



**State of Oklahoma
OKLAHOMA HEALTH CARE
AUTHORITY**

Amendment of Solicitation

Date of Issuance: February 22, 2017

Solicitation No. 8070000933

Requisition No. 8070000933

Amendment No. 8

Hour and date specified for receipt of offers is changed: No Yes, to: _____ CST

Pursuant to OAC 580:16-7-30(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

Sheila Killingsworth
Contracting Officer

(405) - 522 - 7846

Phone Number

Oklahoma City, OK 73105 -

or

Personal or Common Carrier Delivery:

Oklahoma Health Care Authority
4345 North Lincoln Boulevard

sheila.killingsworth@okhca.org

E-Mail Address

Oklahoma City, OK 73105 -

Description of Amendment:

a. This is to incorporate the following:

Amendment Eight to include the following:
Additional answers from Round Two Questions
Question #9 from Amendment Seven, Round Two Questions, has been revised
Two documents are added to the RFP Library:

- ADvantage Waiver Rate Sheet | [Adobe PDF]
- Medically Fragile Waiver Rate Sheet | [Adobe PDF]

b. All other terms and conditions remain unchanged.

Supplier Company Name (**PRINT**) _____

Date _____

Authorized Representative Name (**PRINT**) _____ Title _____

Authorized Representative Signature _____

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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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Question Number	Section or Subsection Number	Section or Subsection Title	Solicitation Page	Question	Response
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.

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Question Number	Section or Subsection Number	Section or Subsection Title	Solicitation Page	Question	Response
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.
11	2.11.6	Assigning Care Management Risk Levels	162	<p>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.</p> <p>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.</p> <p>Please provide the expected care management staffing ratios that are implied in the capitation rates for Level 1, Level 2, and Level 3 members.</p>	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.

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Question Number	Section or Subsection Number	Section or Subsection Title	Solicitation Page	Question	Response
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.
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.

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Questions and Answers

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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.
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.

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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.
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.

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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.
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.

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32	3.6.2	Question 11 References	289	<p>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.</p>	No.
33	Capitation Rate Sheets	Managed Care Adjustment	n/a	<p>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.</p>	<p>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.</p>

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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)	<p>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:</p> <p>Item 18a - Plan Management Narrative Item 18b - Form I (Plan Management) Item 18c - Plan Management job descriptions Item 18d - Plan Management resumes</p> <p>Form I (Plan Management) requires the following:</p> <p>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.</p> <p>Please confirm that the submission of materials related to Item 18 should follow the instructions and tabs listed on Form B.</p>	<p>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.</p>

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Question Number	Section or Subsection Number	Section or Subsection Title	Solicitation Page	Question	Response
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 8087000933-F should be for the bidder's ABD (SSI) population only.
37	Item 2	Transmittal Letter	285-286	<p>Due to the preliminary nature of the provided rates, would OHCA consider revising bullet 7 of the transmittal language to read as follows:</p> <p>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.</p>	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.

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Question Number	Section or Subsection Number	Section or Subsection Title	Solicitation Page	Question	Response
39	Mercer SoonerHealth+ Feb 1 Actuarial Presentation	Rate Development Overview: Covered Benefits Includes/ Excludes	Slide 16	<p>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.</p> <p>What is the level that OU/OSU payments were funded?</p> <p>How is this cost distributed between the various rate cells?</p>	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.
40	Mercer SoonerHealth+ Feb 1 Actuarial presentation	Rate Development Overview: Covered Benefits Includes/ Excludes	Slide 16	<p>What is the total supplemental payments and costs included for each benefit by rate cell and region?</p> <p>Will there be additional reporting around these supplemental payments?</p>	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	<p>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.</p> <p>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?</p>	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.

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42	Mercer SoonerHealth+ Feb 1 Actuarial Presentation	Rate Development Methodology: Managed Care Assumptions	Slide 25	<p>What studies were used to determine the managed care assumptions that were made by category of service?</p> <p>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?</p>	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.
43	Mercer SoonerHealth+ Feb 1 Actuarial Presentation	Rate Development Methodology: Managed Care Assumptions	Slide 25	<p>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.</p> <p>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?</p>	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.

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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.
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 <i>contracted</i> 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.

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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.
52	RFP Questions	Oklahoma Experience		<p>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:</p> <p>"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."</p> <p>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?</p>	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.

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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.
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 .

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57	SoonerHealth+ Capitation Rates	Data book	All calculations	<p>Due to the preliminary nature of the provided rates, would OHCA consider revising bullet 7 of the transmittal language to read as follows:</p> <ul style="list-style-type: none"> 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.
58	SoonerHealth+ Capitation Rates	Administrative Expense	Tabs for Statewide Year 1; Statewide Year 2; Statewide Year 3	<p>Please provide a detailed description of the changes in the administrative expenses loads for years 1, 2, and 3.</p> <p>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.</p> <p>What assumptions, including expense inflation, are changing that cause the administrative percentage by rate cell to decrease each year?</p>	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	<p>For ABD populations, we have seen significantly higher administrative percentages than the 5.0 - 5.5% used in the Oklahoma data book.</p> <p>What studies were used to determine this load?</p> <p>Please split out these expenses by medical management and other administrative costs.</p>	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.

