Delaware Health
And Social Services

DIVISION OF MANAGEMENT SERVICES

PROCUREMENT

DATE: March 14th, 2014

HSS 14 019 Delaware Medicaid Managed Care Organizations

For

Division of Medicaid and Medical Assistance

Date Due: April 4th 2014
11:00AM

ADDENDUM # 3 Please Note:

THE ATTACHED SHEETS HEREBY BECOME A PART OF THE ABOVE MENTIONED BID.

Q&A Document

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Question Number	Pertinent Document	Section Number	Page # in Ref. Doc.	Question	Response
1	Not provided	Not provided	Not provided	When the eligibility files are sent to the MCOs is language provided?	Yes, the eligibility/enrollment file is a standard 834 (5010) transaction.
2	Not provided	Not provided	Not provided	As a result of this bid, if a new MCO is receiving existing members from an incumbent, and the HRA and PASARR was conducted less than a year ago, how much time does the receiving MCO have to conduct the new HRA?	During ongoing operations the MCO must conduct an HRA within 60 days of the member's enrollment. However, during initial implementation, the State will extend that timeframe for new MCOs to reflect the influx of new members. The MCO must ensure a PASRR has been completed by the State before admission to a nursing facility. It does not have to be conducted annually. However, the MCO must re-determine level of care on an annual basis, regardless of whether the previous level of care was done by another MCO or the State.
3	Not provided	Not provided	Not provided	Due to the fact that DMMA will no longer have nurses completing PASARR forms or making LOC determinations, who/how will these functions be carried out? Will the State permit the MCOs to set their own Nursing home methodology?	As specified in section 3.7.2 of the contract, the State will continue to be responsible for the PASRR screening process and will conduct many LOC functions, including the initial PAE for eligibility, evaluation of NF LOC for members moving from HCBS to a nursing facility, and re-evaluations of LOC for members residing in nursing facilities. The MCO will be responsible for re-evaluating the LOC of HCBS members at least annually using a LOC re-evaluation form prior approved by the State. If the MCO determines a member no longer meets HCBS LOC, the MCO will submit the LOC re-determination documentation to the State for review. No, MCOs cannot set their own nursing facility LOC.
4	Not provided	Not provided	Not provided	Will the State require MCOs to publish two separate member handbooks for DSHP and DSHP+ members?	Yes, as specified in section 3.14.1.4 of the contract, MCOs must have two separate member handbooks - one for DSHP members and one for DSHP Plus members.
5	Not provided	Not provided	Not provided	Please define each population within each eligibility category in detail. Please list each eligibility category in DSHP, DSHP Plus, DSHP Plus LTSS.	This information is provided in the data book. Please see Appendix B of the RFP.
6	Not provided	Not provided	Not provided	Will there be an open enrollment in Fall 2014 if there are 1, 2 or 3 new MCOs?	Yes, the State intends to have an open enrollment in Fall 2014. Section 3.2.2.3 of the contract will be revised to reflect that approach.

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7	Not provided	Not provided	Not provided	The methodology described in 3.2.2.1 isn't detailed re: how the state will handle assigning members is there are two incumbents and 1 new MCO, please elaborate. Will the new MCO be assigned every new member who doesn't choose a plan?	The State's methodology for assigning members if there are new MCOs will depend on the number of incumbents and new MCOs, so the State cannot provide details at this time. However, the State intends to establish minimum membership levels by population (e.g., DSHP and DSHP Plus LTSS) to ensure that new MCOs have enough members to be financially viable and will support attainment of those membership levels through automatic assignment of members. Note that the second clause in section 3.2.2.1 of the contract should read: the State will implement an automatic assignment mechanism to assign *clients* to all contracting MCOs such that all contracting MCOs achieve minimum membership levels as determined by the State. Also, section 3.2.2.3 will be revised to reflect an open enrollment in Fall 2014, and the last sentence in section 3.2.2.3.1 starting with "Members who do not select an MCO" will be deleted.
8	Not provided	Not provided	Not provided	If the State will permit a different methodology, will the State dictate what the methodology has to be?	If the bidder is referencing section 3.2.2.1 of the contract, the State will determine the automatic assignment methodology. See response to question 7.
9	Not provided	Not provided	Not provided	There is not much information available on the 1115 Demonstration Waiver program, PROMISE. Is there a detailed description of the parameters of this program, including the level of involvement from MCOs?	Please see the concept paper for PROMISE included in the procurement library for a description of the program. The MCO's responsibilities regarding PROMISE are included in the contract. In general, the MCO is expected to collaborate with DSAMH and the PROMISE care managers regarding any MCO member in the PROMISE program. However, if the MCO member is in DSHP Plus LTSS and PROMISE, the MCO case manager will be the lead CM. See also response to question #93.
10	Not provided	Not provided	Not provided	If the Contractor is unable to contact a new member within 90 calendar days (after 5 attempts), what is the Contractor's responsibilities? Notify the State? Try to reach the member again at a future date? Disenroll the member? Nothing after documenting the 5 failed outreach attempts?	If the bidder is referencing section 3.6.3.4.4.2.1 of the contract, after the five documented outreach attempts the MCO continues to be responsible for all contract requirements other than providing Level 2 clinical care coordination. If the MCO fails to contact a member after five attempts, the MCO can close the member's case for Level 2 clinical care coordination. However, the member may still be eligible for Level 2 clinical care coordination at a future date.
11	RFP	4.2.8.4, Q 18	22	Are the PROMISE enrollment criteria different than the old DSAMH criteria?	The PROMISE enrollment criteria are different from the current DSMAH criteria. Please see the concept paper for PROMISE included in the procurement library for the PROMISE eligibility criteria.
12	RFP	4.2.8.5, Q 22.a	23	Is encouraging a high rate of PDL use related to compliance with Delaware's PDL or the Contractor's Formulary (which would also incorporate Delaware's PDL)?	The requirement is with the DMMA PDL.

