COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

Request for Responses from Integrated Care Organizations
RFR # 12CBEHSDUALSICORFR
Responses to Bidder Questions, Group 2 – August 3, 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.

A. GENERAL

1. In Section 1.4 Number of Contract Awards and ICO Service Areas, the RFR states that partial counties may be awarded. Will the partial county awards be split by geographic regions within a county? Or will some other segmentation be applied?
A: A partial county award would be based on the geographic area proposed by the Respondent. EOHHS will not make partial county awards for any Respondent that did not bid specifically for a partial county, nor will EOHHS award a county area that is different from that proposed by the Respondent.

2. Will the Contract be posted before the response due date?
A: The Contract will not be posted before the RFR response due date. After selection, CMS and EOHHS will provide the Contract for review to those Respondents selected for the Demonstration.

3. Will EOHHS be completing the required sections of the Standard Contract Form (for example Commonwealth Department Name, Procurement Type, Amendment Type, Compensations, etc.) prior to the RFR submission date? If not, do you anticipate the respondents will sign the form only partially completed?
A: Respondents need only fill in their contact information in the top left-hand box of the Standard Contract Form (SCF) and sign it, ensuring that they are informed of and agree to the terms of requirements prior to selection. When a Respondent is selected for contracting, EOHHS will provide a completed SCF for the Integrated Care Organization (ICO) to re-sign.

4. Is the EFT form required to be submitted with the RFR? It is included on the Comm-PASS site but not listed as a required form.
A: The EFT form does not need to be submitted with the RFR response; it was included with the RFR to ensure that all Respondents are aware that EFT will be required of all ICOs with which EOHHS contracts. If a Respondent already receives electronic payments from EOHHS, the Respondent may indicate that fact in its response.

5. Will an electronic version of the Certificate of Legal Existence suffice?
A: Yes.

6. Must an ICO staff to the exact roles defined in the RFR? For example, we have contemplated hiring Medical Directors and the RFR references a Chief Medical Officer.
A: An ICO's organizational structure and/or staff titles may differ from those referenced in the RFR, but all Respondents should have staff fulfilling the roles described in the RFR. If the titles or structure vary from those stated in the RFR, the Respondent should indicate how its approach aligns with the RFR requirements.

7. When will the Federally Required Disclosures Form be posted to Comm-PASS?
A: The form is now posted on Comm-PASS.

8. Section 8.1.A states that the response documents must be formatted to be compatible with Word 2003, not in pdf. Can scanned signature forms and attachments be submitted as pdf files?
A: Yes.

9. Section 8.1.D states that the response should be double sided, and Section 8.1.G states that the page limit for Section 10 is 125 pages. Does this mean 125 double-sided pages?
A: The page limit for Section 10 is 125 pages. A "page" is one side of a sheet of paper. Responses should be printed double-sided.

10. Section 8.4: Please clarify if respondents should submit one box with all business responses and a separate box with all programmatic responses OR if there should be five separate boxes with one set of business and programmatic responses in each box.
A: Respondents should submit two packages: one containing all copies of the Business Response, including attachments relevant to this section of the response, and one with all copies of the Programmatic Response, including attachments relevant to this section of the response. If the packages are too large to contain all copies, multiple packages can be used, but they should be clearly labeled stating which part of the response they contain.

B. ENROLLMENT

1. How and when will the ICO receive enrollment files?
A. The ICO will receive daily enrollments and disenrollments via the HIPAA-compliant Outbound 834 file. The ICO will also receive a monthly 834 file that will include all of the ICO's enrollees as of the date of the monthly 834 file.

2. Is there a required file layout for enrollment files?
A: The fields included on the 834 file are available in the Outbound 834 Companion Guide located on the MassHealth website.

3. Will all maintenance files include both new and existing enrollments?
A: The daily 834 will contain new enrollments, disenrollments, or any changes to an enrollee's demographics. The monthly 834 will show all members who were enrolled in the ICO for the month.

4. Will the member's Primary Care Physician (PCP) be included on the enrollment file passed to the ICO?
A: If a member chooses a PCP at the time of a voluntary enrollment, the PCP information will be sent to the ICO along with the enrollment information.

5. Is there a required enrollment file layout for what the ICO has to send to CMS?
A: EOHHS and CMS will work with the selected ICOs to clarify CMS interface processes and requirements.

6. Section 3.2 states: "Individuals in the State ages 21 through 64 at the time of enrollment who are eligible for MassHealth Standard or MassHealth CommonHealth and who are enrolled in Medicare Parts A and B and eligible for Medicare Part D, and are without other comprehensive public or private insurance…." Should the ICO alert EOHHS if it becomes aware of other insurance? If other insurance information is added to New MMIS after the member is enrolled with the ICO, will the member be automatically disenrolled?
A: Yes. The ICO must alert EOHHS if the ICO becomes aware that the member has other comprehensive insurance. In such a case, the member would no longer be eligible to participate in the Demonstration, and would therefore be disenrolled effective at the end of the month.

7. The RFR indicates the effective date for the product is April 1, 2013. When will individuals be able to choose to enroll? When will the ICO first be notified of enrollments?
A: EOHHS anticipates sending enrollment information to members in January, at which time members would be able to start making selections and MassHealth will be able to record them in our system. ICOs will be notified about enrollments as described in the answer to question B.1 above.

8. Section 3.3.A: How frequently can a member "opt out" and "opt in"? For example, could a member opt in and out every other month?
A: Members may opt-in or opt-out of the Demonstration, or enroll in or disenroll from an ICO, whether selected or Auto-assigned, at any time. Enrollment changes are effective on the first day of the following month.

9. Section 3.3.A: Please confirm that eligible members will be covered only for full month periods of coverage.
A: Enrollees will be covered for full month periods of coverage because enrollment changes are effective at the end of the month.

10. Section 3.3.A.2: Will ICOs be able to review this communication?
A: Yes.

11. Section 3.3.A.2: Will ICOs be able to review/contribute to the enrollment package?
A: Yes.

12. Are End Stage Renal Disease (ESRD) patients covered under this program? If they are, are they only covered for the waiting period required by Medicare? Will the ESRD members be removed from the ICO population after the Medicare waiting period has been fulfilled?
A: ESRD patients who otherwise meet the eligibility requirements for the Demonstration, including individuals with ESRD at the time of enrollment, are eligible to participate in the Demonstration. Enrollment rules for this population are no different than those for all other eligible individuals.

