State of Oklahoma

Amendment of Solicitation

Date of Issuance: February 17, 2017 **Solicitation No.** 8070000933

Requisition No. 8070000933 **Amendment No.** 7

Hour and date specified for receipt of offers is changed: ☐ No ☒ Yes, to: March 1, 2017 12:00 pm CST

Pursuant to OAC 260:115-7-30(d), this document shall serve as official notice of amendment to the solicitation identified above. Such notice is being provided to all suppliers to which the original solicitation was sent.

Suppliers submitting bids or quotations shall acknowledge receipt of this solicitation amendment prior to the hour and date specified in the solicitation as follows:

(1) Sign and return a copy of this amendment with the solicitation response being submitted; or,

(2) If the supplier has already submitted a response, this acknowledgement must be signed and returned prior to the solicitation deadline. All amendment acknowledgements submitted separately shall have the solicitation number and bid opening date printed clearly on the front of the envelope.

ISSUED BY and RETURN TO:

U.S. Postal Delivery:
Oklahoma Health Care Authority
4345 North Lincoln Boulevard
Oklahoma City, Oklahoma 73105
or
Personal or Common Carrier Delivery:
Oklahoma Health Care Authority
4345 North Lincoln Boulevard
Oklahoma City, Oklahoma 73105

Sheila Killingsworth
Contracting Officer

405 - 522 - 7846
Phone Number

sheila.killingsworth@okhca.org
E-Mail Address

Description of Amendment:

a. This is to incorporate the following:

Amendment Seven to include the following:

First batch of Answers from Round Two Questions.

Second batch of Answers from Round Two Questions will post early next week.

RFP receipt of offers is changed to Wednesday, March 1, 2017, 12:00 noon Central Standard Time.

b. All other terms and conditions remain unchanged.

Supplier Company Name (**PRINT**) ______________________ Date ______________________

Authorized Representative Name (**PRINT**) ______________________ Title ______________________ Authorized Representative Signature ______________________

Solicitation No. 8070000933
Questions and Answers

Question Number	Section or Subsection Number	Section or Subsection Title	Solicitation Page	Question	Response
1	1.2	Solicitation information	9	How are individual's [sic] with disabilities involved in evaluating the bids that are submitted for the RFP?	Disabilities are not considered when selecting members of the evaluation team.
2	3.2	Letter of Intent	281	Is the Letter of Intent a prerequisite to bidding on the RFP for the SoonerHealth+ contract?	No, the Non-binding Letter of Intent is not a pre-requisite to bidding on the RFP. As noted in Solicitation 8070000933 RFP, Section 3.2, "Submission of a letter will guarantee receipt of communications regarding the procurement."
3	3.4	Actuarial Bidder's Conference	281	We understand the actuarial bidder's conference will take place on February 1, 2017, at 1 pm per section 1.3, Solicitation Timeline. Please provide the address for the OHCA office where the bidder's conference will take place?	As noted on page 282 of the SoonerHealth + RFP, 3.4 Actuarial Bidders' Conference, the conference was held at the OHCA offices. The Actuarial Bidder's Conference took place Wednesday, February 1, 2017, 1:00 p.m.-3:00 p.m., at the Oklahoma Health Care Authority, 4345 North Lincoln Boulevard, Oklahoma City, Oklahoma 73105. Attendees were to bring their own copies of the Data Book and Capitation Rate Sheets.
4	3.4	Actuarial Bidder's Conference	281	Will there be a phone number or webinar access to the [Actuarial] Bidder's Conference?	The Actuarial Bidders' Conference was open to the public, but did not include a webinar or conference call access.
5	3.4	Actuarial Bidder's Conference	281	Is this conference open to any attendees or is it restricted to bidders of the RFP?	The Actuarial Bidders' Conference was open to the public.
6	1.2.8, 2.1.17, 3.1.5, 3.5.3	Public Records	14, 29, 281, 283	Will the letters of intent be made public?	As noted in the RFP, Section 1.2.8, "Documents and information a Bidder submits as part of or in connection with a solicitation are public records and subject to disclosure, unless otherwise specified in applicable law." Items submitted as a part of the RFP process become public record only upon award of the RFP. Also noted in the RFP, Section 2.1.17, "The OHCA shall allow for the inspection of public records in accordance with the provisions of the Oklahoma Open Records Act, 51 O.S. SS 24A.1 – 29."

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7	2.1.7	Contract Term	20	While we have every intention of serving the SoonerHealth+ program throughout the term of the contract and any applicable renewals, the preliminary nature of the rates creates uncertainty about whether they will be operationally viable, especially long-term. Please confirm that the four annual renewal options are subject to mutual agreement of the parties, such that if the initial rates or any subsequent rate modifications are not viable, Contractors will be permitted to decline the OHCA's invitation to renew, without being held in default or forfeiting any of their performance bond.	Annual renewal options are subject to mutual agreement of the parties. However, in the event that a Contractor rejects a renewal offer, the OHCA retains the right to apply performance bond dollars toward settlement of any sanctions or penalties owed to the State. The OHCA also retains the right to apply performance bond dollars toward any additional costs incurred in re-procuring health plan services resulting from the non-renewal.
8	2.10.9.5	Rebates and Financial Reports	152	In the model contract section listed, OHCA will accrue Pharmacy rebates. In Mercer's presentation during the bidders conference (slide 25) says that MCOs will receive these rebates. Can OHCA clarify?	The OHCA has made the determination that all pharmacy rebates will accrue to the agency. Accordingly, the downward adjustment to Pharmacy Unit Cost for rebates will be removed when the capitation rates are rebased/updated.
9	2.11.3.1	Care Manager Ratios and Staffing Plans	157-158	Based on our review, in order to meet the State requirement that all members receive care management services, we estimate the equivalent of over 300 care managers would be needed, which would require $50 PMPM in care management expenses. Please clarify how this can be accommodated when the overall administrative load in year 1 is $40.16 PMPM.	While each rate component assumption (such as MCO Administration) is important and needs to be attainable, potential bidders should also review the overall draft/modeled capitation rate. If a potential bidder does not believe it can meet all contractual requirements as well as its own business needs via the draft/modeled amounts, the potential bidder should make its own business decision about proceeding.
10	2.11.5.2	Referral to ODMHSAS for Behavioral Health Assessment	161	Does the time frame for scheduling and completing the comprehensive assessment remain the same if a referral is made to ODMHSAS for BH assessment. We are supposed to hold off on completing a face to face visit until the member is assessed by ODMHSAS and a determination of a transfer to the Behavioral Health Home is selected by the member	A referral to ODMHSAS for BH assessment suspends the timeframe until the results are known. Additional time will be accorded the plans for the completion of the comprehensive assessments in these cases.