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13	RFP	4.2.8.7, Q 30.c	24	Does the State have specific expectations or requirements regarding the mode of communication for coordination with the member's PCP and other relevant providers e.g., mail, telephone, scheduled conference calls, etc. Or can the MCO determine this process?	The State does not have specific requirements regarding the mode of communication for coordination with the member's PCP and other providers as part of case management for DSHP Plus LTSS but expects the MCO to use the mode(s) of communication that works best for the provider. The MCO can determine the process for communicating with PCPs as long as it's consistent with that expectation.
14	RFP	4.2.8.7, Q 32	24	What mechanism is currently in place to notify the MCO when a member's eligibility changes to DSHP Plus LTSS? And what is the timeframe/delay in notification?	The 834 daily enrollment file is used to notify the MCO when a member's eligibility changes to DSHP Plus LTSS. As provided in section 3.2.4.2.2 of the contract, the effective date of enrollment for nursing facility resident may be retroactive up to 90 calendar days prior to the member's date of application for Medicaid.
15	RFP	4.2.8.8, Q 33	25	For individuals living out of state, is there a waiting period for residency before they become eligible for LTSS? If there is a waiting period, does time inpatient in Delaware count toward residency requirements?	No, there is no waiting period for residency. As soon as an individual moves to Delaware with the intent to reside in Delaware, he/she is considered a resident of Delaware for purposes of Medicaid eligibility.
16	RFP	4.2.8.8, Q 34	25	Please define 'support brokers'	Support brokers are individuals who are employed or contracted by the MCO's provider of support for Self-Directed Attendant Care Services and conduct the functions listed in section 3.8.8.4 of the contract (supports brokerage functions).
17	RFP	4.2.8.8, Q 36	25	Which agency conducts the PASRR Level II Assessments? How and to whom do they communicate if specialized services are deemed appropriate for an individual? What is the expectation of coordination between PROMISE and LTSS regarding these specialized services?	If, as determined by the PASRR Level I screen, an individual seeking admission to a nursing facility (NF) has a mental illness (MI), then the PASRR Level II is conducted by a DSAMH designee. If the individual has an intellectual disability/developmental disability, then the PASRR Level II is conducted by DDDS. DSAMH and DDDS, respectively, based on the findings of the Level II screen, determine the appropriateness of NF placement for the individual and whether and which specialized services are needed. If the service is in the DSHP or DSHP Plus LTSS benefit package, the MCO must provide the specialized services as specified by DSAMH and DDDS. DSAMH and DDDS will monitor that the specialized services required are provided by the MCO as mandated. There will be a high level of collaboration between the MCO and the State to develop, implement and monitor the effective provision of specialized services. Individuals residing in a nursing facility are not eligible for PROMISE since PROMISE is a HCBS program; therefore there is no expectation regarding coordination of specialized services with PROMISE services while the member is residing in a nursing facility.