13. Section 3.3 states that members may opt out of the Demonstration or disenroll from an ICO, whether selected or auto-assigned, at any time, effective at the end of the month. How does an enrollee disenroll from or opt out of an ICO once enrolled? How is the disenrollment communicated to CMS?

A: All enrollment choices will be processed through the MassHealth Key Operations Services Vendor (MassHealth customer service) and communicated to CMS through an interface between MassHealth and CMS. For additional information, please see the answers to questions B.1 and B.5 above.

14. Will EOHHS provide total current/projected enrollment by county by Rating Category for the target population?

A: The Data Book provides information on the target population by county. EOHHS will not be providing enrollment projections.

15. Section 3.3: Will all enrollment information (enrollment, disenrollments, opt outs, etc.) for this product come from EOHHS? Will there be any enrollment information that ICOs will need to get directly from CMS and their systems? Are ICOs to provide information to CMS regarding moves out-of-area or changes in status (e.g. loss of Medicaid)? CMS also has a process for retroactive enrollments and disenrollments. Would this also be required in the Demonstration?

A. Please see the answer to question B.5 above.

16. Section 3.3 A.2 states that members will receive a packet from MassHealth which will "inform them of how to enroll." Is that process documented yet and if so can Respondents obtain a copy of it so we can understand the member process?

A. Members will receive an Enrollment Package consisting of a cover letter, an Enrollment Guide, an ICO Comparison Chart, a summary of benefits, and a list of helpful phone numbers. We anticipate that stakeholders including ICOs will have the opportunity to review and give input to enrollment materials.

C. SERVICES, CARE DELIVERY, AUTHORIZATIONS

1. Per Section 4.2 of the RFR, ICOs are responsible for covering services listed in Appendix C, Tables 1 through 4. However, per information received in Pre-RFR documents (All Covered Benefits and Suggested in Lieu Benefits), some of the services were required but others were could be covered. Are all the services listed in the Appendix C, Tables 1 – 4 considered part of the cap?

A: Yes.

2. Section 4.6.D.3.e: Does "psychiatric hospital" admission as used here include acute/crisis admissions or is this referring to long term stays?

A: In the context of this specific section related to the IL-LTSS Coordinator, the reference to an admission to a psychiatric hospital refers to long-term stays.

3. Section 4.6.B.3.b requires all members of the ICT to participate in approved training. Who administers the training and who develops the training?

A: ICOs are required to ensure that their providers are appropriately trained. As discussed in Section 5.6, EOHHS may also convene learning opportunities for ICO staff and providers, and ICOs must make available key ICO staff and contracted provider staff as appropriate to attend these learning opportunities.

4. Section 4.9.A.5.a Coverage Rules and Service Authorization states that Medical Necessity criteria must at a minimum "be developed with input from practicing physicians in ICOs service area." Does this mean the ICO needs to have an MA-licensed physician on our Provider Advisory Committee?
A. Yes, a local representative must be included as part of NCQA-required advisory committees.

5. Section 4.9.B.7 states that the turnaround time for an ICO to make a standard authorization decision is 14 calendar days. Section 5.1.B.1.a appears to indicate that an ICO must make the same decision within 72 hours. Which is the correct timeframe?
A: Please see RFR Amendment #2, Item 3.

6. Section 4.2.B states that Covered Services include "All MassHealth Standard Fee-For-Service services (including Long-Term Services and Supports (LTSS)), excluding ICF/MR services, targeted case management services, and rehabilitation option services purchased by DMH." Please clarify "rehabilitation option services purchased by DMH." The reference to Appendix C, Table 1 does not offer any clarification on what is meant by this.
A: Rehabilitation option services and Targeted Case Management services are purchased and provided by state agencies for certain individuals, and will continue to be purchased and provided by those agencies for those individuals. EOHHS will work with ICOs and the state agencies to coordinate services between them, and to clarify roles and responsibilities.

7. Section 4.2.E: Please provide clarification regarding "Dental Services." What services are included?
A: ICOs must cover all dental services as described in 130 CMR 420.421(E) for **all** Enrollees.

8. Appendix D, page 2: Please clarify the following definition regarding Care Transitions: "Telephonic or other follow-up with Enrollees within 48 hours of an inpatient encounter." Does this mean from discharge?
A: Please see RFR Amendment #2, Item 9.

9. Appendix C Covered Services: Please clarify what EOHHS means by Independent Nursing.
A: Independent Nursing is continuous skilled nursing (a nurse visit of more than two continuous hours of nursing services) by a provider who bills independently for such services.

10. ICOs are asked to appoint state agency liaisons. Will each state agency have regional representatives identified/available to help co-manage ICO members that may be in common?
A: EOHHS will identify the state agency representatives with whom each ICO state agency liaison will work.

D. PROVIDER NETWORKS

1. Section 4.5.F.4: Please provide guidance regarding when an ICO has to complete contracting and/or credentialing. The paragraph states that as part of the readiness review "prior to contracting" the ICO will have to demonstrate its proposed credentialing process. It does not state by which date either contracting or credentialing be completed. We would like clarification as to when contracting is required vs. full Network participation.
A: Contracting and credentialing must be completed by the time of signing the three-way Contract, which is anticipated to be December 15, 2012.

2. With regard to Personal Care Attendant (PCA) evaluations, ICOs must ensure that PCA evaluations are done in a timely manner to ensure appropriateness and continuity of services. Is it expected that all newly enrolled members shall receive a PCA evaluation?

A: The ICO must perform in-person comprehensive initial and ongoing assessments for each enrollee using an assessment tool approved by EOHHS. The comprehensive assessment will cover the domains listed in Section 4.7.B of the RFR. If, during the comprehensive assessment, it is determined that the enrollee requires physical assistance, cueing or monitoring to perform an Activity of Daily Living or Instrumental Activity of Daily Living, the ICO should complete a PCA evaluation.

3. How are ICOs expected to manage/audit the PCA evaluations through the Personal Care Management (PCM) Agency or can their staff conduct the evaluations?

A: The ICO may choose to use ICO staff to conduct the PCA evaluations. Alternatively, the ICO may contract with PCM Agencies under contract with EOHHS to perform the PCA evaluations. The ICO must comply with contract management specifications, including those within Section 5.9 of the RFR.