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11	2.11.6	Assigning Care Management Risk Levels	162	The administrative expense loads used in rate development is not consistent with the care management staffing requirements outlined in Section 2.11.6 of the Oklahoma SoonerHealth+ RFP. Based on our review, in order to meet the State requirement that all members receive care management services, we estimate the equivalent of over 300 care managers would be needed, which would require $50 PMPM in care management expenses. Please provide the expected care management staffing ratios that are implied in the capitation rates for Level 1, Level 2, and Level 3 members.	Please see the response to Question #9. Also, as described in the February 1, 2017 Bidders' conference, and as seen in the rounded whole (X.0%) or half (Y.5%) percentage levels for the 1st year for a population, the assumed MCO Administration levels are more broad in nature actuarial assumptions. Hence specific detail around Level 1, Level 2, and Level 3 are not available.
12	2.11.8.5	Care Plan Timeframes	171	What the timeframe is for completion of care plans for level 1 members, since they will not have a comprehensive assessment performed.	30 days.
13	2.12.3.3	Access to Out of Network IHCP's and Referrals under Contract Health Services	193	This section allows for Native American members to see out of network IHCPs. Will these providers be subject to the SoonerCare fee schedule? Is this question asking for the fee schedule for AI/AN that are seen at a non I/T/U provider?	This was Question 48 in Round One Questions. Round One Answer: The OHCA will pay providers directly using the OMB rate. In other words, Providers will be paid at the OMB rate for being seen at an IHCP and the IHCPs are paid directly by OHCA.
14	2.13.4	Health Plan Accreditation Requirements	201	Can you verify the state’s expectations around health plan accreditation and clinical performance measures outlined in sections 2.13.4 (Health Plan Accreditation)?	The expectations are as written regarding accreditation in 2.13.4. See 2.13.5 for Quality Performance Measures.

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15	2.13.4	Health Plan Accreditation Requirements	201	Contracted plans are required to be accredited by a CMS approved accreditor (NCQA is an approved accreditor). Does this include NCQA Long-Term Services and Supports (LTSS)? Note, we recently launched two new programs specifically intended to support state Medicaid programs with LTSS oversight.	Plan accreditation is required. LTSS recognition is not required.
16	2.13.4, 2.13.5, 2.13.6.1	Health Plan Accreditation, HEDIS, CAHPS		I'd also like to see if there is a role for NCQA's Long Term Services and Supports program for the SoonerHealth+ population (aged, blind, disabled)?	A role is not specified in the contract.
17	2.13.5	HEDIS	201	Contracted plans (are) required to contract with an NCQA certified compliance auditor. Can you verify the state's expectations around health plan accreditation and clinical performance measures outlined in section 2.13.5 (HEDIS)?	The state verifies that the expectations around health plan accreditation and clinical performance measures outlined in section 2.13.5 (HEDIS) are as written.
18	2.13.6.1	CAHPS	203	Contracted plans are required to conduct an annual CAHPS survey, beginning 2019, and must enter into an agreement with an NCQA Certified Vendor. Can you verify the state's expectations around health plan accreditation and clinical performance measures outlined in section 2.13.6.1 (CAHPS)?	The expectations are as written.
19	2.18.3	Third Party Liability	248	Please confirm that the Contractor can cost avoid claims for a known casualty.	Restatement of Question 73 from Round One: Paid Medicaid claims for casualties are included in the base data for purposes of establishing Contractor rates and Contractor therefore is expected to pay such claims when submitted by providers. Pursuant to RFP Section 2.18.3.7, Contractors are obligated to identify and report potential subrogation cases to OHCA. The OHCA will be responsible for pursuing subrogation and will retain all subrogation recoveries.

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20	2.4.2.2	General Medical and Related Benefits	59	What percentage and how many members are currently limited by the 6 prescription pharmacy benefit limit? How many waiver members are limited by the 13 prescription limit in Section 2.4.2.6.?	Please see the OHCA SFY 2016 Annual Report. Page 74 shows the unduplicated number of ABD members served, while pages 76 and 77 contain the numbers of Home and Community-Based Services waiver member enrollees. Note that waiver members receive unlimited medically necessary prescriptions, as per Amendment Six. The specific details are not available.
21	2.6.1	Transition of Care General Provisions	81-82	It is clearly an expectation that risk level is used to determine clinical needs and the greater level of care management and support that is required. However, there is no differentiation between Levels 1-3 in revenue in any rate cell when the cost of administering to these various levels are significantly different. Please provide an explanation for why risk adjustment, for example using the CDPS+Rx risk adjustment model, will not be used to adjust the revenue in this contract.	At this time the OHCA has chosen not to utilize any risk adjustment approach (other than the separate identified rate cells).
22	2.7.7.2	Website content	103	Would a notification to members on the website "that they can obtain services from an out of network provider" be a sufficient method for advising members?	The OHCA will review and approve website content as part of readiness review activities.
23	2.7.8.2	Member Service Call Center Performance Standards	104	Please provide the definition for measuring "Average Wait Time"	The average wait time is the average amount of time callers were waiting until their call was answered.
24	2.7.8.2	Member Service Call Center Performance Standards	105	The model contract states that Contractor shall maintain a remote monitoring system that the OHCA may be able to use to survey the Contractor/member interaction, Can more details be provided on this process? Can there be clarification or more specific expectations around "a remote monitoring system that the OHCA may be able to use" [sic]	OHCA should have access to recorded calls and should be able to access them without having to go through Contractor.