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60	SoonerHealth+ Capitation Rates	Underwriting Gain	Tabs for Statewide Year 1; Statewide Year 2; Statewide Year 3	<p>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.</p> <p>Please provide a detailed description of the changes in the risk/contingency loads in years 1, 2, and 3.</p>	The 0.25% reductions for Year 2 and Year 3 that a population is in the program represent changes in risk.
61	SoonerHealth+ Capitation Rates	Other	West Year 1 Tab	<p>Are case management services also included in the "Other" expenses? Please provide more detail about what services are included in the "Other" expense category.</p> <p>For example, in ADvantage non-dual West, the "Other" bucket is \$335 PMPM out of \$3,235 total PMPM, or 10%.</p> <p>For ADvantage dual West, the "Other" bucket is \$269 out of \$1,152 PMPM, or 23%.</p> <p>For I/ID members, the "Other" bucket is \$1,963 out of \$3,391 total PMPM, or 58%.</p>	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.

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63	SoonerHealth+ Data Book	Data Sources	1. General Information Tab	<p>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.</p> <p>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?</p>	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.
64	SoonerHealth+ Data Book	Data Disclaimer	1. General Information Tab	<p>Does the claims PMPM information in the data book include any case management expenses?</p> <p>If so, please detail these expenses by region, rate cell, and category of service.</p>	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	<p>It is our understanding that the voluntary population experience is not in the data book.</p> <p>Please provide a separate data book of the voluntary population experience for CY 2015.</p>	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.

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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.
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.

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Question Number	Section or Subsection Number	Section or Subsection Title	Solicitation Page	Question	Response
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.
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.

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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.
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

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Question Number	Section or Subsection Number	Section or Subsection Title	Solicitation Page	Question	Response
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.
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.

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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.
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.

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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.
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.

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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.

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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.

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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.
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.

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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.
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.

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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.
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.

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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.
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.

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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.
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.
122	3.6.2	Item 8 Item18	291 292	FORM 8070000933-I PLAN MANAGEMENT instructs bidders to attach the resume of the person in each listed position directly behind the corresponding job description. However, FORM 8070000933-B BIDDER PROPOSAL SUBMISSION CHECKLIST indicates that all the job descriptions should be together as Item 18c and all the resumes should be together as Item 18d. Please confirm that bidders should put job descriptions together and resumes together as Items 18c and 18d pursuant to FORM B.	Please see the response to question 35.

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Question Number	Section or Subsection Number	Section or Subsection Title	Solicitation Page	Question	Response
123	3.6.2	Technical Proposal Contents: ITEM 96	325	<p>Please confirm that the enrollment to use in Item 96: Pro Forma Financial Statement should assume the same Voluntary Opt-in and enrollment growth assumptions that are used in the Draft Capitation Rates.</p> <p>Specifically that total annual member months in the pro forma should be 1,415,524 divided by 3 for year 1 and 1,471,333 divided by 3 for year 2 for a single Contractor.</p>	Correct. Please use the projected member month values in the draft/modeled capitation rate sheet exhibits rather than historical values as originally stated in the submission item. Note that the figures quoted in the question apply if the bidder is submitting a statewide proposal.
124	Draft Capitation Rates	Draft Capitation Rates	N/A	<p>Sections 2.11.6.1, 2.11.6.2, and 2.11.6.3 lay out requirements around care management responsibilities for the Contractors. These requirements alone cost about 5.9% of net premium in year 1 - excluding any implementation costs. This is higher than the 5.7% administrative expense built into the rates.</p> <p>This leaves all other administrative responsibilities of the Contractors unfunded. ASOP 49 requires that for rates to be actuarially sound "the actuary should include a provision for administrative expenses appropriate for the Medicaid managed care business in the state." Please explain how the draft capitation rates are actuarially sound.</p>	Please see the response to question #9.
125	Draft Capitation Rates	Draft Capitation Rates	N/A	Please describe the methodology used to develop the administrative expense component of the draft capitation rates.	Please see the response to question #9 and #34.

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Question Number	Section or Subsection Number	Section or Subsection Title	Solicitation Page	Question	Response
126	Draft Capitation Rates	Draft Capitation Rates	N/A	ASOP 49 requires that for rates to actuarially sound the managed care adjustments "should be attainable in the rating period." A 45% reduction in Hospital Inpatient admissions and ER visits beginning on the first day of the new program is an unreasonable actuarial assumption for any population. Please provide the study that Mercer used to validate those assumptions.	Please see the response to question #33.
127	Draft Capitation Rates	Draft Capitation Rates	N/A	Please describe the methodology used to develop the managed care savings assumptions used in the development of the draft capitation rates.	Please see the response to question #33.
128	Draft Capitation Rates	Draft Capitation Rates	N/A	Where are costs for covered services that were paid outside the claim system included in the data book? Please provide a summary of these costs.	Data Book adjustments are listed on slide 20 of the February 1, 2017 Bidders' conference presentation. The item corresponding to the question is "Capitated payments" totaling \$7.4 million.
129	General	General	N/A	The actuarial presentation from February 1 indicated amounts that would be additional costs to OHCA to implement managed care. Could you please also provide a list of any administrative savings the state will experience due to the implementation of this program.	The OHCA hopes to achieve administrative savings as the program reaches a steady state but has not yet developed formal savings projections.
130	Draft Capitation Rates	Draft Capitation Rates	N/A	Section 2.11.3 states that there are existing case management agencies. How are these agencies currently reimbursed? How was this cost included in the draft capitation rates? Please provide a summary of these costs.	The respective waiver documents include reimbursement methodology. The claims are included in the populations data. Detailed cost by rate cell is not readily available.
131	Draft Capitation Rates	Draft Capitation Rates	N/A	In order to properly project costs for Item 96: Pro Forma Financial Statement we need to understand what care management/case management costs are built into the data book vs. administrative costs in the rates. Please provide a summary.	The data is not readily available. Bidders should allocate their projections of these costs based upon their own care/case models.