4. With regard to promoting Self-direction of PCA Services, ICOs must pay for services rendered by the PCA hired by the Enrollee if the PCA meets MassHealth requirements in 130 CMR 422.411(A)(1) and has completed the required FI paperwork. What are the MassHealth requirements; 130CMR 422.411(A)(1)?

A: 130 CMR 422.411(A)(1), within the personal care regulations at 130 CMR 422.000, states:

(A) MassHealth covers the following fiscal intermediary and PCA services:
(1) activity time specified in the evaluation described in 130 CMR 422.422(C) and (D), authorized by the MassHealth agency, and performed by a PCA who is:
(a) not a family member, as defined in 130 CMR 422.402;
(b) not the member's surrogate;
(c) not the member's foster parent;
(d) legally authorized to work in the United States;
(e) able to understand and carry out directions given by the member or the member's surrogate;
(f) willing to receive training and supervision in all PCA services from the member or the member's surrogate; and
(g) not receiving compensation from any other entity for that activity time except where such entity:
(i) is nonprofit;
(ii) does not receive funds from any state agency other than MassHealth; and
(iii) has a board of directors consisting of at least 51 percent members, family members, and/or siblings of members;

5. ICOs must establish and conduct an ongoing process for enrolling in their Provider Network any willing and qualified Provider that meets the ICO's requirements and with whom mutually acceptable Provider Contract terms, including with respect to rates, are reached. Do ICOs have any discretion or must the ICO extend a contract regardless of network need? For example, we have a robust network of durable medical equipment (DME) suppliers. Would an ICO need to contract with additional DME suppliers if they are willing to accept contract terms?

A: The purpose of this provision is to maximize the extent to which enrollees can continue to access providers with whom they have established relationships and who have experience serving the target population. It is not intended to require ICOs to unnecessarily expand their networks for services that do not affect continuity of care for their Enrollees.

6. Section 4.5.C: May the ICO limit provider participation due to quality and performance issues or failure to meet minimum network standards, either at the start of the contract or during the term of the contract?

A. Yes.

7. For Personal Care Attendant Services covered in the Demonstration, does the Fiscal Intermediary contract directly with the ICO or only with the PCM Agency?

A: The ICO must also contract directly with the Fiscal Intermediary(s). Each PCM Agency must select one Fiscal Intermediary; however, PCM Agencies do not contract directly with a Fiscal Intermediary. For each contract with a PCM Agency, the ICO should ensure it contracts directly with the selected Fiscal Intermediary of that PCM Agency.

8. In order to best meet the needs of dual eligible population covered in the Demonstration, do PCM Agencies have to maintain their current FI contract, or could they work with a different FI for the Demonstration?

A: Per MassHealth regulation (130 CMR 422.404(C)(1)), "…the personal care management agency must select one fiscal intermediary from the MassHealth agency list of approved fiscal intermediaries for all eligible MassHealth members that the personal care agency serves and notify the MassHealth agency in writing of the selection. Requests by personal care agencies to change fiscal intermediaries must be made in writing and approved by the MassHealth agency in accordance with 130 CMR 422.419(A)(17)(i)." A PCA consumer cannot change FIs in the middle of a calendar year because the IRS typically only recognizes one fiscal employer agent per employer per tax year.

9. Please provide clarity regarding the contracting timing (including contract amendments) with providers for the Demonstration. It would seem appropriate to finalize provider network contract terms once the ICO has agreed to the CMS, EOHHS, and ICO contract requirements. In order to accommodate that, is an acceptable deadline for having all provider contracts that need amending complete by the time of the execution of the CMS/EOHHS/ICO contract?

A: The expectation is that Demonstration plans will have executed agreements with their provider network during the readiness review. At that time, CMS will request a sample of executed signature pages based on the CMS application submission.

10. Do we need to have provider contract templates (outside of what has been submitted to CMS) approved by either CMS or EOHHS?

A: No.

E. PHARMACY

1. Section 4.2.C: Based on the information included in this section and previous information shared in the 6/5/12 Duals Initiative: Guidance for Pharmacy Coverage, could EOHHS confirm that OTC nicotine gum, OTC nicotine lozenges, and OTC nicotine patches are covered under the MassHealth OTC list?

A: Yes, OTC nicotine gum, OTC nicotine lozenges, and OTC nicotine patches are covered under the MassHealth OTC products list.

2. Section 4.2: Please provide a valid link to the Over the Counter drugs currently covered by MassHealth. The link, provided in the RFR appears to be invalid.

A: The MassHealth Drug List website is: https://masshealthdruglist.ehs.state.ma.us/MHDL/. On this page, you will find a link (updated periodically) to the Over the Counter product list.

3. Is there a continuity of care requirement for the enrollee's drug profile?

A: Demonstration plans will be required to follow all laws, regulations, and policies in place for Part D, including those related to continuity of care. ICOs should direct any questions on this issue to CMS at: MMCOcapsmodel@cms.hhs.gov.

4. Typically in a Medicare Part D environment, lowering the cost sharing for low income members beyond the already established levels set by CMS requires the plan to give up the federal low income cost sharing subsidy. This raises the plan sponsor's liability significantly since those dollars either need to be charged to the member as premium or paid for by the plan. Since EOHHS has suggested that carriers reduce the cost sharing for low income members, is it the State's intention to make up for the loss of the federal subsidy in some way? Will EOHHS and/or CMS be structuring the program in such a way that the low income cost sharing may be reduced from the standard copayments without forgoing the federal low income cost sharing subsidy? Will the standard Part D financing rules apply to this population and program? Can the plan pay for this expense out of administrative costs? Typically, Dual Special Needs Plans (SNPs) plans wanting to cover the generic benefit at $0 need to prepare the PBP as such and the Bid Pricing reflects lost CMS benefit subsidy revenue. CMS would not allow for the cost difference to be paid out of admin cost in a dual SNP. Are the current dual integration demo plans exempt from that requirement?

A: CMS is exploring whether it may be possible to allow plans to use administrative dollars to pay for these supplemental benefits. More information will be provided when and if available.

F. ENROLLEE RECORDS AND HEALTH INFORMATION EXCHANGE

1. Section 4.10.B.11: Please clarify what is meant by "disenrollment" and what would be included in a "disenrollment agreement".

