA072502. A copy of EOHHS's model contract with FIs is also available on Comm-PASS under Document Number 12PBEHSPCAFI.

4. Please confirm that payment for emergency and post-stabilization care is based on MassHealth's fee schedule (PAPE/SPAD), not Medicare fees.

A: Please see RFR Amendment #1, Item 9.

5. Are ICOs *required* to contract with DMH Emergency Service Providers?

A: ICO must maintain relationships with the Emergency Services Programs (ESPs – identified in Appendix G) which are located within the ICO's Service Area to provide ESP services. Each ICO must execute and maintain contracts with ESPs that are not operated by the Department of Mental Health (DMH). ICOs are required to execute a Memorandum of Understanding with DMH ESPs to provide ESP services. Of the ESPs identified in Appendix G, the DMH ESPs are: Brockton Multi-Service Center, Cape & Islands Emergency Services, Corrigan Mental Health Center, and Norton Emergency Services. Please see RFR Amendment #1, Item 7.

6. When will CMS and MassHealth complete the full and final review of provider network adequacy?

A: CMS and EOHHS will make a final assessment of Demonstration plans' provider networks during the readiness review process, which is expected to occur in the fall of 2012.

7. Will providers (e.g., physicians, hospitals) that ICOs contract with under this Demonstration be required to be certified as both Medicare and MassHealth providers? Will they be required to have met the standards or completed the process to become certified as a provider by both Medicare and Medicaid to provide services to a dual member in this Demonstration? Would a dual eligible member be able to receive service from a provider who is only Medicare certified? Would a dual eligible member be able to receive service from a provider who is only Medicaid certified?

A: CMS requires that the providers submitted in HPMS to demonstrate ICO network adequacy are Medicare-certified providers. Medicaid managed care providers must be credentialed by the ICOs to be included in their networks (per regulations at 42 CFR 438.214), but EOHHS does not require ICO providers to be enrolled as Medicaid FFS providers with the Commonwealth.

F. PHARMACY

1. Please clarify the $250 out-of-pocket copay cap on drugs, which appears contradictory. In one reference, caps according to MassHealth policy apply (that is expected, $250 cap on Medicaid drug copays); and in another reference, "all pharmacy copays under the ICO pharmacy benefit will count toward this cap." Which is true?

A: Please see Section 4.3 of the RFR. ICOs must establish a cap equal to the amount established by MassHealth for a given year. Co-pays paid by the Member for any ICO-covered pharmacy product must count toward the $250 cap, without regard to whether the product, absent the Demonstration, would be covered under Medicare Part D or by MassHealth.

2. Is the prospective ICO required to include the products *dronabinol, megestrol, oxandrolone, and somatropin* on the Additional Demonstration Drug (ADD) File submission if already submitted on the Part D formulary file?

A: By requiring Respondents to submit those products on the ADD file, EOHHS is requiring prospective ICOs to demonstrate that these products are covered for all indications, not just for the indications Part D covers. That is why the guidance advised that Respondents submit them on the ADD file with a note or flag showing coverage for uses other than the Part D-covered indications. Respondents may also include those products on their Part D base formulary, with the appropriate PA indicating coverage for the Part D-covered uses.

3. We submitted formulary files to CMS on June 8. However, we encountered certain errors regarding the Excluded Drug Supplemental File, including validation rejections for certain barbiturate products, barbiturate combination products, and prescription vitamins and minerals. Can MassHealth provide any guidance?

A: EOHHS has worked with CMS to provide a response to this question. To be on the Excluded Drug file, a drug has to be in a category/class that is excluded from coverage under Part D, but must otherwise meet the requirements to be a Part D drug. This includes FDA approval and e-listing of the drug with the FDA; also, the product cannot be designated as a Drug Efficacy Study Implementation (DESI) "less-than-effective" drug. If the drug fails to meet any of those criteria, it may be rejected from the Excluded Drug file. If rejection errors for the Excluded Drug or Supplemental OTC Drug files prevent listing of products that are not Part D-covered drugs that EOHHS requires ICOs to cover in the Demonstration, the Respondent

should default to including those products in the ADD file. Respondents will have at least two opportunities to resubmit information to ensure that all CMS and EOHHS requirements are satisfied.

G. ENROLLEE RECORDS AND HEALTH INFORMATION EXCHANGE

1. The Centralized Enrollee Record (CER) requirements for the ICOs apparently go beyond the SCO CER requirements. What is the reasoning behind that?