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Question Number	Section or Subsection Number	Section or Subsection Title	Solicitation Page	Question	Response
132	Draft Capitation Rates	Draft Capitation Rates	N/A	The responses to questions 199 and 202 mention future pharmacy pricing changes – how have these changes been built into the data book and capitation rates?	Please see the response to question #41 and #77.
133	Draft Capitation Rates	Draft Capitation Rates	N/A	Section 2.10.9.5 of the RFP indicates that the MCOs cannot collect and retain rebates for prescription drugs, but the actuary indicated at the 2/1/17 meeting that he included assumptions that the MCOs would collect and retain supplemental rebates. Please advise if section 2.10.9.5 does not apply to supplemental rebates negotiated by the MCOs.	Please see the response to question #8.
134	Amendment 3	Amendment 3	Amendment 3: Page 86 of 93	The fibrosis score requirement for Hepatitis C pharmacy coverage is being phased-out - how is this be accounted for in the rates? From Amendment 3: "The removal of the minimum METAVIR fibrosis score of F2. The removal of the fibrosis score requirement will be phased in as follows: Members with a fibrosis score of F1 will be eligible for approval July 1, 2017 and members with a fibrosis score of F0 will be eligible for approval January 1, 2018."	Please see the response to Question #41.
135	Data Book	Data Book	N/A	Where is the administrative cost component for EVV vendor(s) included in the data book?	The administrative cost components for EVV vendor is not included in the data book. The state will work with the selected plans to determine to what degree this can be accommodated in the current administrative cost projections when it is time to update/refresh the rates.

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Question Number	Section or Subsection Number	Section or Subsection Title	Solicitation Page	Question	Response
136	Data Book	Data Book	N/A	Where is the administrative cost component for FMS entities included in the data book?	The administrative cost components for FMS entities is not included in the data book. The state will work with the selected plans to determine to what degree this can be accommodated in the current administrative cost projections when it is time to update/refresh the rates.
137	Data Book	Data Book	N/A	<p>The data book released in January states that Medical education (Graduate, Indirect, and Direct) is not in the data book. Also, at the Actuarial Conference on February 1st it was stated that plans will not be responsible for these costs.</p> <p>Please confirm that OHCA will reimburse providers directly for Medical education (Graduate, Indirect, and Direct).</p>	OHCA confirms that OHCA will reimburse providers directly for Medical education (Graduate, Indirect, and Direct).
138	Data Book	Data Book	N/A	Please provide a summary of the different components that make up the "all other" claims service category along with their contribution amount to the total of this bucket.	This detail is not readily available. As shown on the "Data Reference" tab of the SoonerHealth+ Data Book, the All Other services service category includes stated categories, but is not limited to, transportation services, TCM, and State Program services.
139	Draft Capitation Rates	Draft Capitation Rates	N/A	<p>At the Actuarial Bidder's Conference it was stated that the draft capitation rates include a reduction for a Medicare crossover claims change that occurred on 7/1/15.</p> <p>Please describe the change to the covered benefits or provider reimbursement behind this adjustment.</p> <p>Was it from paying cost share amounts to paying under the "lessor of" language?</p>	Please see the response to question #111.
140	General	General	N/A	Please provide a description of the Emergency Room prudent layperson program in Oklahoma today.	Emergency Room prudent layperson is not a program but a component of the definition of Emergency Medical Condition. Please see Appendix 1 for the complete definition.

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Question Number	Section or Subsection Number	Section or Subsection Title	Solicitation Page	Question	Response
141	1.1.3	Population Counts	7	Please describe the difference between the population counts in the RFP section 1.1.3 and the data book. The RFP states 154,795 members. The data book has a total of 1,711,510 member months in 2015 which is an average of 142,626 members.	Point-in-time snapshot vs. CY 2015. Data Book also removes retroactive period member months (and claims) for which the MCOs do not have responsibility.
142	Draft Capitation Rates	Draft Capitation Rates	N/A	The IID waiver has a waiting list. How were these waiver members treated in rate setting?	Waiting list persons are included with IID State Plan only. I/ID State Plan Only rate cells were determined via separate Program Code/Eligibility Code and Aid Category determinations. These criteria were confirmed with OHCA staff.
143	Amendment 3, Question 179	Amendment 3, Question 179	Amendment 3, Question 179	Do plans have to contract with all three FMS entities? Are there any foreseen changes in the FMS entities or will they remain constant?	Yes, to contracting. FMS vendors are selected by the State through periodic competitive procurements. There are no pending changes in vendors.
144	2.16.2.4	Timely Payment Requirements	230	<p>How are non-standard services currently paid? For example: pest control, community transition services, career assessment, etc. Traditionally these providers may not have submitted a standard health claim and may be invoicing the OHCA instead.</p> <p>Please describe the current process of translating these services into encounters. Will these services count toward encounter metric targets for Contractors?</p>	OHCA generally does not pay for nonstandard services outside the fee schedule. If HCBS waivers offer certain nonstandard services, the methodology is included in the approved waiver. Waiver services will count toward encounter metric targets.