A: The referenced use of the term "disenrollment" in Section 4.10.B.11 refers to disenrollment from the ICO. For an individual who has disenrolled from the ICO, the individual's Centralized Enrollee Record should capture evidence of the disenrollment and effective date, such as a copy of a disenrollment confirmation letter sent to the individual.

G. GRIEVANCES AND APPEALS

1. Are there required grievance categories, or may the ICO use the categories deemed by the required CMS reporting?

A. At a minimum, the ICOs must comply with CMS reporting requirements. EOHHS will provide further guidance regarding any additional categories.

2. Does the ICO notify EOHHS upon receipt of each grievance or through required reporting? If through required reporting, please indicate the frequency.

A. The reporting process will be defined for the selected ICOs.

3. Section 5.1.A.1 states that an Enrollee may file an internal grievance at any time with the ICO or its providers, by calling or writing to the ICO or Provider. What is the expectation for the ICO to monitor, track and resolve grievances submitted directly to the provider? Are these grievances to be accounted for in our required CMS reporting figures?

A. ICOs are responsible for tracking and reporting all grievances, including those that may be related directly to the care of a Provider, and/or are submitted to the Provider.

4. Section 5.1.B: For Enrollees that Appeal with the BOH and receive aid, does the plan receive aid to cover the services while the decision from the BOH is pending or does the Enrollee receive the aid and is responsible for paying the Provider?

A. As stated in Section 5.1.B.3, an Enrollee who chooses to appeal to the BOH may request aid pending appeal for services that have been prior authorized at the time of filing for the duration of the appeal process. "Aid pending appeal" means that the ICO must continue to provide previously authorized Covered Services to the Enrollee until the conclusion of the BOH appeal. The ICO is responsible for those costs under the prospective monthly global payment.

5. Section 5.1.B.2, Internal Appeals: Is this section referring to pre-services appeal or for post-service appeals?

A. It refers to both.

6. Section 5.1.B.3 states that the Demonstration will utilize a coordinated Appeals process that will ensure Enrollees have access to all Medicaid and Medicare Appeals processes. If on internal Appeal the ICO does not decide in the Enrollee's favor, the Enrollee may Appeal to either the CMS Independent Review Entity (IRE) or the MassHealth Board of Hearings (BOH), or both. Does the enrollee have a right to file an appeal directly to the IRE or BOH? If the enrollee appealed to both IRE and BOH, does ICO have to automatically forward external Appeals regarding Medicare services to the BOH?

A: For services that are provided by both MassHealth and Medicare, the enrollee may appeal to either or both the IRE and BOH; the ICO must, however, automatically forward those appeals to the IRE. For services that are not provided by Medicare (generally, LTSS and non-emergency medical transportation), the IRE will not adjudicate appeals. Members must appeal ICO decisions regarding those services to the BOH. The ICO will be required to provide members notice about how to file an appeal with the BOH.

7. Section 5.1.B.3 states that the ICO must automatically forward external Appeals regarding Medicare services to the CMS IRE. Will the IRE be MAXIMUS Federal Services or another vendor? Do we automatically forward upon our denial of an Appeal? Or if the case is misdirected to us?

A: The IRE will be CMS's vendor. The ICO must automatically forward the case to the IRE upon its internal appeal denial.

8. Section 5.1.B.3 states that an Enrollee may also request a hearing from the MassHealth BOH for an external Appeal regarding Medicare services. For Behavioral Health Diversionary Services, dental services and LTSS, an Enrollee may only appeal to the BOH. Will the ICO track Behavioral Health Diversionary Services, dental services and LTSS appeals?

A. ICOs will be required to track all appeals, including Behavioral Health Diversionary Services, dental services and LTSS appeals.

9. Section 5.1.B.3.b.3 states that whenever an Enrollee submits a written request for a BOH Appeal within 10 calendar days of the date of mailing of the ICO's internal Appeal decision, the ICO is responsible for the continued authorization or provision of any ongoing service in dispute during the pendency of a BOH Appeal. Will the BOH notify the ICO of receipt of all Appeals so that the ICO can continue to provide service?

A. Yes.

10. Section 5.1.B Enrollee Appeals: What is the resource and value of the aid being referenced: "Enrollees that pursue further Appeal to the MassHealth Board of Hearings will receive aid pending the BOH decision, upon their timely request." To whom must "timely request" be submitted and under what circumstances is a request determined to be timely?

A. The request for aid pending must be submitted to the BOH within required timeframes as specified in the RFR and/or the Contract.

11. Section 5.1.B.4.a: This section includes reference to Notice of Discharge and Medicare Appeal Rights (NODMAR). This form is no longer used by CMS. The form used is "Important Message" (see MMCG Chapter 13 Section 150.) Will this be amended so that successful bidders are not noncompliant by use of the form listed in this Section?"

A: EOHHS will clarify this with CMS.

H. OUTREACH, MARKETING, AND CUSTOMER SERVICE

1. Section 5.3: When is Marketing Material due to CMS for review?

A. The due date for marketing materials is to be determined.

2. Will all CMS's Medicare Managed Care Manual Chapter 3: Medicare Marketing Guidelines be enforced under the Demonstration?

A: CMS and EOHHS seek to establish a flexible approach to both minimum marketing requirements and review processes as part of their memorandum of understanding (MOU). This approach will include a consistent set of required beneficiary information, and we expect that the Demonstration standards will defer to whichever standard – CMS' or the State's – is most beneficiary friendly. MOU development is ongoing and will shape final marketing requirements for Financial Alignment Demonstration contracts in each State, though we do expect that marketing requirements under the Demonstration will be at least as stringent as for Medicare Advantage and Part D plans under the Medicare Marketing Guidelines.

3. Under CMS's Medicare Managed Care Manual Chapter 3: Medicare Advantage Guidelines, marketing by physicians, pharmacies, or other providers for one or a subset of plans is generally prohibited. In general, if providers choose to market plans, they must market all plans with which they hold contracts. Given the circumstances of provider engagement (especially the requirement to essentially contract with "any willing provider"), provider marketing of select plans may not be realistic to operationalize in accordance with the aforementioned CMS provider marketing rules. What is permitted for provider marketing under the Demonstration?

A: Please see the answer to question H.2.

4. Section 5.3.A.4.d: Can the ICO make its provider directory available exclusively on its website, provided it notifies enrollees in writing that it is available on the web and provides a printed version upon request?