A: The CER requirements outlined in the RFR for this Demonstration are similar to the CER requirements for the SCO program. The three elements added for this Demonstration (Sections 4.10.B.3, 4.10.B.4, and 4.10.B.14) reflect the fact that individuals in the target population for this Demonstration are people with disabilities, and that the population overall has a higher rate of behavioral health needs.

H. GRIEVANCES AND APPEALS

1. Must both CMS and MassHealth appeals and grievances processes apply?

A: CMS and EOHHS will work together to define joint requirements in a way that is as clear as possible to Enrollees and ICOs. It is important that the protections of both the Medicare and MassHealth programs remain available to all dual eligible individuals. Respondents should carefully review the RFR to understand the requirements in Section 5.1. ICOs must comply with Medicaid requirements at 42 CFR 438 et seq. and Medicaid requirements at 42 CFR 422 et seq., unless those requirements are expressly waived in the RFR or three-way Contract.

I. OUTREACH AND MARKETING

1. When can ICO marketing activities begin in advance of the April 1, 2013, first effective enrollment date? Can you provide details around the marketing time line?

A: ICO may begin marketing activities once all readiness activities, including submission of and approval of all marketing materials, are completed. A more detailed timeline will be provided to selected ICOs.

2. Section 5.3.A.4.d.3 states the ICO must, "Within a reasonable time after enrollment, provide each Enrollee with a postcard notification that a copy of the Network Provider Directory can be accessed online at the ICO's website, or available in writing by calling the Enrollee Services department." Can this be included in our initial enrollment packet, rather than sent separately?

A: Yes.

3. So that interested parties may begin work on a Member Handbook for beneficiaries under the Demonstration, can you provide information on the requirements or expectations relative to such a document:

- Will it be an integrated document for all covered services?
- Will it be subject to review by both MassHealth and CMS?
- Will a template be provided?
- Will the document need to cover any or all of the following:
    - Enrollment and termination
    - Benefits
    - Coverage limits and cost sharing
    - Appeals and grievances
    - Excluded services

- Coordination of benefits
- Authorization of services

A: The ICO member handbook will need to be an integrated document reflecting all covered services. It will be subject to review by CMS and EOHHS. Additional guidance will be provided by CMS and/or EOHHS when available.

J. QUALITY

1. Quality metrics mention both HEDIS and NQF. Some metrics are the same. Would we default to the HEDIS methodology?

A: The RFR references the NQF number when NQF has endorsed an existing measure such as a HEDIS measure or a CAHPS measure. If the measure is a HEDIS measure, it is appropriate to utilize the HEDIS methodology.

2. In Section 5.7, there appears to be a duplicative domain listed for "Patient/Caregiver Experience." Is this an error?

A: Yes. Please see the RFR Amendment #1, Item 10.

K. ASSESSMENT

1. Is submission of MDS-HC information going to be required for all enrollees or only those enrollees for which there is a change in Rating Category (e.g., change from C1 to C2 or C3)?

A: Please see Sections 4.7.A.1 and 4.7.A.2 of the RFR. ICOs will be required to complete the MDS-HC assessment on Enrollees both within 90 days of enrollment and on an ongoing basis, as described in Section 4.7.A.2.

2. Please provide the assessment logic and form MDS-HC for purposes of understanding the level of care categorization.

A: The MDS-HC is available at http://www.mass.gov/eohhs/docs/masshealth/provider-services/forms/mds-hc-2.pdf. EOHHS is developing special instructions for completing this tool, which will be shared when finalized.

3. The RFR states that ICOs will be required to develop a comprehensive assessment and have it approved. Will EOHHS supply the comprehensive assessment tool or will ICOs develop their own assessment tool for EOHHS approval? If the latter, what will the process be for submitting and approving the assessment?

A: Please see Section 10.5.C of the RFR. The Respondent is required to submit its draft assessment tool with its response to the RFR. EOHHS will work with the ICOs during the readiness review period to review, finalize and approve the comprehensive assessment tools.

L. PAYMENT

1. Re: Section 7.3, Base Global Rates – How will the "anticipated savings" be developed? Will it be ramped from year 1 to year 3 to reflect the time necessary to achieve savings?

A. EOHHS and CMS are working on setting savings targets. EOHHS expects that savings targets will reflect a ramp-up over the course of the Demonstration.

2. When will rates be available? Will the rates be posted on Comm-Pass prior to the RFR response due date? Can you estimate the base global rates and/or regional rates?

A: EOHHS and CMS are working on developing the rates. The rates will be shared when they are finalized.

3. Has the state selected an actuary or actuarial firm yet?
A: EOHHS and CMS have each contracted with an actuary to support ICO rate setting activities.