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Question Number	Section or Subsection Number	Section or Subsection Title	Solicitation Page	Question	Response
145	General	General	N/A	Will the member-level rate cells be communicated on the 834 file? If not, how will a rate cell for an individual member be communicated to a Contractor?	Q1 – Yes Q2 – Not applicable
146	General	General	N/A	If a plan determines that a member should be eligible for LTC waiver services, how does the Contractor report this to the state? What is the process for moving a member into a waiver program and subsequently changing a member's rate cell?	The selected plans will be informed about procedures for coordinating LTC needs for members with the Department of Human Services. Rate cells are prospective and will not change during a month.
147	Data Book	Data Book	N/A	The response to Question 145 states that when rates are paid they will be prorated daily - do member months in data book reflect true enrolled member days?	The data book reflects true past enrolled member days.
148	Draft Capitation Rates	Draft Capitation Rates	N/A	If a member exceeds the HCBS cost limit how will it be handled for rate setting? Are there any members in the base data that exceed this amount? What adjustments were made for them?	From the waiver operations standpoint, the operating agency will assist the plan if any transfers to a different program are needed. See Amendment Six, Question 147, to note the applicability of the cost cap being individual or in the aggregate. For ADvantage, the waiver operating agency cannot permit an individual to remain in the waiver if a member would exceed the individual cost cap.
149	Draft Capitation Rates	Draft Capitation Rates	N/A	The administrative expense percentage is declining each year in the draft capitation rates. What is ultimate target percentage in future years?	Administrative expense percentages vary by population. Administrative expense percentages were not developed beyond Year 3 of the SoonerHealth+ program.
150	2.9.5.1	Rate Setting	133	Please explain the methodology that is used in creating the HCBS fee schedule. Will the OHCA continue to maintain and update the HCBS fee schedule?	Please see #131. The fee schedules are developed by the operating agencies. Copies of the current fee schedules/rate sheets for the ADvantage and Medically Fragile waiver programs are posted in the RFP Library.
151	2.11.13.8	Fiscal Management Services (FMS) Responsibilities	181	Please describe how fee schedules/rates are set for self-directed providers.	The methodology for setting rates for self-directed services is outlined in the approved waiver document. Please see Question 78 for the link to these documents.

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152	2.9.5.1	Rate Setting	133	Will Contractors be required to pay minimum fee levels to any providers? If so, please list which providers.	Yes, as identified in Sections 2.9.5.1 and 2.9.5.4 - 2.9.5.8. Please also see the response to question 77.
153	2.4.2.8	Services or Settings in Lieu of Services or Setting Covered under the State Plan	67	How will IMD stays be handled in rate setting?	Draft/modeled capitation rates based upon State-Plan services only so this is not an issue with SoonerCare claims as the base data.
154	Draft Capitation Rates	Draft Capitation Rates	N/A	We are concerned that the draft capitation rates are not actuarially sound and may result in little or no competition in this procurement. Is OHCA confident that the draft capitation rates are actuarially sound?	The OHCA has full confidence in the process and results. Please see the response to question #9.
155	Draft Capitation Rates	Draft Capitation Rates	N/A	We are concerned about the actuarial soundness of the draft capitation rates and note that CMS has not yet made a determination regarding the rates. Are the draft capitation rates subject to change to the extent determined not to be actuarially sound or otherwise not approved by CMS? Will selected bidders have an opportunity to negotiate rates before finalization of the Contract?	The OHCA has full confidence in the process and results. Please see the response to question #9. The OHCA will only submit, and CMS will only review, certified actuarially sound capitation rates. There will not be rate negotiations with the selected bidders.
156	Amendment 4	Rate Development	n/a	Please provide details around the dental program changes driving the roughly 3% claims reduction for certain rate cells. In addition to the changes themselves, please provide the effective date for each as well.	The non-NFLOC impact of the dental program change is a result of the "Across-the-Board", January 1, 2016, 3% rate cut for providers, which included dental providers.
157	Amendment 4	Rate Development	n/a	Can the state provide the average units per dental visit associated with each rate cell? We would like to have this information in order to convert the base claims info into utilization and cost per unit as opposed to visit.	The data is not readily available.

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158	Amendment 4	Rate Development	n/a	Please provide additional detail around the utilization and average cost adjustments being made to the dental claims due to assumed Managed Care Adjustments. It is not clear to us why the state/Mercer would expect a sizeable increase in utilization and corresponding decrease in the cost per visit as a result of introducing Managed Care.	The managed care adjustments for Dental add dollars into the system. As described during the February 1, 2017 Bidders' conference, utilization and unit cost adjustment assumptions will often partially offset each other. Dental utilization is expected to increase; however the increase is assumed to be lower acuity or more preventive services, resulting in a mix decrease in average unit cost.
159	Amendment 4	Rate Development	n/a	Please provide additional support detail for the trend assumptions (both utilization and cost) assumed for the dental program, for years 1-3. We would like to better understand the state's/Mercer's trend development process, as well as having access to any of the data or analyses used to arrive at these assumptions.	Please see the response to question #113.
160	Amendment 4	Rate Development	n/a	We would like to understand what portion of the 4.1% annual trend in Year 1 is not associated with scheduled increases of the Fee Schedule. Please outline what portion of the Annualized Unit Cost Trend factor is associated with the annual update of the fee schedule?	The annualized Unit Cost trend factors are in place of explicit fee schedule changes analyses. Please see slide 4 and 23 from the February 1, 2017 Bidders' conference presentation.
161	Amendment 4	Rate Development	n/a	How did Mercer use Oklahoma experience to determine their Managed Care Adjustment assumptions?	Please see the response to question #33.
162	Amendment 4	Rate Development	n/a	Please list the data sources and states used to determine that the aggressive managed care assumed reductions are achievable in each of the three years.	Please see the response to question #33.
163	Amendment 4	Rate Development	n/a	Please provide a list of the state programs where 40%+ reductions for inpatient hospital and emergency room (ABD populations) were achieved in year 1 of a new managed care program.	Please see the response to question #33.