A. Yes.

5. The RFR requires very little in terms of describing marketing and communication to the Duals audience. Does this presume that the state defaults to CMS' guidelines?
A. Yes, unless those requirements are specifically waived.

6. Section 5.2.E. states: "With Enrollee consent, [the ICO shall] assist Enrollees in providing MassHealth with their current address (residential and mailing), phone numbers and other demographic information including pregnancy, ethnicity, and race, by entering the updated demographic information into the change form via the My Account Page [(MAP)] Application on the Virtual Gateway…." Currently our organization has Read Only access in MAP. Will ICOs have the ability to make changes in MAP?
A. ICOs will be given the ability to make changes in MAP.

7. Section 5.2.E.1 states: "If the ICO learns from an Enrollee or an Eligibility Representative, orally or in writing, that the Enrollee's address or phone number has changed, or if the ICO obtains demographic information from the Enrollee or the Enrollee's Eligibility Representative, the ICO shall provide such information to EOHHS...." What other information exchange process will be used? Some members are not found in MAP.
A. An alternate process will be determined at a later date.

8. Section 5.3.A.4.d.4: Regarding the requirement to "[p]rovide written notice to Enrollees of any changes in the Network Provider directory at least 30 days before the intended effective date of the change or as soon as the ICO becomes aware of such change," please clarify if the intent is to notify all Enrollees of all changes. Many changes to the network may only impact a few members and this could result in many notifications that may not be relevant to a particular Enrollee. In addition, there is a requirement to notify Enrollee of changes that impact their particular PCP or specialist.
A. It is acceptable to target written notice about changes in the Network Provider directory to affected enrollees, and to ensure wider notice in other media available to all enrollees.

9. Section 10.11.H requires the ICO to have 24/7 enrollee on-call response capabilities. Section 5.2.B.1 requires the ICO to have an enrollees service telephone line 9 hours/day. Can you tell us which standard is applicable?
A: Section 5.2.B.1 relates to requirements for general ICO customer service. The requirement referenced in Section 10.11.H specifically regards access for urgent or emergency medical care or supports and relates to the Nurse Advice Line requirement described in Section 5.2.D.

10. Do provider communications need to be sent to CMS and the state for review?
A. Unless otherwise required in the RFR or Contract, provider communications do not need to be reviewed by EOHHS and CMS.

11. Is EOHHS requiring the use of TTY, or rather requiring that the respondent has the capability to assist disabled individuals and would therefore allow other systems similar to TTY?
A. Yes, the use of similar systems is allowed.

I. QUALITY

1. Section 5.7 Quality Monitoring specifies a number of HEDIS and CAHPS measures. Given that enrollment will not begin until April 2013, a threshold of 1,000 members must be reached before there is statistical accuracy, and the selected measures all have a continuous enrollment requirement of 12 months, when do you anticipate the first year of HEDIS and CAHPS reporting?

A: ICOs will be required to collect quality measurement data from the point of the first enrollment of dual eligible members, April 2013, through the end of calendar year 2013 for a partial measurement year. ICOs will aggregate this data in spring 2014 and report it to EOHHS in June 2014. Starting in calendar year 2014, ICOs will gather all quality measurement data for the full measurement year, collect the data in spring 2015 and report in June 2015. In other words, the usual quality reporting cycle for 2014 and thereafter will apply.

J. ASSESSMENT

1. Please provide clarity regarding the expectations of CMS for a Health Risk Assessment and the State's expectation for an initial assessment (i.e., MDS-HC, and the initial assessment). Are there three assessments being required (i.e. HRA, MDS-HC, and initial assessment) OR can these be collated into one document?

A: The ICOs are required to complete an initial assessment using the MDS-HC, as described in the RFR. The key purpose of that initial assessment is for rating category determination. For care planning purposes, ICOs are required to comprehensively assess their Enrollees' needs, per Section 4.6.C. of the RFR, using an assessment tool that includes the domains listed in that section. The Respondent will submit its draft assessment tool with their response to the RFR. The final tools will be determined and agreed to by EOHHS, CMS, and the ICO as part of the readiness review/contracting process. Approved tools for the comprehensive assessment will satisfy CMS's Model of Care requirement for a Health Risk Assessment.

2. Section 4.7 Assessments and Individualized Care Plan and Section 7.2 Rating Categories: For F1 (Facility-based Care), do ICOs need to produce the facilities' MDS or will the state agencies which collect these be able to make these available to EOHHS?

A: The F1 rating category determination is not based on an assessment by the ICO (see question K.4 for additional information).

3. Is consideration being given to requiring plans to use a standardized assessment tool to capture some of these additional domains needed for this population in addition to the MDSHC?

A: EOHHS will have further discussion with the selected ICOs on this issue.

4. Section 4.7.A.1 states: "Initial assessments must be completed in-person within 90 days of enrollment for all new Enrollees and recorded in the Centralized Enrollee Record (see Section 4.10). ICOs must send certain assessment information completed by a Registered Nurse to MassHealth via MDS-HC application in the Commonwealth's Virtual Gateway to ensure accurate assignment of Rating Categories (see Section 7.2)." Will the assignment and effective date of the rating category be retroactive to the date of enrollment? Will access to the MDS-HC system be made available to staff that are not clinical staff for the purpose of researching enrollees' assigned rating categories?

A: The rating category will become effective on the date the assessment is entered into the MDS-HC application. Access to the MDS-HC system may be made available to non clinical staff.

K. PAYMENT

1. Section 7.6: What are the quality objectives that must be met to receive back the withhold, and when will settlements take place?
A: These objectives and details will be defined in the Contract.

2. Risk Mitigation Strategies: Please indicate whether the Medicaid High-Cost Risk Pool will be based on the aggregate expenditures, or on an enrollee basis.
A: For rating categories F1 and C3, the High-Cost Risk Pool (HCRP) process will be based on individual enrollees exceeding the defined cost threshold. The pool will be redistributed to plans based on their high-cost member expenditures that are over the threshold as a percentage of all high-cost member expenditures that are over the threshold. HCRP reconciliations will occur after each Demonstration year when sufficient run-out is available to determine which members have exceeded the cost thresholds and by what amounts.

3. Section 7.2, F1 – Facility-based Care includes individuals identified by MassHealth as having a long-term facility stay of more than 90 days. Will there be different levels for members in the F1 rating categories? If so, will the levels be determined by the Score/MMQ data in the MMIS system? Will a Long Term care segment be needed in the MMIS system for accurate payment to be generated?
A: There will only be one F1 rating category. Members eligible for this rating category will be identified from the MassHealth MMIS system.