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25	2.8.1.4	Form-8070000933-O	110, 300	Regarding question #41 of RFP section 3.6.2, submission of Form -O-8070000933, in the Stakeholder meeting on November 8, 2016 the State indicated that "As a reminder, the OHCA will not require bidders to submit complete provider networks with their proposals" and "Providers are free to have discussions with plans and to sign contracts at any time but should not view the proposal submission date as an OHCA deadline for contracting." Please confirm that OHCA does not have the expectation of a complete contracted network at bid submission, and that a comprehensive Network Development plan can be submitted instead.	The OHCA will review networks as part of the evaluation process but is not requiring submission of complete provider networks. Form 8070000933-O has been revised to more closely align with the classifications used in the OHCA provider directory. In some cases, the categories are more specific with respect to provider type than those listed in Section 2.8.3.3. The revised form has been posted in the bidder's library.
26	2.8.1.4	Provider Network Development and Management Plan	110, 300	2.8.1.4 describes the Network Plan as a future document, but proposal item 41 requires an existing network summary and rosters (8070000903-O). In public meetings the agency has said network development is not required until after the contract award. Are you now requiring the network as part of the proposal?	The OHCA will review networks as part of the evaluation process but is not requiring submission of complete provider networks. Form 8070000933-O has been revised to more closely align with the classifications used in the OHCA provider directory. In some cases, the categories are more specific with respect to provider type than those listed in Section 2.8.3.3. The revised form has been posted in the bidder's library.
27	2.8.2.1	Provider Network Contract Termination	112	Is contractor required to notify OHCA when terminating any provider type for the circumstances listed on 2.8.2.1? If so, what method of notification will required?	Yes. The method will be finalized after contract award.
28	2.9.3	Credentialing	125	What is the minimum level of acceptable licensure for Providers?	Providers must have a current license to perform the duties outlined in the applicable practice act, certification from the applicable waiver program and so forth.
29	2.9.3	Credentialing	125	Are MCO's required to track Supervisor's for those Providers which are under supervision? (e.g. Professional Counselor)	Yes.

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30	2.9.3.1	Credentialing and recredentialing Timeframes	125	What is considered a complete application? Is the definition of a complete application fall under the state statute for clean claim?	The contractor is responsible for determining if the application is complete, as outlined in 2.9.2.1, Application for SoonerCare Participation and 2.9.2.2, Application for Provider's Network Participation.
31	2.9.5.9	Performance-Based Provider Payments	136	Which claim types should be used when determining whether or not an MCO is compliant with meeting the 80% requirement for Performance Based Contracting?	All claim types will be used to make this determination. The RFP does not limit this to a single provider type.
32	3.6.2	Question 11 References	289	Since many State Medicaid agencies are only willing to provide a confirmation of contractor status, or are unable to provide a qualitative reference due to an active procurement, would OCHA consider allowing all bidders to submit a maximum of two references (similar to bidders with individual commercial products) from benchmark plans, even if they have selected three. This will enable bidders to include viable benchmark plans (with comparable populations, covered benefits) even if the respective State limits the information in, or completion of, bidder references. An alternate option would be to allow bidders to submit a third reference for a non-benchmark plan that meets all criteria for benchmark plans.	No.

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33	Capitation Rate Sheets	Managed Care Adjustment	n/a	The Managed Care Adjustment factors used by Mercer in year one are significantly higher than industry standard for a newly managed care program. They are instead commensurate with other states' factors assumed by the end of the second year, not the average of the first year. Please describe how a ramp-up for achieving savings was incorporated, particularly with continuity of care requirements included in the contract. Additionally, please identify specific areas of opportunity that justify the average assumptions used by Mercer are attainable in the first year.	As indicated in the February 1, 2017 Bidders' conference, the managed care adjustments are averages over the entire rate year. Mercer also indicated that several sources of data and information were utilized when developing the adjustment factors. Among, but certainly not limited to, those sources are two publicly available documents: https://www.actuary.org/files/publications/Pub_Pol_Monograph_Medicaid_Managed_Care_Savings_Access_Quality_960401.pdf (pages 9-11) and https://legislature.idaho.gov/wp-content/uploads/sessioninfo/2012/interim/healthcare0910_unitedhealthcare.pdf (page 10). As indicated during the Bidders' conference, if selected, MCOs are tasked with identifying areas of savings opportunities, either consistent with the assumptions within the draft/modeled capitation rates, or elsewhere such as where Utilization or Unit Cost managed care adjustments are zero or positive.
34	Capitation Rate Sheets	Administrative Expense	n/a	Although Mercer commented the Administrative Expense percentages used in the rates are consistent with other states' rates for similar populations, our experience is these percentages are significantly lower than other states where we do business, particularly since they are intended to include care coordination services. Please provide justification that the assumptions used provide for an appropriate and attainable level of administrative funding in order to adhere to the contract requirements.	Please see the response to Question #9.

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35	Form B; Form I	Bidder Proposal Submission Checklist; Plan Management	Form B (pg 2); Form I (pg 1)	According to Form B (Bidder Proposal Submission Checklist), the order of material to be submitted in relationship to Item 18 (Plan Management) is as follows: Item 18a - Plan Management Narrative Item 18b - Form I (Plan Management) Item 18c - Plan Management job descriptions Item 18d - Plan Management resumes Form I (Plan Management) requires the following: Include a job description for each position directly behind this form. Include a current resume for each individual listed on the form behind the corresponding job description. For example, include the President/CEO/COO job description, followed directly by the resume of the person filling this position. Please confirm that the submission of materials related to Item 18 should follow the instructions and tabs listed on Form B.	The submission order should follow the instructions as provided in Form 8070000933-I, with resumes placed directly behind job descriptions. The Form B checklist is intended to verify that all required components within a submission item have been included, not to specify the order of placement.
36	Form F	Medicaid & Medicare (Dual Eligible) Experience (Non-Oklahoma)	Form F (page 1)	Our organization serves Medicaid members in a number of states where the ABD (or SSI) population is a subset of the overall membership that we serve. In completing the enrollment table on Form F, should we include the entire Medicaid membership that we serve (including TANF and CHIP members for example) or limit our response to the ABD (or SSI) membership?	The information provided in Form 80870000933-F should be for the bidder's ABD (SSI) population only.