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Question Number	Section or Subsection Number	Section or Subsection Title	Solicitation Page	Question	Response
164	Amendment 4	Rate Development	n/a	The contract specifies a 90 day continuity of care requirement, which limits the ability to manage costs in the first quarter. How did Mercer take this contractual requirement into account when calculating the Year 1 rates?	Please see the response to question #33. Management of care is expected to increase as the SoonerHealth+ program matures. Year 1 assumptions are lower than Year 2, and Year 2 assumptions are lower than Year 3.
165	Amendment 4	Rate Development	n/a	Please explain the process Mercer will go through to determine if the managed care assumptions should change when the base data changes.	A determination has yet to be made re if the draft/modeled capitation rates will be rebased (updated base data) or updated (same base data, but with additional claim cost trend, program changes, etc.). Please see slide 8 from the February 1, 2017 Bidders' conference presentation.
166	Amendment 4	Rate Development	n/a	Mercer's presentation focused on making sure managed care costs would be less than the state's fee-for-service costs. Please clarify how Mercer will ensure that these rates are achievable, attainable and reasonable (i.e., actuarially sound) for the each of the three years.	Comparison to the current SoonerCare program was but one portion of the presentation's focus. At the appropriate times, Mercer will certify the Year 1, Year 2, and Year 3 final capitation rates as actuarially sound, per CMS requirements.
167	Amendment 4	Rate Development	n/a	How was the 5% transition target developed for the HCBS/NF rate cell in year 3?	Based upon reasonable progress from current levels over a several year horizon
168	Amendment 4	Rate Development	n/a	Please list states that achieved the 5% HCBS mix change in the first year of the members being in managed care? (Note FL was mentioned but only achieved this target after multiple years).	Please see response to question #167. No mention of 5% over a single year was made. If Florida was mentioned, it was inadvertent. Neighboring states of Nebraska and Texas were referenced as providing strong annual progress on HBCS percentage increases.
169	Amendment 4	Data Book	n/a	Please provide the hospital admissions and readmission rate for the three historical years, by rate cell.	This data is not readily available.
170	1.1.3	Population Count	7	Page 7 of the RFP puts the June 2016 count of ABD Kids and Adults at 154,795. Mercer's Year 3 membership projection comes out to 136,756 members on average (1,641,076/12). After including all of the potential voluntary enrollment members the count is still well below the 154,795 in the RFP. Please explain the gap in the membership in the RFP and Rate Development.	Point-in-time snapshot vs. Year 3 projection. Data Book and capitation rate exhibits also remove retroactive period member months (and claims) for which the MCOs do not have responsibility.

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171	Amendment 4	Rate Development	n/a	<p>We have observed that the ER utilization and IP utilization tends to materially vary by region. For example, the ABD <21 Non-Dual population in the West has CY15 Adjusted Base IP utilization of 1,067 days / 1,000. In the East it is only 3,652 days / 1,000 or 3.4 times higher than in the West. Yet the Managed Care Utilization Adjustment is the same -45% in each region.</p> <p>Furthermore, the ER utilization in the East is 23-36% higher in the East than in the West across the rate cells that weren't smoothed.</p> <p>How did Mercer consider geographical differences in the Managed Care Savings estimates they developed? Will Mercer refine Managed Care Savings assumptions by region in the final rates paid to the MCOs since a contractor could be awarded a contract in one or both regions?</p>	<p>Please see slide 8 from the February 1, 2017 Bidders' conference presentation. Regional variation of managed care adjustment factors may take place. Adjustment to one or more factors would likely trigger adjustment to other factors, which may have an offsetting, or partially-offsetting, impact.</p>
172	Amendment 4	Rate Development	n/a	<p>What level of reimbursement (expressed as an average % of Fee Schedule) does Mercer believe contractors will be able to achieve when developing their networks? Do the Draft Rates reflect this percentage?</p>	<p>Provider reimbursement and network development are the responsibility of each respective MCO. The draft/modeled rates were developed using historical SoonerCare data.</p>
173	Amendment 4	Rate Development	n/a	<p>Please provide the level of reimbursement (as a percentage of the fee schedule) assumed in the draft rates, specifically for OU/OSU. Please separate out the OU/OSU state-employed physician supplemental payments built into the draft rates.</p>	<p>Please see the response to Question #39.</p>

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Question Number	Section or Subsection Number	Section or Subsection Title	Solicitation Page	Question	Response
174	Amendment 4	Rate Development	n/a	Are there any protections in the State of Oklahoma that would allow the contractors to achieve an average reimbursement level of 100% of the Medicaid Fee Schedule? (Ex. Defined reimbursement for non-participating providers / facilities)	No.
175	Amendment 4	Rate Development	n/a	The Behavioral Health service category in the rates is a mix of services at different settings (Inpatient, Mental Health Clinic, etc.). Please provide a more detailed breakout of the Behavioral Health service category. At the very least, please provide a % composition of the major service categories (IP, OP, Physician, etc.) by rate cell.	This data is not readily available.
176	Amendment 4	Rate Development	n/a	What types of service make up the "All Other" Category of Service? What are the main services in this category?	Please see the response to question #138.
177	Amendment 4	Rate Development	n/a	Please provide the expected cost of vision services by rate cell in Year 1.	This data is not readily available.
178	Amendment 4	Rate Development	n/a	Where are the care coordination expenses located in the data book/rates? Please also clarify what these expenses represent.	Please see the responses to questions #59, #63 and #73.