4. Must the ICO produce the information necessary for an F1 (Facility-based Care) rating category determination to be made, or, will EOHHS use information from another source?
A: If a member in the Duals Demonstration is in a long term facility and has been there for more than 90 days, MassHealth will place that member in the F1 rating category based on information from the MassHealth MMIS system.

5. Section 7.2: Will there be a different and separate capitated rate for C1 (Community Tier 1) and C2 (Community Tier 2) rating categories?
A: Yes.

6. Section 7.3: How will administration costs be determined? Will care management be part of the medical costs or administrative costs?
A: While Demonstration plans will not be subject to a medical loss ratio requirement, Demonstration plans will report medical costs, administrative costs, and gain/loss. CMS will provide future guidance regarding how various costs, including care management, are to be categorized.

7. Section 5.2.E: How will you report to plans about rating category changes?
A: Rating category changes will be reflected on the 834 transaction.

8. What impact does EOHHS envision the high-risk pool will have on the ICO's need for re-insurance for members in the covered rating categories?
A: The HCRP should not be viewed as a replacement for reinsurance.

9. In January 2012, the Medicare inpatient and outpatient rates for Medicare Advantage plans in Massachusetts increased significantly. The Affordable Care Act (ACA) included a provision for the calculation of the Rural Floor through a national adjustment based on the wage index of rural hospitals; Nantucket Hospital was designated as a rural hospital. Massachusetts Medicare payments were then based off the wage index for Nantucket Hospital. Massachusetts had the most significant increase in rates across the US, ranging from 8% to 22% depending on the hospital's SMSA. There is, however, no concomitant increase in the form of Medicare payments to account for this significant increase in costs. If Medicare rates for the ICO are determined using the same methodology as the Medicare Advantage plans, Massachusetts will start off at a significant disadvantage given the new rural floor rates. Will the Medicare rates be calculated differently than for Medicare Advantage Plans?

A: CMS will develop payment rates for Medicare A and B services using baseline estimates of what Medicare would have spent on behalf of the beneficiaries absent the Demonstration. To the extent that beneficiaries are coming into the Demonstration from both the Medicare FFS and Medicare Advantage programs, the Medicare A/B baseline spending will include both FFS and Medicare Advantage spending assumptions. For beneficiaries coming from Medicare Advantage, the baseline will be calculated using plan-specific assumptions regarding bids, quality bonus payment-adjusted benchmarks, and rebate amounts for each county. For beneficiaries coming from FFS, CMS will use standardized county FFS rates. These standardized county FFS rates reflect projected national per capita FFS costs, adjusted to reflect the historic relationship between the county's fee-for-services per capita costs and the national average FFS per capita cost. For the 2013 payment year, this geographic adjustment is based on the relationship of each county's spending to national spending for the period 2006-2010. CMS is currently exploring the possibility, for future payment years (i.e., for 2014 and later years), to calculate FFS rates that reflect policy and reimbursement changes that are not included in the historic data.

10. How often are the risk scores updated in Medicare A/B and D?

A: It is anticipated, for the Demonstration plans as for other Medicare Advantage plans, that the 2013 risk scores will be updated twice -- once during 2013 and again after the payment year has ended (2013 will be finalized in August 2014) to account for additional run-out.

11. Please discuss how crossover claims will be priced given that currently facility providers collect much of the Medicare A/B cost sharing through bad debt reimbursement which will not be available to them if members are in managed care.

A: CMS will be providing more information on how supplemental payments, including bad debt, will be treated under the Demonstration.

L. DATA

1. Data Book Clarification: We assume that in the Data Book that Community-based Flexible Supports (CBFS) expenses are taken out. However, are other Medicaid expenses that are part of the DMH budget included, and particularly funds for housing?

A: CBFS services are purchased directly by DMH, including rehabilitation option services. These costs are not included in the Data Book and are not part of the ICO capitation payment. Housing costs paid by DMH are also not included in the Data Book and are not part of the ICO capitation payment.

2. Data Book – Medicare AB & Medicaid. According to the documentation, the data excludes individuals enrolled in any Medicaid Waiver programs and ICF/MR. Approximately how

many dually eligible individuals (on the average) are excluded? Do these exclusions account for approximately $8M in spending?

A: Based on CY 2010 data, approximately 7500 dually eligible members have been excluded due to enrollment in a HCBS waiver or residence in an ICF-MR.

3. Data Book – Medicare AB & Medicaid. The number of unique Crossover utilizers is different from the Medicare number. Is there any information about the overall number of unique utilizers for each service that has both Medicare and Crossover spending? How would the state recommend estimating the number of utilizers per service regardless of its payment source?

A: Cross-over claims only reflect Medicare services for which MassHealth cost sharing assistance was paid. Medicare claims should be used to estimate the number of utilizers per Medicare service.

4. Data Book, Part C. Definition of a C3 member. Data book states: "C3 are members with the first 3 member months and costs of a facility stay lasting at least 3 months OR all member months and costs not included in F1, of an LTSS episode lasting at least there months, where episodes are consecutive months in which the member is in a facility or using more than $500 in community based LTSS." To qualify for C3, what is the time frame for the $500 in community based LTSS? Over 3 months, 12 months, etc.?

A: In the Data Book, each member month was evaluated separately. If a month included more than $500 in community LTSS spending for a member, or the member was in a facility, that month was considered a high LTSS month. Three or more consecutive high LTSS months constituted a qualifying C3 episode for a member.

5. Data Book: Please provide additional historical data and information related to the pharmacy component of the program. Ideally, the data provided would be illustrated using 11-digit NDC codes as opposed to 9-digit codes. Also, the data should be segmented by rate code to identify the historical costs into the various population categories. Finally, cost information (average wholesale price, ingredient cost, dispensing fees, etc.) is being requested to supplement the previously provided pharmacy data.

A: EOHHS expects to provide 11-digit NDC codes soon. EOHHS will not be able to provide Part D cost information.

M. FINANCIAL REQUIREMENTS

1. Appendix F: What is the definition of “Contract loans”?

A: Please see RFR Amendment #2, Item 10.