4. What is meant by "ICO-level tiered Risk corridors"? Will each ICO have a different corridor? Will the ICO have a choice of corridors?
A: Risk corridors will be evaluated for each ICO in aggregate. This means that gains/losses will be determined based on all rating categories combined, and across an ICO's entire Service Area. Any risk corridors would be the same for each ICO. ICOs will not have a choice of corridors.

5. Will the High-Cost Risk Pools (HCRPs) be separate for categories F1 and C3? What services will be included in the HCRP?
A: HCRPs will be established separately for rating categories F1 and C3. The HCRPs will be based on spending for selected Medicaid long term services and supports.

6. The rating categories in the RFR appear to be different than the definitions used to develop the Data Book. Please revise the data provided in the Data Book to match the RFR definitions.
A: Rating categories will be determined from assessment data during the Demonstration. Assessment data for this population does not exist for use in the Data Book rating category determinations. Claims data has been used to proxy rating categories under the Demonstration.

7. How often will the rating category be updated for an individual? Annually? Monthly?
A: A rating category for an individual may be updated throughout the year based on status changes for the individual. Please see Section 4.7.A of the RFR.

8. As the state works to develop an enhanced risk adjustment methodology, will you consider experience from other states using multiple predictors such as functional status and disease conditions combined?
A: Yes.

9. Will the state consider adding the C2 rating category to the High-Cost Risk Pool?
A: EOHHS does not expect to apply a HCRP to the C2 rating category.

10. Does the statement in Section 7.3. D, "Payments to ICOs for each component of the Global Payment rate," mean that the ICO will receive two payments (and associated payment files) – one from CMS, and one from EOHHS?
A: EOHHS and CMS will make separate payments.

11. Will CMS use Medicare fee-for-service encounter data for risk adjustment purposes or will they start risk adjusting as ICO data becomes available?
A: Specific questions on the Medicare portion of the payment rate should be directed to CMS at MMCOcapsmodel@cms.hhs.gov.

12. Will ICOs make separate payments to providers for Medicare and Medicaid benefits, or will the payments be combined?

A: ICOs will not make separate payments to providers for Medicare and Medicaid benefits. EOHHS requires the ICOs to deliver an integrated, unified package of covered benefits and to develop provider payment methodologies accordingly.

13. Will all enrollees be put into the lowest rating category to begin the Demonstration?
A: At the time of enrollment in an ICO, EOHHS expects to be able to identify certain members who have been in a nursing facility for 90 days or more, and who therefore fall into the rating category of F1 – Facility-based Care. All other enrollees will default into the lowest-cost rating category of Community Other. ICOs will assess their enrollees using the MDS-HC and submit the assessment data to EOHHS to determine placement into the High Community Needs and Community High Behavioral Health categories.

M. DATA

1. Can we get the PMPM data on pharmacy?
A: Part D data released by CMS does not contain pricing information.

2. From the Data Book, it appears that the crossover data is the Medicaid portion of the member's financial liability under traditional Medicare coverage. This amount appears to be lower than what one would expect under traditional Medicare. For example, for physicians/prof expenses, the Data Book shows about 10.6% of the total expense is the crossover member cost-share. I would expect this to be in the 20% range, is there a reason for this?
A: In accordance with 130 CMR 450.318(C), EOHHS reprices crossover claims.

3. Will members' claims history be available to ICOs?
A: EOHHS is exploring the privacy and technical issues involved in providing this information.

4. Regarding the Data Book for Medicaid, can you please provide level of care assessment and ADL information on data summaries?
A: In general, assessment data is not available for this population.

5. Please affirm that the Data Book released June 4, 2012, is synonymous with the Data Book released on June 20, 2012.
A: Yes, this is affirmed.

6. Are all costs associated with the demonstration population included in the Data Book? Specifically, are all waiver costs included?
A: The waiver populations are not eligible at this time to enroll in the Demonstration. Their costs, including waiver costs, have been excluded from the Data Book.

7. What are the major cost differences between the data presented on April 9, 2012, and the Data Book released on June 5, 2012?
A: The major differences between the April 9 presentation data and the Data Book released on June 5, 2012, are that the Data Book: 1) excludes Home and Community-Based Services (HCBS) waiver services and all other service costs for individuals in HCBS waivers; 2) excludes Targeted Case Management and Rehab option services provided by state agencies other than EOHHS; 3) excludes Part D cost data; and 4) was created independently from the April presentation, such that the rating categories in the Data Book differ from levels of care stratifications in the presentation.

N. FINANCIAL REQUIREMENTS

1. There is a request for projections. Should the financial projections include the projections on the Duals program, and if so, what assumptions should we be using?