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Question Number	Section or Subsection Number	Section or Subsection Title	Solicitation Page	Question	Response
179	Amendment 4	Rate Development	n/a	There are several care management programs in place (e.g. Health Management Program, Patient Centered Medical Home, Health Access Networks, Population Care Management, Chronic Care Management Unit, Health Homes, etc.), and it isn't clear to what the state's current costs are in running these programs and if these costs are in the data book. Depending on the exact nature of the programs, we believe that some of these costs should be in the data book since they are part of the current delivery system and are direct influencers of the level of fee-for-service costs that the state pays. Please provide a summary of the care management program cost in the rate development and a list of the costs that were intentionally excluded.	Please see the responses to questions #63 and #73.
180	Amendment 4	Rate Development	n/a	Please outline the next steps and timeline Mercer and the State anticipates in taking to finalize the rates for Year 1 of the contract. What involvement is anticipated from the successful contractors in the rate development process? Note this is very important to clarify in writing since it needs to be a component of the transmittal letter.	Although no timeline has been formally developed at this point, a reasonable guideline would be finalization of Year 1 capitation rates, certification, and submission to CMS sometime during November or December, 2017, in order to have CMS receive more than 90 days from the April 1, 2018 effective date. With regard to successful bidders, involvement is TBD, but it will not include negotiation of rates.
181	Amendment 4	Rate Development	n/a	Please explain the State's rationale for not including any risk mitigation in the SoonerHealth+ program outside of the 85% Minimum MLR and the option for contractor purchased reinsurance. For example, please provide the rationale for not calculating and passing on a risk adjustment given an MCO's membership will likely reflect a disproportionate risk experience/costs.	Please see the response to questions #21 and #116.

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Question Number	Section or Subsection Number	Section or Subsection Title	Solicitation Page	Question	Response
182	Amendment 4	Rate Development	n/a	Given the program risks, will the state consider a risk corridor so savings and losses are shared?	Please see the response to question #116.
183	Amendment 4	Rate Development	n/a	Please clarify the formula for the MLR calculation to be used. Can any expenses associated with penalties/sanctions be counted towards the calculation?	The MLR is consistent with the Medicaid Managed Care Final Rule under 42 CFR Section 438.8.
184	Amendment 4	Rate Development	n/a	To what extent did Mercer use the requirements of the SoonerHealth+ contract to determine their Administrative Load assumption? If the Administrative Load was based on other State programs, what State programs were used?	Please see the response to question #59.
185	Amendment 4	Rate Development	n/a	What process did Mercer follow to calculate the admin and margin load? What states were used as a starting point for Mercer's assumptions? How were Oklahoma specific contract requirements taken into account (e.g., extra staffing required due to penalties/sanctions)?	Please see the response to question #59.
186	Amendment 4	Rate Development	n/a	Please explain how the decreasing margin (as a percentage of premium) is appropriate, given the populations phasing in over time and the increase risk due to expected ranges of costs.	Please see the response to question #60.
187	Amendment 4	Rate Development	n/a	Are there other payments / cost outside of SHOPP, Supplemental OU IP and OP facilities, ETPS, and NHNSGO that were not included in the Draft Rates that will be included in the Final Rates? Can a list and amounts of each of these be provided now?	No other costs or payments were excluded.
188	Amendment 4	Rate Development	n/a	Please provide insight into the future of the SHOPP payment, the potential to change the structure and amount, and the facilities reaction.	The state is exploring the future of this payment with providers and with CMS. The state cannot speak for providers.

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Question Number	Section or Subsection Number	Section or Subsection Title	Solicitation Page	Question	Response
189	Amendment 4	Rate Development	n/a	How were the 90/180 day thresholds for removing experience associated with retroactive periods from the base data determined for the Aged and Blind / Disabled populations respectively?	The thresholds were established in consultation with OHCA subject matter experts. The resultant base period PMPM impact is consistent with percentages that Mercer has observed for similar populations in other states.
190	Amendment 4	Rate Development	n/a	The Medicaid Fee Schedule is pegged to the Medicare Fee Schedule and is updated on an annual basis. What percentage of the Medicare Fee Schedule does the Medicaid Fee Schedule represent? Has this percentage changed over time?	Prior to April 1, 2010, OHCA paid 100 percent of the Medicare fee schedule. On April 1, 2010, rates were reduced to 96.75 of the Medicare fee schedule. This was followed by a reduction to 89.25 percent on July 1, 2014, and to 86.57 percent effective January 1, 2016.
191	Amendment 4	Rate Development	n/a	The average annual FFS utilization trend used in the rates ranges from -2.0% to 1.0%. Please describe in more detail the results from the Oklahoma experience, Consumer Price Index, and other Federal and Industry reports that support negative to flat utilization projection trends.	Please see slide 23 of the February 1, 2017 Bidders' conference for a partial list of claim cost trend sources. With regard to Utilization trends for Medicaid populations, an independent source of note is https://www.medicare.gov/medicaid/financing-and-reimbursement/downloads/medicaid-actuarial-report-2016.pdf (page 55+)
192	Amendment 4	Rate Development	n/a	Please describe how Mercer avoided any double counting of negative trends and managed care savings. Please also describe how the rates can be actuarially sound given both sets of current assumptions.	The claim cost trends take the SoonerCare (current part FFS/part PCCM-like program) claims and project them forward. The managed care adjustment factors then model those costs under full-risk Medicaid managed care. The two sets of assumptions are independent. The assumptions utilized are not inconsistent with the actuarial soundness process.
193	2.10.9.5	Rebates and Financial Reports	152	This section of the RFP states: "All rebates for pharmaceutical products and diabetic testing supplies shall accrue to the OHCA and shall not be kept or shared by or with the Contractor or its PBM." The rate development reflects a 3% reduction for MCO Supplemental Rebates. Please clarify whether the MCOs will be able to keep the supplemental rebates.	Please see the response to question #8.