2. Section 11.4.A.11 Non-qualifying Proposals: One of the criteria for rejection of Response is: Fails to demonstrate to EOHHS’s satisfaction that it, and all Material Subcontractors, are in sound financial condition; The RFR does not ask for Material Subcontractor financials – only proof of certificate of insurance. How can we demonstrate if this is not being asked?

A: EOHHS intended to ask for financial information on Material Subcontractors in Section 9.6.C.1, but this section contained a typographical error cross-referencing the wrong section of the RFR. Please see the RFR Amendment #1, Item 14 that corrects the cross-reference; consequently, Section 9.6.C.1 now requires Respondents to provide relevant financial information on their Material Subcontractors.

3. We received a deficiency notice about not having a completed State Certification form, and also a deficiency for not having an executed copy of a State licensing certificate. These deficiencies must be addressed by June 22. Does MassHealth have any guidance?

A: EOHHS will use the financial information that plans submit in their RFR response to determine whether they meet solvency standards. From that information, EOHHS will complete the necessary documentation to satisfy both the licensing certificate and state certification requirements. EOHHS will send those forms to both the Respondent and CMS. Until that occurs, the application will continue to generate a deficiency notice. This area of deficiency will not affect CMS's processing of the application. State certification will be resolved for all selected plans prior to executing the three-way contract.

N. BUSINESS RESPONSE REQUIREMENTS

1. Section 9.5.C: Please clarify that this subsection applies only to a parent, subsidiary, affiliate, or Material Subcontractor of the Respondent, and not to officers, employees, agents, consultants and or subcontractors of those entities.

A: That is correct. Section 9.5.C. applies to the Respondent and any parent, subsidiary, affiliate, or Material Subcontractor of the Respondent.

2. Section 9.6: In Section 9.6 related to the material subcontractors are attachments included in the limit to 15 pages?

A: No. Attachments responsive to Section 9.6 (i.e., résumés, job descriptions, organizational charts, references) are excluded from the page limitation for both the Respondent and its Material Subcontractors.

3. Section 9.7.E.1: For projection purposes, will contract years run from April 1 through March 31 or Jan 1 thru Dec 31?

A: Please see Amendment #2, Item 1.

4. Section 9.1: Prompt Pay Discount Form. We currently do not have a Vendor Code (VCUST). As such. please provide guidance on how the Prompt Payment Discount Form should be completed?

A: The vendor code field may be left unpopulated.

5. Section 9.4.B.1 Compliance with Contracts: Please confirm the timeframe for sanctions is three years – the same timeframe requested for Section 9.4.A.

A: Please see the RFR Amendment #2, Item 3.

6. Sections 9.6.A.7 and 9.6.B.5: Please clarify the difference between these two organization charts.

A: The chart requested in Section 9.6.A.7 should give an executive-level overview of the Respondent organization and those individuals responsible for the Contract. The chart requested in Section 9.6.B.5. should focus more specifically on key personnel that will be involved in the Demonstration line of business, including executives, operational leadership, and staff accountable for the ICO requirements.

7. Section 9.6.B Key Personnel and Staffing: Is there a listing of designated key personnel? If not, will EOHHS be providing this information?

A: The Respondent has discretion to define key personnel.

8. In Section 9.10.A.1.b, what does EOHHS mean by "HTS"?
A: HealthCare Transactions Services (HTS) is an alternate web-based method for exchanging member information securely.

9. Section 9.10.A.1.a.2 uses the phrase, "The User Experience and Style Guide Version 2.0." Should the RFR say: "The User Experience and Style Guide Version 3.0"?
A: Yes. Please see RFR Amendment #2, Item 5.

10. Section 9.10.A.1.a.3 uses the phrase, "Information Technology Architecture Version 2.0." Where we can find this document?
A: The Information Technology Architecture document and other documents referenced in this section of the RFR are posted at http://www.mass.gov/eohhs/gov/commissions-and-initiatives/enterprise-technology-standards-documentation.html.

11. Section 9.10.A.2.c – Regarding the items listed under (1) and (2), can EOHHS provide us – or point us to on the EOHHS site – more details on the business functions that these file interfaces are meant to support? For example, what is – and what is the intended use – of an "Inbound Co-pay Data File (daily)"?
A: EOHHS will provide the selected ICOs with specification documents for all of the appropriate file interfaces.

12. Section 9.1: The Respondent must complete a section on the Standard Contract Form and must complete the Prompt Payment Discount Form specifying what discounts the Respondent will grant the Commonwealth for receiving early payment from the Commonwealth. Are we required to provide a percentage or can we show zero percent?
A: Respondents may indicate zero percent.

13. Section 9.12 Onsite Readiness Review. This section does not appear to need a response in the RFR. Is that correct? If so, is it appropriate to put NA for this section?
A: No response is needed for Section 9.12.

14. Regarding Section 9.8.D.1.b, will capitation payments to the ICO continue for the 45 day period in question?
A: ICOs will be paid for whatever period of time services are provided by them.

15. Section 9.3.B states that Respondents need to provide: "the business address, telephone number, and business hours of any site(s) other than the Respondent's principal place of business that will be used for directing or administering the Covered Services to be provided under the Contract." Does EOHHS only want the Respondent's site(s) that fit the criteria, or does EOHHS also want the Respondent to include the site(s) of subcontractors providing services, (such as vision or dental). Additionally, we interpreted the question to mean only the sites where management of the contract should be listed and a very lengthy listing of clinics, practitioners, etc. is not required. Is this correct?
A: For Section 9.3.B, please provide both the Respondent's site(s) and any Material Subcontractor's site(s) that fit the specified criteria. Only sites that will be used for management purposes should be included; a listing of delivery sites (i.e. providers, clinics, etc.) is not required.

16. Section 9.4.B.1 asks if the Respondent, parent, subsidiary, affiliate or Material Subcontractor "has ever had a contract terminated or not renewed for poor performance or non-performance." Is the term "contract" in this section limited to contracts with government agencies, or does it include contracts with any other party?
A: Please respond with respect to contracts with any party.

17. Section 9.7.A asks for three years of certified audited financial statements; our organization is a new entity and as such would not have the majority of the required documents. Are we able to provide documents from the parent companies?
A: Yes.