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37	Item 2	Transmittal Letter	285-286	Due to the preliminary nature of the provided rates, would OHCA consider revising bullet 7 of the transmittal language to read as follows: A statement that the Bidder has reviewed the preliminary rates and accepts said SoonerHealth+ preliminary capitation rates so long as they are not materially lower once finalized and are certified as actuarially sound, and Bidder accepts the methodology for updating the rates.	Bullet 7 of the transmittal letter is hereby revised as follows: "A statement that the Bidder has reviewed and accepts the SoonerHealth+ draft/modeled capitation rates and methodology for updating the rates."
38	Item 96 of the RFP	Instructions	286	As confirmed in the bidders conference on 2/1/17, there is a discrepancy between the historical enrollment as presented in the actuarial data book compared to both the historical and projected enrollment shown in the capitation rate sheets. For purposes of Question 96 regarding the Pro Forma Financial Statement, we strongly suggest using the "Projected Member Months" included in the capitation rate sheets in order to provide the most accurate Pro Forma view. Is this approach acceptable to the State?	The Data Book member months and the draft/modeled capitation rate exhibits will not match as the Data Book contains all voluntary population individuals, while the draft/modeled capitation rate exhibits assume only a portion of voluntary individuals will enroll. With regard to RFP Question 96, we agree that use of "Projected Member Months" from the capitation rate exhibits is acceptable.
39	Mercer SoonerHealth + Feb 1 Actuarial Presentation	Rate Development Overview: Covered Benefits Includes/ Excludes	Slide 16	In the actuarial bidder's conference, it was mentioned that OU/OSU payments were funded at a level in excess of 100% of Medicaid. This provider group is claiming they are currently reimbursed well above 100% of Medicaid. What is the level that OU/OSU payments were funded? How is this cost distributed between the various rate cells?	OU/OSU State-employed physicians receive payment amounts at 140% of Medicare, not Medicaid. A distribution of these costs within the CY 2015 Base Data is not readily available at this point in time.

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40	Mercer SoonerHealth + Feb 1 Actuarial presentation	Rate Development Overview: Covered Benefits Includes/ Excludes	Slide 16	What is the total supplemental payments and costs included for each benefit by rate cell and region? Will there be additional reporting around these supplemental payments?	As described on slide 7 of the February 1, 2017 presentation, there are multiple issues around exclusion/inclusion/reconfiguration of several supplemental payments. Hence, total dollars and a distribution of these costs within the CY 2015 Base Data is not available at this point in time.
41	Mercer SoonerHealth + Feb 1 Actuarial Presentation	Rate Development Methodology: Prospective Adjustments - Trend	Slide 24	This has been a recent change in many state Medicaid programs due to strong lobbying by Hepatitis C advocacy groups. This has had a significant impact on projected pharmacy costs. Have any changes in criteria for Hepatitis C medications (decrease in F-levels from 3 to 1 or 2) been factored into the 2018 projected pharmacy costs?	The OHCA Pharmacy area provides constant pharmacy market review and response. The average 8.1% Pharmacy PMPM claim cost trend factor assumed is above recent OHCA projections and hence could be considered conservatively favorable to potential bidders. Claim cost trend factors (including Pharmacy) will be reviewed for potential revision when capitation rates are rebased/updated and certified.
42	Mercer SoonerHealth + Feb 1 Actuarial Presentation	Rate Development Methodology: Managed Care Assumptions	Slide 25	What studies were used to determine the managed care assumptions that were made by category of service? There is an increase in utilization projected for physician services. Many members receive their care through FQHCs; however there is no projected increase in utilization for physician services from an FQHC (0% managed care adjustment). Why was increased utilization at FQHCs not considered to be an increase in costs due to managed care like physician services?	Please see the response to Question #33. FQHC's make up part of the "Clinics" consolidated category of service. That category does have an assumed Utilization/1,000 claim cost trend factor. While there is no Utilization or Unit Cost managed care adjustment applied to Clinics, increased usage could potentially further reduce average higher-cost services.

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43	Mercer SoonerHealth + Feb 1 Actuarial Presentation	Rate Development Methodology: Managed Care Assumptions	Slide 25	58% of the NFLOC population is in HCBS currently. It is assumed that by Year 3 HCBS makes up 63% of the NFLOC population -- resulting in a 2.9% reduction to the NFLOC rate. If one MCO has 65% HCBS members in NFLOC and another MCO has 55% HCBS members in NFLOC, their medical costs will be materially different, and this is not reflected in the blended capitation rate. How will the State address a mix factor to account for the cost difference between the HCBS and institutional populations in this blended rate cell?	The blended rate is as is, no mix factor to differentiate rates between MCOs is involved. MCOs bear the opportunity, and risk, of the capitation rate structure.
44	Mercer SoonerHealth + Feb 1 Actuarial Presentation	Rate Development Methodology: Managed Care Assumptions	Slide 25	Please provide the beginning and ending HCBS members as a percentage of the total LTSS-eligible members for years 1, 2, and 3.	The requested information is not readily available in a timely manner.
45	N/A	Data Book	N/A	What benchmarks were used – were they national benchmarks, Mercer internal benchmarks, or other benchmarks? This question applies to both utilization and unit costs assumptions.	The Data Book displays actual SoonerCare data (with stated adjustments) for CY 2013, CY 2014, CY 2015.
46	N/A	Data Book	N/A	What are some of the main drivers of inefficiencies that warrant some of the larger managed care assumptions, for example, IP decrease on utilization in the ABD non-duals by 45%? Understanding this break-down will help plans to understand where OHCA has identified the inefficiencies so that plans can address those specifically.	The Data Book displays actual SoonerCare data (with stated adjustments) for CY 2013, CY 2014, CY 2015.

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47	N/A	Data Book	N/A	Were any particular tools or models used to assess the appropriateness of the assumptions, such as classifications via Agency for Healthcare Research and Quality (AHRQ) prevention quality indicators (PQI) or New York University Center for Health and Public Research (NYU CHPSR) Emergency Department Algorithm, or other internal Mercer tools?	Please see the response to Question #33. As indicated at the February 1, 2017 Bidders' conference, the type of tools mentioned in this question typically involve analyses of MCO encounter data.
48	Q - Item 8	Provider Network Participation Application	124	How will the Oklahoma state master file (containing all attested Providers with the state of Oklahoma) be structured? When will this file be released to MCO's and how often will it be refreshed?	OHCA will finalize details about the state master file containing all *contracted* providers and timeframes for release and refreshing after contract award.
49	Question 41	Question 41	Form "O"	When determining how to list partial hospitalization, should we include any professional providers in the partial hospitalization category or just include them under the appropriate Behavioral Health specialists category?	Professional providers should be listed under the appropriate specialist category and not within the partial hospitalization category.
50	Question 41	Question 41	Form "O"	What provider type on form "o" should all of the residential treatment centers fall under?	Psychiatric Residential Treatment Facility.
51	Questions 85 and 86	Questions 85 and 87	321	Would OHCA prefer to receive required reports for Items 82, 85 and 86 (Quality Improvement, HEDIS, CAHPS) electronically only? Currently, these comprehensive reports are several hundred pages combined.	The reports should be submitted in hard copy, as well as within the electronic submission.