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194	Amendment 4	Rate Development	n/a	Please explain the reason for the 5% managed care reduction to unit cost, given the contract requirement to pay no less than fee-for-service.	For 3% of the adjustment (to be removed), please see the response to question #8. The remaining is a mix adjustment. 5% more prescriptions (the Utilization adjustment) implies slightly lower-cost prescriptions on average.
195	Amendment 4	Rate Development	n/a	Does the unit cost portion of the Managed Care Adjustment reflect the change in severity of services after management? Are there any other considerations that make up this portion of the rate development?	Yes. No.
196	Amendment 4	Rate Development	n/a	It is our understanding is that the state will not adjust the blended HCBS/NF rates in year 3 of the program based on actual HCBS/NF mix for any given plan. This puts a plan at considerable financial risk if that plan enrolls a large number (i.e., mix of NF members much larger than the average) of NF members even if that plan manages costs very efficiently and is successful at transitioning members from the Nursing Facility to their home/community. Will the State/Mercer reconsider their position on not rebalancing the NFLOC rate for contractor specific enrollment, so that plans can compete on the basis of efficiency and not on how well they can enroll a favorable mix of members?	Not at this time.
197	Amendment 4	Rate Development	n/a	In addition to the NF and HCBS members, the NFLOC population group contains several populations where rates vary drastically (e.g., Medical Fragile vs. In-Home Supports). Will the state consider some protection for the MCO if their mix is different than the projected mix?	Not at this time.
198	Amendment 4	Rate Development	n/a	Please provide a distribution of the amount of time the current NF members have been in the institutions, by rate cell.	This data is not readily available.

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199	Amendment 4	Rate Development	n/a	Please clarify whether the state currently has a ER prudent layperson policy.	Please see the response to question 140.
200	Amendment 4	Rate Development	n/a	How will Mercer's adjustments change if more than 3 MCOs are awarded a contract? For example, what if there were 3 winners statewide and an additional winner in the West?	Any change(s) to any adjustment factors would be determined at a later date.
201	Amendment 4	Rate Development	n/a	Please provide average PMPM cost of Native Americans. It appears that these costs are more than some of the groups they will be part of, if they enroll in managed care. Please explain why the rates won't be adjusted if the take-up rate is different than expected.	Native Americans are identified in the SoonerHealth+ Data Book when the Voluntary column = "Y". Historical costs for this population are sometimes higher, sometimes lower, than the overall rate cell average. While each rate assumption (such as Voluntary population take-up) is important and needs to be reasonable, potential bidders should also review the overall draft/modeled capitation rate.
202	Amendment 4	Rate Development	n/a	Please clarify the methodology and process that the State/Mercer intend to employ to calculate the HIPF.	The OHCA and Mercer have not finalized the methodology for the rate adjustment to recognize the ACA Section 9010 Health Insurance Providers Fee in the capitation rates.
203	1.1.3	Population Count	8	In October of 2016 there were 7,442 children and adults on a waiver list maintained by Oklahoma Department of Human Services. Please outline the rate cells these members are in a) in the three base years and b) in the projected rates.	Children and adults on the waiting list for HCBS services may be included in the I/ID State Plan only counts. Please see the response to question #142.
204	Amendment 4	Rate Development	n/a	The Mercer rate development targets a 63% HCBS / 37% Nursing Facility mix for the NFLOC in Year 3 from a base mix of 58%/42%. How does Mercer intend to adjust their target mix if the actual HCBS / NF mix changes prior to the institutional members being introduced into the SoonerHealth+ program in Year 3?	The targeted HCBS/NF mix for program Year 3 (April 2020 through March 2021) will be finalized with rates for that program year. Data available for that rate development is expected to be claims incurred through March 2019 with three to six months of runout, including recent data on the actual HCBS/NF mix. Attainable Year 3 targets will be determined from multiple data and information sources.

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Question Number	Section or Subsection Number	Section or Subsection Title	Solicitation Page	Question	Response
205	Amendment 4	Rate Development	n/a	What is the CY15 Generic Fill Rate of the SoonerHealth+ populations and what is assumed in the rates for Year 1? Year 2? Year 3?	SoonerHealth+ or ABD-specific data and information is not readily available. Across all SoonerCare populations (including TANF, etc.) the CY 2015 GFR was 89.2%. Both CY 2014 and CY 2016 were somewhat higher. An implied modest improvement in GFR was part of the overall Pharmacy claim cost trend assumption. An annualized trend was used across all 3 years.
206	Amendment 4	Rate Development	n/a	We understand the units for the inpatient category of service are days in the data book and rate development. We believe short length of stay admits are most likely to be reduced with managed care. What is the corresponding reduction in admits associated with the managed care savings assumptions? As an example, a 45% reduction in days is assumed for the ABD Non-Dual population in Year 1. What percent of admits does this 45% reduction represent?	Managed care adjustment factors were not separately developed for Admissions and Average Length of Stay.
207	2.4.2.2	General Medical and Related Benefits	55	Please clarify that there is currently no ER copay, but there is a copay for physician/PCP visits.	Correct.
208	Amendment 4	Rate Development	n/a	Given the anticipated distribution differences of HEP C members by MCO, will the state consider a case rate?	The OHCA will not consider such a case rate at this point in time.
209	2.9.5.8	Payments to Pharmacy Providers	136	RFP states that pricing to pharmacies must not be less than FFS pricing. Is this requirement in aggregate or on claim by claim basis?	See clarification in #77. The requirement is claim by claim for brand names.
210	Amendment 4	Rate Development	n/a	For the Pharmacy section of the rate development there is a -5% unit cost managed care adjustment. Please detail what that 5% reduction to the pharmacy portion of the rates represents.	Please see responses to questions #8 and #193 for rebate discussion and #158 for service mix change discussion.