18. Regarding the requirement to obtain a certificate of good standing form the MA Department of Revenue, if you are a 501C 3 organization exempt from taxes, that files PC-1 form to Attorney General's office, what are we to do?
A: Massachusetts entities withholding payroll taxes (even if exempt from taxes) are able to obtain a Certificate of Good Standing. Instructions for applying for a Certificate of Good Standing online (preferred) or via paper application are located here: http://www.mass.gov/dor/businesses/programs-and-services/certificate-of-good-standing.html. If your organization is unable to apply online because it does not use WebFile, please follow the instructions on the webpage for completing a paper application and write "State Bid" across the top of the application.

O. PROGRAMMATIC RESPONSE REQUIREMENTS

1. Section 10.7.A.1 requests Medical Necessity guidelines, program specifications and service components for Behavioral Health services. This information will total almost 125 pages. Can we submit this information in a separate appendix?
A: In response to Section 10.7.A.1, please provide a high-level description of these elements so that EOHHS can understand your overall approach to authorizing and managing utilization of behavioral health services. EOHHS will request submission of any additional details needed during the readiness review period.

2. Section 10.10.A.3 asks Respondents to: "Propose a performance measure focused on service integration across acute and LTSS. Include in the proposal the metric, the specifications, how the respondent will establish the baseline and the improvement target used to measure success;" Please clarify the above definition of "acute". Does this refer to acute inpatient medical admissions, acute BH admissions or both?
A: Please refer to RFR Amendment #2, Item 6.

3. Section 10.2.C states: "The Respondent shall describe its experience and that of any Material Subcontractor in serving adults with disabilities, including those who are eligible for Medicaid or Medicare or dually eligible." Should organizations talk about SCO experience, or does this refer only to experience with adults under 65?
A: The Respondent should describe any and all experience that it determines relevant.

4. Section 10.5.E.10 requires Respondents to describe how they "will ensure that IL-LTSS Coordinators are present at every initial assessment and available on an ongoing basis as needed." However, in some cases, members might not have existing relationships with LTSS coordinators at the time of the initial assessment. Additionally, initial assessments are required to be conducted in person by a registered nurse. This means that at least three different people (and possibly more if the member wishes a family member/caregiver in

attendance) must be present (the member, the LTSS coordinator, and the RN). Especially during the initial roll-out of the program this requirement (especially if the member is not currently involved with an IL-LTSS) has the potential to delay the assessment of the member's needs and therefore delay the formulation of the ICP. Would the State consider relaxing the requirement for an IL-LTSS Coordinator to be present, and accept a solution whereby the ICO offers all members the opportunity for a face-to-face meeting with an RN and an IL-LTSS Coordinator but allows the assessment to proceed if the member is not currently involved with an IL-LTSS Coordinator or agrees to complete the assessment without the coordinator if it would inhibit the timely completion of the initial assessment?

A: The initial MDS-HC assessment does not have to include the IL-LTSS Coordinator. The IL-LTSS Coordinator must be included in the comprehensive assessment.

5. Section 10.11.B: Please confirm whether the required customer service hours for this program will be 8:00 AM to 5:00 PM Eastern time, as required in Section 10.11.B.5 of the RFR, or 8:00 AM to 8:00 PM, as required by CMS?

A: Customer service hours for this program will be 8:00AM to 8:00PM as required by CMS (see 80.1 of the Medicare Marketing Guidelines: https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/index.html). Please see RFR Amendment #2, Item 7.

6. Section 10.11.B.7: Please confirm that "for providers including procedures for verifying enrollment" should be deleted from Section 10.11.B.7, and that section should read, "After-hours procedures and services: [delete: for providers including procedures for verifying enrollment:]

A: Please see RFR Amendment #2, Item 8.

7. Section 10.11.H: Please clarify whether elements 1-4 should describe the Respondent's after-hours capabilities or should apply when the customer care center is open?

A: Section 10.11.H.1-4 apply to Subsection "H" only.

8. Section 10.1: Please clarify the requirements for submitting "a detailed map (with a scale) of the complete list of counties or partial counties that will comprise the ICO Service Area, clearly showing the boundaries, main traffic arteries, and any geographical features such as mountains and rivers," including the locations of "hospital providers, home and community-based [LTSS] providers, nursing facilities and primary care practices within the Service Area." Does EOHHS only want to see differences from what was submitted to CMS (including all LTSS providers that may not have been required for CMS application?).

A: Respondents should include the service area and provider information requested, not limited to differences from what was submitted to CMS. The Respondent should highlight any difference between the service area being proposed in the response and the service area proposed in the CMS application.

9. Section 10.2.C: Will EOHHS allow the Respondent to use the experience of our parent company and affiliate health plans in response to this question?

A: Respondents should answer the question in light of the most relevant experience they have.

10. Section 10.1 requests that the ICO include "a detailed map… clearly showing the boundaries, main traffic arteries, and any geographic features such as mountains and rivers...." Standard mapping software is available to address typical geographic features, but mountains are not easily overlaid onto a network and are not part of traditional geomapping software. Does EOHHS have any suggested resources for this process or

would EOHHS consider eliminating the requirement for mountains for a response to this section?

A: EOHHS will accept a map that excludes mountains.

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11. There is a 125 page limit for Section 10. Are Respondents required to include the entire question and response or can the question be truncated to allow space for a more complete response.

A: It is not necessary for the Respondent to include the text of the question in the response.

P. OTHER

1. Training is discussed throughout the RFR in many capacities. For provider training, a recommendation may be to have standardized training programs available for things like ADA compliance, disability training, Patient centered care training etc. Is this something EOHHS is considering?

A: Please see Section 5.6 of the RFF. EOHHS expects to convene learning opportunities for ICO staff and providers on a variety of topics.

2. Section 5.9.A – Hold Harmless Language. Our interpretation would be that plan needs at a minimum to amend templates to include this exact language. Do we need to go back and amend existing contracts? Is it expected that this exact language would be used or will the current hold harmless language already present in ICO contracts suffice?

A: All contracts that an ICO uses to support the delivery of and payment for services to ICO enrollees must include the language set forth in Section 5.9.A. of the RFR without modification.

3. How should Respondents inform EOHHS of future vendors or Material Subcontractors that will not be identified by the RFR response submission date?

A: A process for this will be defined during the readiness review period.

4. Section 5.2.E.1 starts with the phrase, “If the ICO learns from an Enrollee or an Eligibility Representative….” How does ICO identify an Eligibility Representative?

A: Eligibility Representatives and any other persons identified by the enrollee to represent the enrollee must be captured in the Centralized Enrollee Record.