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52	RFP Questions	Oklahoma Experience		During Round 1 QA, the OHCA was asked to assist MCO's by providing Insure Oklahoma (IO) enrollment data by county, which is required on Form E - Oklahoma Experience. In Amendment 2, Item 245 OHC responded as follows: "The OHCA expects Insure Oklahoma plans to have this information for the purpose of communicating with members, e.g., sending remittance advices/explanation-of-benefit statements. However, if a bidder does not have county-level information, provide a state total only. The OHCA reserves the right to take into consideration the lack of county-level data during evaluation of proposals." There appears to be a disconnect or misunderstanding related to OHCA's response and the actual IO Data that is available to IO Plans. Plans assist employer groups with enrollment in IO compliant products. However, those groups contain both IO and non-IO members, and the flow of specific IO member information and financial data occurs between the OHCA and the employer; not the health plan. Plans certainly communicate with IO members via EOB's remittance advices, etc., but those communications are provided to all members of the group, not just IO members. Within the records of the health Plan, IO members are indistinguishable from non-IO members. OHCA employees responsible for the IO program can confirm that plans do not have access to enrollment data by county, nor does OHCA provide county level data to the plans. Given the above, will the OHCA provide IO health plans with enrollment data by county, so it can be included on Form E? Alternatively, will the OHCA agree to not penalize MCO's for their inability to provide this data?	The OHCA will not be providing additional data. However, the OHCA acknowledges the limitation associated with furnishing county-level IO data as described in the question.
53	SoonerHealth + Capitation Rates	All data tabs	All data tabs	The CY 2015 membership detailed in the RFP does not match the CY 2015 membership in the data book. Please clarify which membership should be used in the projected financials.	The membership data in the RFP was provided as a courtesy, prior to release of the data book. The data book membership should be used for the development of the pro forma financial projections. Also, please see the response to Question #38.

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54	SoonerHealth + Capitation Rates	All tabs	All tabs - general data book	Please confirm the reimbursement rates.	We are unsure of the specific question. If the reference is to the Unit Cost figures in the CY 2015 Adjusted Base data, OHCA Medicaid fee schedules underly base claims data, except as noted.
55	SoonerHealth + Capitation Rates	Data book	All calculations	Please confirm that FQHC and CAH settlements are not part of an MCO's responsibility and are not in the capitation rates. How were changes in FQHC/CAH visit rates reviewed and used in trend setting? Please provide a fee schedule of FQHC/CAH rates and effective dates.	The OHCA no longer makes wrap-around payments to FQHCs. All FQHC reimbursement is within the underlying claims data. No CAH settlements are within the underlying claims data. As indicated, issues around several supplemental or supplemental-like payments are yet to be resolved. FQHC/CAH were part of overall Utilization trend review. Bidders should check the OHCA website for historical fee schedule data and dates.
56	SoonerHealth + Capitation Rates	Data book	All calculations	Please identify where the Bidder would obtain the "Supplier ID" required in Section 2., Bidder General Information, of Form OMES-CP-076, Responding Bidder Information.	The Supplier ID is the same as Vendor Registration with State of Oklahoma. See this site for more information: https://www.ok.gov/DCS/Central_Purchasing/Vendor_Registration/index.html . With questions or for assistance in registering, contact the State of Oklahoma Office of Management and Enterprise Services (OMES) Help Desk: Vendor Registration at 405-521-2444 or servicedesk@omes.ok.gov.
57	SoonerHealth + Capitation Rates	Data book	All calculations	Due to the preliminary nature of the provided rates, would OHCA consider revising bullet 7 of the transmittal language to read as follows: · A statement that the Bidder has reviewed the preliminary rates and accepts said SoonerHealth+ preliminary capitation rates so long as they are not materially lower once finalized and are certified as actuarially sound, and Bidder accepts the methodology for updating the rates.	See response to question 37.

Question Number	Section or Subsection Number	Section or Subsection Title	Solicitation Page	Question	Response
58	SoonerHealth + Capitation Rates	Administrative Expense	Tabs for Statewide Year 1; Statewide Year 2; Statewide Year 3	Please provide a detailed description of the changes in the administrative expenses loads for years 1, 2, and 3. The percentage loads are decreasing each year which is causing the PMPMs to decrease substantially when the level of managed care savings expectation is increasing. What assumptions, including expense inflation, are changing that cause the administrative percentage by rate cell to decrease each year?	The assumed MCO Administration percentages and changes are contained within the drafted/modeled capitation rate sheets and were discussed at length during the February 1, 2017 presentation. The 0.25% Year 2 and Year 3 decreases represent assumed increased efficiencies in Administration. Please also see the response to Question #9.
59	SoonerHealth + Capitation Rates	Administrative Expense	West Year 1 Tab	For ABD populations, we have seen significantly higher administrative percentages than the 5.0 - 5.5% used in the Oklahoma data book. What studies were used to determine this load? Please split out these expenses by medical management and other administrative costs.	Please see the responses to questions, 9, 11, 34, 58. Mercer primarily used our work with multiple states and Medicaid populations to inform the broad percentage adjustment assumptions utilized for MCO Administration. As Targeted Case Manager (TCM) Services amounts are also contained within the underlying claim cost data, a split between medical management and other administrative costs in the manner suggested would not be appropriate.
60	SoonerHealth + Capitation Rates	Underwriting Gain	Tabs for Statewide Year 1; Statewide Year 2; Statewide Year 3	The underwriting gain percentage loads are decreasing each year, causing the PMPMs to decrease substantially when the risks increase as additional populations are added to the program. Please provide a detailed description of the changes in the risk/contingency loads in years 1, 2, and 3.	The 0.25% reductions for Year 2 and Year 3 that a population is in the program represent changes in risk.