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Question Number	Section or Subsection Number	Section or Subsection Title	Solicitation Page	Question	Response
211	Amendment 4	Rate Development	n/a	For the behavioral health category of service, are the Unit Type of Visits composed of Outpatient and Community Based Services? Or one or the other?	Visits are used for all non-inpatient behavioral health services.
212	Amendment 4	Rate Development	n/a	The inpatient category of service is reimbursed under a DRG methodology, but the data book and rate development use days as the unit type. Were the expenses adjusted in anyway from DRG to FFS?	In the Data Book and draft/modeled rate development there was no adjustment of inpatient hospital expenses for any effect of DRG-based reimbursement.
213	Amendment 4	Rate Development	n/a	Please explain why an MCO cannot waive copays (as a value add - given it supports the most appropriate utilization)?	The OHCA does not consider co-payment levels to be an appropriate basis for members to differentiate between plans.
214	Amendment 4	Rate Development	n/a	Does Mercer believe the penalties/sanctions are reasonable? Even though they are not taken directly into account when developing rates, Mercer still should opine on whether the rates will be actuarially sound.	The reference to the actuary opining on contractual penalties/sanctions is incorrect. Given they have nothing to do with the capitation rate development process, Mercer will not be providing any opinion on contractual penalties/sanctions. Also, see #215.
215	Amendment 4	Rate Development	n/a	Would the state consider the penalties/sanctions be implemented on a sliding scale for cause?	The penalties will not be revised. Please note that many of the penalties/amounts are mandated by CMS.

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Question Number	Section or Subsection Number	Section or Subsection Title	Solicitation Page	Question	Response
216	2.11.5	Initial Member Outreach for Health Risk Screenings	160	<p>First round of Q&A response states, "In-person and secure web are acceptable methods for Health Risk Screening. No, mail is not an acceptable method of Health Risk Screening."</p> <p>Historically, we have offered completion of the HRS through multiple methods including telephone, web, in-person and mail. We include a hard copy in our Welcome Packet along with a stamped, return envelope and instructions that the HRS can also be completed by phone, web, and in person. In addition, we then make multiple attempts to contact members by phone to complete the HRS. We feel the mail option is especially important given the ABD population who may not be comfortable giving personal information over the phone or using a website. In our experience we do receive a significant HRS's returned by mail. We follow up within one business day of receiving the mailed HRS to respond to urgent needs or clarify answers. Would the state reconsider allowing mail as an option to complete the HRS?</p>	<p>Mail is an accepted additional method, when combined with phone attempts for non-responders, and phone follow-up for responders.</p>
217	General			<p>Can the state please provide historic facility PH level utilization with CMS Medicare ID, Medicaid ID, NPI, Name, Admits, Days, CMI, Billed Charges, Allowed Amount, and Paid Amount for IP discharges and CMS Medicare ID, Medicaid ID, NPI, Name, Claim Count, Admits, Days, Billed Charges, Allowed Amount, and Paid Amount for OP claims</p>	<p>This data and information is not readily available. The OHCA will consider these and other data information requests with contractors post-award.</p>

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Question Number	Section or Subsection Number	Section or Subsection Title	Solicitation Page	Question	Response
218	General			Can the State please provide historic PH professional claims with TIN, NPI, Name, Specialty, Claim Count, # Services, Billed Charges, Allowed Amount, and Paid Amount	This data and information is not readily available. The OHCA will consider these and other data information requests with contractors post-award.
219	General			Can the state please provide the Top 20 facility by Physical Health spend	This data and information is not readily available. The OHCA will consider these and other data information requests with contractors post-award.
220	2.11.14	EVV System	190	Regarding the statement: <i>Information about the capabilities of the Oklahoma DHS EVV system shall be made available in the Bidder's Library.</i> We have not found this information in the Bidder's Library. Does OHCA still plan on making additional EVV information available in the Bidder's Library?	The EVV contract procurement has not yet been concluded. The contract will be added to the Bidders Library when it is available.
221	Question 45	HCBS Provider Education	303	Question 45 asks Contractors to describe how they will assist HCBS providers to comply with plan requirements concerning encounter submissions and other specified topics. Can we assume that the term "encounter submissions" in this context is synonymous with "claim or encounter submissions from HCBS Providers to the Contractor" for adjudication by the Contractor? If not, please correct us.	Correct.

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222	2.11.5.4	Health Risk Screening Timeframes	162	<p>2.11.5.4. describes HRS timeframes. It states “Notwithstanding the above timelines, if the member is identified as having an ER visit, crisis center visit, hospital admission or change in condition prior to or following completion of the Health Risk Screening, the Contractor shall assign a care manager, if one has not already been assigned, and perform a face-to-face comprehensive assessment within seven days of notification of the event.”</p> <p>Question: Can we assume that the face to face assessment requirement is for those members who have not completed an HRS and/or have not yet been assigned a CM and is not intended for every instance in which a member has visited an ER or had an admission, etc.? If not, please explain how to interpret this in light of transition requirements in 2.6.5.1.</p>	Assumption is correct.