A: For the financial projections requested in Section 9.7.E., it is acceptable to base them on current lines of business. Please see the RFR Amendment #1, Item 15, for changes to Section 9.7.E.

2. Medical loss ratio (MLR) definition – will care management and other payments to providers be involved?

A: MLR should include care management expenses and all Medicaid and Medicare payments.

3. The RFR asks for: "…projections using the pro-forma financial statement methodology," including the following:
"a. Quarterly balance sheets for the Respondent, using the GAAP Financial Report #1 Format
b. Quarterly projections of revenues and expenses for the legal entity, using GAAP Financial Report #2 Format
c. Quarterly cash flows, using GAAP Financial Report #3 format."
Can you provide templates for Report Formats #1, #2, #3?

A: EOHHS is developing reporting templates and will post them on Comm-PASS as soon as they are finalized.

4. Will the financial projections (3 years) have any impact on rate development or selecting ICOs?

A: All information the RFR requires Respondents to submit may be considered by EOHHS to determine whether to select the Respondent.

5. Section 5.8.C.2 states that Respondent must fund an Insolvency Reserve of 45 days. If we had $100 million in medical benefits expenses annually, such a reserve would be $14.5 million. Is this required, notwithstanding the fact that Respondent is DOI-licensed? This requirement appears to be stricter than DOI's requirements.

A: Yes, Respondents are required to fund an Insolvency Reserve of 45 days regardless of whether or not a Respondent is DOI-licensed.

6. The RFR states that an ICO must "Provide an independent auditor's report on the processing of the transactions using the American Institute of Certified Public Accountants (AICPA) Statement on Auditing Standards SAS 70 protocol and Chapter 647 of the Acts of 1989 (also known as the Internal Control Law)." Please confirm the State's audit form language. Will the State consider replacing the requirement for a SAS 70 audit, which is no longer industry standard, with an SSAE #16 audit instead? This is what most organizations now use, and updating the reference would serve the interest of financial efficiency and would ensure contractual consistency between the new Contract and existing State contracts.

A: EOHHS will accept an SSAE #16 audit in place of the SAS 70 protocol. See RFR Amendment #1, Item 11.

O. BUSINESS RESPONSE REQUIREMENTS

1. Can the ICO include provisions relating to Provider Preventable Conditions (PPCs) in its Provider Manual as opposed to its contract template if the contract template allows for adherence to requirements stated in the Provider Manual?

A: ICO contracts with providers must include the payment rules and reporting requirements for when a PPC occurs. However, it is permissible to include in the Provider Manual a list of the PPCs, which must be updated from time to time at the direction of EOHHS.

2. The RFR states: "The ICO shall ensure that its Enrollee and Provider web portal functions and phone-based functions are available to Enrollees and Providers 24 hours a day, seven days a week." Can you define "web portal"?

A: As used in the RFR, this term means the member- and provider-specific tabs, links, entrance or portal to an ICO's web page that an Enrollee or Provider may access to obtain member- and provider-specific information.

3. Regarding the requirement to provide assurance that no participants in the Respondent's application are contributing to other applications, what about subcontractors that may be involved in more than one?

A: Material Subcontractors may contract with one or more ICOs and contribute to more than one Respondent's response. Section 9.5.B. is intended to prohibit an entity that had worked on developing the RFR in any way from assisting with a response.

4. Section 9.6 requests a 15-page limit. Section 9.6 C requests that plans respond to the same question in Section 9.6.A, B, and C. Is it 15 pages total for the entire section or for each subsection (9.A, 9.B, and 9.C)?

A: The page limit for the complete response to Section 9.6 (which has three subsections – A, B and C) is 15 pages. Please note: Section 9.6.C.1 contains an incorrect cross-reference to "Section 9.6.A"; the correct cross-reference is to Section 9.7.A. Please see RFR Amendment #1, Item 14, correcting the cross-reference.

5. Regarding Section 9.6.A.8, if formulating a partnership, do the leadership positions identified in subsection 8 need to be exclusively from the Respondent's organization?

A: If one or more leadership positions identified in Section 9.6.A.8 are filled by a partner organization, please note this and explain throughout Section 9.6.A how the partnership is organized.

6. For Material Subcontractors in Section 9.4, 9.5 and 9.6: (1) are these Material Subcontractors the Respondent contracts with, or (2) Material Subcontractors for this demonstration, or (3) both?