Question Number	Section or Subsection Number	Section or Subsection Title	Solicitation Page	Question	Response
61	SoonerHealth + Capitation Rates	Other	West Year 1 Tab	Are case management services also included in the "Other" expenses? Please provide more detail about what services are included in the "Other" expense category. For example, in ADvantage non-dual West, the "Other" bucket is $335 PMPM out of $3,235 total PMPM, or 10%. For ADvantage dual West, the "Other" bucket is $269 out of $1,152 PMPM, or 23%. For I/ID members, the "Other" bucket is $1,963 out of $3,391 total PMPM, or 58%.	Targeted Case Manager (TCM) Services amounts are contained within the underlying claim cost data. While the PMPM amounts and percentages of "All Other" vary by rate cell, overall, across all populations for Year 3, All Other is approximately 7.7% of projected claim cost. To keep manageable Mercer and OHCA had determined that 15 standard consolidated categories of service were reasonable. For the rebase/update of the capitation rates expanding that list will be considered.
62	SoonerHealth + Capitation Rates	West Year 1 Tab	West Year 1 Tab	The medically fragile members have costs that are 200% of the “normal” dual/non dual costs in a small population of less than 100 members. How will the State ensure that this risk is fairly spread amongst the MCO’s given that there will be no distinct rate cell for the medically fragile in year 3?	Year 3 NFLOC rates do not vary by MCO. MCOs bear that opportunity and risk.
63	SoonerHealth + Data Book	Data Sources	1. General Information Tab	Standard practice is to include care management as a separate expense or even as a separate administrative load such that the MCOs may properly gauge their respective care management and administrative costs compared to amounts included in the capitation rates. Since the claims expenses are trended and adjusted by managed care savings, will the State consider including the care management expenses as a separate line item?	Please see the response to question 59. The State will not include a separate line item for care management expenses within the draft/modeled capitation rates.

Question Number	Section or Subsection Number	Section or Subsection Title	Solicitation Page	Question	Response
64	SoonerHealth + Data Book	Data Disclaimer	1. General Information Tab	Does the claims PMPM information in the data book include any case management expenses? If so, please detail these expenses by region, rate cell, and category of service.	Yes. Please see response to question 59. The requested detail is not available in a timely manner.
65	SoonerHealth + Databook	Data Sources	1. General Information Tab	It is our understanding that the voluntary population experience is not in the data book. Please provide a separate data book of the voluntary population experience for CY 2015.	This statement is incorrect. The eligible voluntary population member months and claims are separately identified within the Data Book.
66		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		How is the current enhanced reimbursement for University employed physicians going to be administered under the MCO model?	As discussed, potential approaches for these supplemental payments are TBD.
67		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		Please clarify the rates that will be paid to carriers: will carriers receive the blended regional rates for all members regardless of population type, or will the rates paid to carriers be specific to the member's population type and region?	The latter. The "All Rate Cells" for regions and Statewide are for illustration only.
68		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		Is the intent to include all waiver types and LTC institutional types in one LTSS rate cell as of year 3?	Year 3 NFLOC rates (separate Non-Dual and Dual) combine waiver types as well as ICFs for Individuals with Intellectual Disabilities/Nursing Facilities.
69		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		Do the IID state plan only and waiver rate cells go away in year 3 when the NFLOC rate cells are introduced?	See response to question 68. I/ID State Plan Only rates remain separate.

Question Number	Section or Subsection Number	Section or Subsection Title	Solicitation Page	Question	Response
70		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		How were members stratified for rate development when they changed rate cells or lapsed in the middle of a month?	Data based upon days.
71		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		Please provide documentation supporting how members were identified for inclusion in the NFLOC rate cells.	See response to question 68.
72		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		Please provide documentation supporting the CY 2015 adjusted base cost model for the NFLOC rate cells.	This data and information is contained within the Data Book.
73		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		Where are care management and case management included in the capitation rate development? Is provision for these services included in the capitation rates when state workers have served as case managers?	Care management and case management are partially included within the claim cost (see response to question 59), and partially included within the MCO Administration assumption. Non-TCM State administrative expenses are included in limited fashion in the MCO capitation rates.
74		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		Please provide the breakdown of care management and case management included in the administrative component.	The detail requested is not available.
75		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		Do any expenses identified as medical services for purposes of the capitation rate development not meet the definition of medical services for inclusion in the Medical Loss Ratio calculation, or vice versa? If so, please identify and quantify these expenses.	The Medical Loss Ratio numerator calculation would be based on MCO services. OHCA and Mercer cannot answer this question for MCOs.

Question Number	Section or Subsection Number	Section or Subsection Title	Solicitation Page	Question	Response
76		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		How will capitation payments be made for members who change rate cells or lapse in the middle of a month?	OHCA pays capitation once per month and it is prospective. If a change occurs mid-month OHCA will not be making a reconciliation. The member cap payment will be based on the new rate cell the next month.
77		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		We are requesting clarification of section 2.9.5.8 that states that the rate paid to pharmacy providers should be no less than the fee for service payment rate employed by the OHCA for the SoonerCare program. If the MCO's contracted rates with national pharmacies and DME suppliers are less than OHCA's FFS rates, is the MCO required to pay more than its contracted rate?	OHCA has recently changed its calculation for pharmacy reimbursement and as a result, is revising this requirement to apply to brand name drugs only. The new requirement is that the rate paid to pharmacy providers for brand name medications should be no less than the fee for service payment rate employed by the OHCA for the SoonerCare program. The rate paid for brand name medications is the lower of National Average Drug Acquisition Cost-Brand (NADACB) or Wholesale Acquisition Cost (WAC) plus a professional dispensing fee of $10.55 per prescription. Specialty medications are typically brand name drugs and are paid at the lower of NADACB, WAC or the agency's Specialty Pharmaceutical Allowable Cost (SPAC) plus the professional dispensing fee of $10.55. Only DME supplies provided through the pharmacy benefit must meet this requirement. See 2.4.2.4 for a list of diabetic supplies covered under the pharmacy benefit. For diabetic test strips and meters, the plan must use the OHCA preferred products (2.4.2.4) which are reimbursed at WAC with no professional dispensing fee added.

Question Number	Section or Subsection Number	Section or Subsection Title	Solicitation Page	Question	Response
78		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		Does benefit eligibility vary by level of care assignment? Do waiver members have care plan expectations that vary by waiver type?	Benefits do correlate with levels of care, which is a function of evaluation for long-term care services. NF level of care (NFLOC) corresponds with the ADvantage waiver. SNF level of care and hospital level of care are for Medically Fragile waiver. In addition, NF LOCs may qualify individuals for institutionalization in an appropriate facility. Individuals with intellectual disabilities with an institutional level of care may qualify for the HCBS waivers Community or In-Home Supports for Adults or Children. An institutional level of care can also be determined for individuals with intellectual disabilities. State Plan Personal Care services are authorized for a lower level of care for qualifying members. Each waiver is approved for a specific array of services in addition to State Plan benefits. The waivers are located here: http://www.okhca.org/individuals.aspx?id=8137
79		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		How is level of care established for nursing facility and I/ID members?	DHS utilizes specified assessment tools for each population.
80		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		Please clarify the distinction between the I/ID State Plan Only rate cell and Medicaid members using ICF/MR services.	I/ID State Plan Only members are not institutionalized and not enrolled in HCBS waivers.
81		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		The I/ID state plan only rate cell shows significantly higher nursing facility utilization than ICF/MR utilization, and the per diem rates for the two types of facilities vary significantly. Please explain why institutional cost is included for this subset of the population effective in Year 1, when Oklahoma law states institutional populations will not be enrolled until Year 3?	Please see Section 2.3.4.6 of the model contract. Also note that OAC 317:30-5-123(a)(3)(C)(iii) provides for respite days of admission to a NF on a calendar year basis.

Question Number	Section or Subsection Number	Section or Subsection Title	Solicitation Page	Question	Response
82		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		Q135. of the RFP Q&A indicates that OHCA will not provide historical enrollment data. Does this include all historical claims and enrollment data? MCOs will need detailed member experience history for care management initiatives.	The OHCA will be sharing existing prior authorizations and long term care waiver service plans with contractors prior to go live. The OHCA does not currently have plans to share historical enrollment and claims data, as contractors are required to perform a health risk screen on all members at time of enrollment and a comprehensive assessment on moderate and high risk members. However, the OHCA will review this decision with contractors during the readiness review period.
83		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		Please provide support for the assumption of 3% MCO supplemental rebates on pharmacy expenditures. In order to achieve rebates, MCOs will need to negotiate various pharmacy pricing components such as transaction fees, dispensing fees, and AWP discounts. However, the RFP indicates that MCOs will be required to reimburse pharmacies at a rate no less than current FFS, which uses AAC plus $10.55 dispensing fee. Where are additional savings opportunities available in the pharmacy pricing formula?	Please see the response to Question #8.
84		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		Please clarify whether the nursing facility unit cost trend includes explicit nursing facility fee schedule changes.	The annualized 2.5% nursing facility Unit Cost trend factor is in place of explicit nursing facility fee schedule changes analyses.
85		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		Were nursing facility unit cost trends developed on a basis which was gross or net of patient liability amounts?	All OHCA claims data utilized in draft/modeled capitation rate development are net of patient liability.

Question Number	Section or Subsection Number	Section or Subsection Title	Solicitation Page	Question	Response
86		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		Please provide a history of nursing facility fee schedule changes between CY 2013 and the contract period.	www.okhca.org contains several references to fee schedule changes, including but not limited to: http://www.okhca.org/providers.aspx?id=2538. Annually, OHCA rebases to the Medicare Fee Schedule for most provider groups (including physicians & hospitals). Future changes are TBD.
87		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		Will capitation rates be adjusted to reflect significant FFS fee schedule changes? It is general practice in other state Medicaid managed care programs to adjust the medical cost component of capitation rates when fee schedule changes are mandated because many MCO contracts with medical providers are based in some way on those FFS fee schedules. If changes are made in FFS and not reflected in capitation, additional risk is introduced and we are unable to quantify that risk without knowing what changes could be made.	This will be considered on a case-by-case basis, depending upon multiple factors, including perceived impact upon the provider contracting landscape.
88		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		Mercer indicated in the draft rate presentation that they were not sure what all was included in the "all other" service category. How can managed care adjustments be applied to services that are classified ambiguously? How can MCOs manage utilization for services that have not been clearly defined? Consider this revision: Please detail services in the "all other" service category so that MCOs can appropriately apply managed care adjustments.	Please see response to question 61. Managed care savings opportunities may be available, or not, on any or all services. Mercer feels very comfortable with the aggregate (as displayed in the modeled 'Statewide" exhibits) PMPM adjustments of -8.9% Year 1, -7.9% Year 2, and -5.9% Year 3.
89		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		Mercer indicated there was some concern with the utilization per 1,000 metrics in the rate development cost models. Please provide additional information about which categories have utilization that should not be used.	Mercer indicated that as with any claims data set, while total dollars are relatively easily quantified, units are not as straight-forward, and hence derived Unit Cost values should be reviewed. Units have been gathered in a consistent manner across years and programs.

Question Number	Section or Subsection Number	Section or Subsection Title	Solicitation Page	Question	Response
90		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		Please provide additional information about how utilization is counted for the categories of service included in the rate development cost models.	This information is contained within the Data Book.
91		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		Please provide additional detail for the "all other" service category included in the data book.	Please see response to question 61.
92		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		Please provide admits per 1,000 and days per 1,000 for inpatient hospital, nursing facility, and ICF/NR [sic] categories by rate cell.	The Days/1,000 data is contained in the capitation rate exhibits.
93		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		Please provide cost model information specific to targeted case management and case management services by rate cell and region.	Please see the response to question 74.
94		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		Please provide average churn rates by rate cell. (i.e., percentage of members who lapse out of the program in a year and percentage of members who are new to the program in a year).	This information is not readily available.
95		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		Please provide average annual exposure by rate cell for the CY 2013 through CY 2015 base data. (i.e., Total MMs divided by Total unique members in each year for each rate cell/region).	This information is not readily available.

Question Number	Section or Subsection Number	Section or Subsection Title	Solicitation Page	Question	Response
96		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		Please provide a claims probability distribution for dual categories and non-dual categories. Additional splits for waiver/institutional/non-LTSS populations are also requested if possible; Please split claims into LTSS vs non-LTSS benefits for CPD.	This information is not readily available.
97		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		Please provide member months for children under age 1 who were included in the base data and rate development.	This information is not readily available.
98		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		Please provide the number of births that were included in the base data and rate development.	This information is not readily available.
99		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		Please provide any expected fee schedule or policy changes that may occur before the end of the contract period.	The OHCA has been highly active in both areas. The OHCA website provides an excellent source for historical changes and known prospective changes. As the contract periods for Years 1, 2, and 3 are well into the future, additional changes are unknown at this time.
100		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		Please provide prevalence reports by region and rate cell. For example, identifying CDPS disease categories for members included in the CY 2015 base experience and illustrating the percentage of each rate cell flagged for each category.	This data and information is not readily available.
101		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		Please provide utilization per 1,000 rates by region and rate cell for provider claims where enhanced reimbursement rates are paid by the state.	This data is not readily available.