A: As stated in RFR Amendment #1, Item 5, a Material Subcontractor is any entity to which the Contractor delegates the responsibility to meet all the requirements of any complete, enumerated subsection as allowed under the RFR or the Contract. A Respondent does not need to answer Sections 9.4, 9.5 or 9.6 for any of its subcontractors that are not performing as Material Subcontractors in the Demonstration.

7. For required state forms such as the standard contract, if you currently do not have a vendor code or vendor ID, do you leave such fields unpopulated or must we acquire said information, and if so, how?

A: Respondents may leave such fields unpopulated. Organizations that do not have a vendor code will be assigned one if they become ICOs.

8. Section 9.1 states that the "Consultant ICO Mandatory Submission Form" is required with the Business Response and that, "All of the referenced forms and certifications may be downloaded from the "Forms and Terms" tab for this solicitation on the Comm-PASS website." However, there is no document with that title on the "Forms and Terms" tab of the Comm-PASS website. Can MassHealth please advise where to obtain the "Consultant ICO Mandatory Submission Form"?

A: This form is now posted under the "Forms & Terms" tab on Comm-PASS for this solicitation. Its title on Comm-PASS is "Consultant Contractor Mandatory Submission Form."

9. For Section 9.6.A.7, can you clarify the bold text? "Submit an organizational chart of the Executive Management Staff of the Respondent organization and an **organizational chart of the Contract**, including functional titles and names of incumbent individuals." Does this mean that we should submit an organizational chart for personnel performing duties under the Contract to be awarded from this RFR? Would the State prefer a single integrated organizational chart for the Respondent and its material subcontractors, or are separate organizational charts (as appear to be called for in Section 9.6.C) acceptable?

A: Please see RFR Amendment #1, Item 13. Please submit separate organizational charts for the Respondent and its Material Subcontractors.

10. In Section 9.7, Financial Ability, there are references to General Accepted Accounting Principles (GAAP) Financial Report formats #1, #2, and #3. Does this simply mean the requested three financial statements must be developed in accordance with GAAP or are there specific, defined formats and templates that Respondents should use to submit their financial statements?

A: EOHHS is developing reporting templates and will post them on Comm-PASS as soon as they are finalized.

11. Section 9.10.A.4.b says: "The ICO is prohibited from sharing or publishing EOHHS data and information without prior written consent from EOHHS." Does this apply to Treatment, Payment and Operations (TPO) needs? Can Respondents share eligibility data with their own material subcontractors, providers, etc., as needed for TPO purposes?

A: ICOs must comply with all applicable state and federal requirements for using and disclosing personal information**.** ICOs should consult with their respective compliance and legal experts to ensure that the sharing of all information with providers and subcontractors complies with applicable law.

12. Section 9.7.E.1: Given that no payment information is yet available for this demonstration project, we interpret this section to refer to the Respondent's existing business. Is that an accurate determination?

A: Please see the RFR Amendment #1, Item 15, for changes to Section 9.7.E. It is appropriate to base the requested financial projections on current lines of business.

13. Per the RFR instructions, response documents are to be in Word 2003 format. Since the bulk of our attachments are not in Word, would it be okay to submit two files electronically each for the Business and Programmatic Responses? For example, for the Business Response, we would include the written response as one file in Word 2003, and then the Attachments in a separate file that would be in PDF format.

A: Yes, this approach is acceptable. The response documents (Programmatic and Business) that the Respondent is creating for the proposal must be provided in Word 2003 format. Documents that exist in some other form, such as financial statements (required in RFR Section 9.7.A) or samples of materials prepared by the Respondent for MassHealth populations

or other educational materials intended for broad distribution to Enrollees (required in RFR Section 10.11.G), do not need to be submitted as Word documents and may be submitted in .pdf format instead.

P. PROGRAMMATIC RESPONSE REQUIREMENTS

1. Should all references requested in Sections 10.3.A and 10.3.B be sent directly to EOHHS or included in the programmatic response?

A: References provided to comply with Section 10.3 of the RFR should sent by the reference directly to EOHHS.

2. Sections 10.4.C and 10.4.D ask for the names of providers. Will provider directory listings be counted in page limits?

A: No. Provider directories do not count toward the programmatic response page limit. Please provide the provider directories as a separate attachment to your RFR response.

3. Regarding Section 10.7.A-C, please provide clarity regarding whether or not this section is specific to Behavioral Health only.

A: Section 10.7.A-C is not specific to Behavioral Health only.

Q. OTHER

1. Could you please advise if CMS and MassHealth will facilitate one readiness review for the Capitated Financial Alignment Project OR will there be two readiness reviews (i.e., CMS and MassHealth)?

A: EOHHS anticipates that there will be a single, joint readiness review process conducted by CMS and EOHHS.