Question Number	Section or Subsection Number	Section or Subsection Title	Solicitation Page	Question	Response
102		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		Please provide prevalence of Hepatitis C and Cystic Fibrosis in the CY 2015 experience for each region and rate cell.	This data is not readily available.
103		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		Please provide cost models for members residing in a nursing facility separate from members residing in an ICF/MR.	This data is not readily available.
104		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		Please provide the number of member months in which a member has reached the 6 prescription limit by region and rate cell.	This data is not readily available.
105		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		Please provide an actuarial report documenting the intended methodology for capitation rate setting, including but not limited to: clear definition of covered services, clear definition of rate cells, development of assumptions such as trend and managed care adjustments, etc.	As discussed in the February 1, 2017 Bidders' conference, the draft/modeled capitation rates are not certified capitation rates that MCOs would ultimately receive. The capitation rates will be rebased/updated. Hence no formal actuarial certification document will be produced for the draft/modeled capitation rates. The Bidders' conference presentation as well as the draft/modeled rate exhibits and Data Book contain the appropriate information.
106		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		Please provide detailed information regarding the rebalancing assumptions used in capitation rate development.	HCBS waivers make up 58% of the member months in CY 2015. The Year 3 blend was rebalanced so HCBS waivers made up 63% of the member months, resulting in an effective 2.9% reduction to the NFLOC rate.

Question Number	Section or Subsection Number	Section or Subsection Title	Solicitation Page	Question	Response
107		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		Please provide documentation of the development of the CY 2015 adjusted base data for the NFLOC rate cell.	The NFLOC base data is a blend of HCBS waiver and institutional (ICFs for Individuals with Intellectual Disabilities/Nursing Facilities) projected enrollment and claim costs. Data is gathered separately for Non-Dual and Dual populations.
108		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		Please provide information supporting how third party liability payments were included in rate development.	OHCA paid claims data is net of third party liability payments.
109		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		Please provide documentation detailing any gross (non-claims based) adjustments that were made in the development of the draft capitation rates.	Please see slides 20 and 21 from the February 1, 2017 Bidders' conference for base data adjustments made to the Data Book, as well as base data adjustments made post-Data Book. Slide 16 also mentions supplemental payments not currently included in the draft/modeled capitation rates (but which may be included, depending upon final implementation considerations and decisions, in the eventual capitation rates to be paid).
110		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		Mercer indicated there was a 3% rate reduction to many categories of service, and an adjustment was applied in the capitation rate development. Were the rate reductions reversed going forward, and will that be reflected in future capitation rates?	The 3% "across the board" fee schedule reduction contained many exceptions for the applicable SoonerHealth+ populations. Hence, it's overall impact was measured at an approximate 1/2% downward impact. This change was effective 1/1/16, so should based data be rebased (versus a rate update) to CY 2016 for the next version of capitation rates, the adjustment would be completely reflected in the base data.
111		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		Please provide detailed information regarding the policy changes for crossover claims between CY 2013 and the end of the contract period.	This information is available on the OHCA website. The approximate impact was measured at -2/3% for the combined 7/1/15 and 1/1/16 changes impacting the draft/modeled capitation rates.

Question Number	Section or Subsection Number	Section or Subsection Title	Solicitation Page	Question	Response
112		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		Please provide additional clarification of the details regarding the aggregate 1.1% reduction to capitation rates for program changes by category of service and rate cell.	Please see the individual draft/modeled capitation rate exhibit sheets and the columns labeled "Prospective Program Changes" for the indicated impacts.
113		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		Please provide documentation of methodology supporting the trend analysis used in developing draft rates and which will be used in developing trends for final capitation rates, including but not limited to: data used in trend models, populations included, population stratification, service category stratification, incurred versus paid basis, adjustments applied, data-driven results, etc.	Please see slide 23 from the February 1, 2017 Bidders' conference presentation for an overview. Slide 24 provides average annual utilization, unit cost, and PMPM trend factors by service category. The individual capitation rate exhibit sheets provide rate cell detail. Potential bidders should utilize their own experience with populations similar to SoonerHealth+ in evaluation of claim cost trend. Alternatively, https://www.medicaid.gov/medicaid/financing-and-reimbursement/downloads/medicaid-actuarial-report-2016.pdf page 62 provides but one set of benchmarks for trends in costs for Aged and Disabled individuals. (This particular report was published after the draft/modeled capitation rates were developed, but prior versions displayed similar results.)
114		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		Please provide a summary of patient liability amounts by rate cell and region.	All claims data is net of patient liability. That data is not readily available.
115		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		We request that the state consider risk adjusting acute care premiums for this program. Other states have observed risk adjustment corridors of up to 30%, where one MCO may have a population that is 15% healthier than average and one MCO may have a population that is 15% sicker than average based on a risk scoring algorithm. The risk that is introduced for anti-selection is very concerning when taken into consideration with the low risk margin.	Risk adjustment between MCOs is not currently part of the model contract.

Question Number	Section or Subsection Number	Section or Subsection Title	Solicitation Page	Question	Response
116		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		We request that the state consider risk mitigation for the LTSS populations beginning in year 3. If one MCO enrolls a higher percentage of institutionalized members than average, the premium will not be sufficient to cover the cost of serving its members.	No State-sponsored risk mitigation provisions are currently part of the model contract.
117		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		Please provide CY 2013 through 2015 claims and enrollment base data split between institutional members with an ID diagnosis and all other institutional members.	This data is not readily available.
118		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		There is significant ICFMR and waiver cost under the custody kids rate cell. Why were custody kids receiving LTSS not included in the LTSS rate cells? Please provide a distribution of custody kid member months split into institutionalized, waiver, and non-LTSS.	Custody Kids rate cells were determined via separate Program Code/Eligibility Code and Aid Category determinations. These criteria were confirmed with OHCA staff. The costs for these individuals is materially different than the combined NFLOC costs. The data splits requested in the question are not readily available.
119		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		Please provide a cost model for custody kids who aren't receiving LTSS.	The data is not readily available.
120		SoonerHealthPlus Databook / SoonerHealthPlus Capitation Rates		Which year of enrollment will serve as the basis of rebalancing for the NFLOC capitation rates?	In the current draft/modeled capitation rates, CY 2015 serves as the base data year. Depending upon if capitation rates are rebased or updated, the CY 2015 time period may change.

Question Number	Section or Subsection Number	Section or Subsection Title	Solicitation Page	Question	Response
121		Written Clarification, Oral Presentations & Best and Final Offers	328	Can OHCA provide additional clarification around when Oral presentation will be and in what format?	Oral presentations are tentatively planned for the first week of April. Additional information will be provided in March to organizations that submit a proposal.