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18	RFP	4.2.8.19, Q 75.c	32	"The service provider must include a list of software that the State needs to utilize the solution..." Can you please clarify what types of systems the State requires access to?	Although the State will not normally need to access any of the MCO's systems, periodic file transfers (from State to MCO via secure server) will take place. The purpose of this requirement is to ensure that the State is aware of any state-based software that will need to be resident on the State's computing environment to interact with MCO systems in any way.
19	RFP Appendix A, Contract	3.4.2.2	49	What is meant by inpatient services in a psychiatric hospital? Freestanding psychiatric facility (private/psych only hospital), State Hospital, or both? What do the "age>65" and "age>18 and <21" guidelines mean? Who covers members outside these age ranges? Is the MCO responsible for all residential treatment for members under 21 or just those members age >18 and <21?	For adult members (18 and older) under age 22 or over age 64, the MCO is financially responsible for all psychiatric hospital care regardless of whether that care is in a psychiatric hospital that is a private freestanding psychiatric facility or a State hospital. For members age 22 - 64, the MCO is financially responsible for all psychiatric care in a hospital under the Medicaid state plan. MCOs are financially responsible for the inpatient hospitalization with no limits.
20	RFP Appendix A, Contract	3.4.1.4	48	Is the MCO restricted, in any way, by the State with respect to which set of medical necessity criteria (MNC) are utilized for review of behavioral health and/or chemical dependency services (e.g., ASAM must be used for chemical dependency or State has its own set of MNC for behavioral health)?	As specified in section 3.12.6.3.2 of the contract, the MCO must use the Delaware American Society for Addiction Medicine (DE-ASAM) criteria for behavioral health services. DE-ASAM includes criteria for both substance use disorder and mental health services. Additional information regarding DE-ASAM is contained in the State's Medicaid behavioral health certification and reimbursement manual, which may be found in the procurement library.
21	RFP Appendix A, Contract	3.4.2.2	49	Is there any expectation that the MCO must cover custodial care situations e.g., member inpatient behavioral health, MNC no longer met but disposition (nursing home, group home, state hospital) not available? If MCO must cover, are sub-acute/custodial care rate agreements for such situations acceptable?	No, the MCO is not expected to cover custodial care situations.
22	RFP Appendix A, Contract	3.4.2.2	51	For children, do crisis services fall under the same 30 unit limit as outpatient services or are they separate limits?	Crisis services for children are included in the 30 unit limit, and services in excess of that limit are provided by DSCYF. There is no limit on the adult side.
23	RFP Appendix A, Contract	3.5.2.2.4	75	Our interpretation of this requirement is that when supplemental contracts are obtained, the terms of the supplemental contracts cannot require that a drug on the PDL be placed in a less advantageous position in the MCO formulary than it is on the PDL. Please confirm if this is the correct interpretation.	A drug covered by a supplemental rebate agreement shall not be placed in a less advantageous position in the MCO's formulary than it is on the State's PDL.
24	RFP Appendix A, Contract	3.5.2.5	76	Are the State's guidelines to monitor certain diagnoses publically available?	DMMA monitors drugs that potentially have off labeled use where the risk benefit has not been demonstrated. Pulmozyme for cystic fibrosis is an example of drugs that fit this type of monitoring. The State will provide these guidelines to the contractors.

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25	RFP Appendix A, Contract	3.5.4.2	77	Does the State have an expectation as to how an MCO approaches the OOP threshold? Should the MCO reimburse members who exceed the $15/30 day threshold or should POS editing be in place to set copay to $0 when the threshold is met?	The MCO should have POS editing in place to set the copay to $0 when the member has met the threshold.
26	RFP Appendix A, Contract	3.5.6.2 and 3.5.6.3	78	It is our assumption that the Member Transfer Coordination of Care form and the requirement that the previous MCO transfer relevant data mentioned in RFP Appendix A: 3.8.1.4.1 would include the diagnoses necessary to determine the 60 or 90 day transition requirements for medications depending on diagnosis. Please confirm if it is the correct assumption.	The current member transfer coordination of care form does not include diagnosis. The State will work closely with the MOs to implement and effective member transition process.
27	RFP Appendix A, Contract	3.5.7.6	79	Will members who are already locked in to a pharmacy or PCP from FFS or another MCO be identified in some way during enrollment to ensure that members remain locked-in? Is this something that can also be obtained in the coordination of care and relevant data discussed in RFP Appendix A: 3.8.1.4.1?	The State currently only locks members into a pharmacy (not a PCP), and information on pharmacy lock-in will be provided to the contractors prior to go live. PCP lock-in is new to this contract, so information on PCP lock-in will not apply during initial implementation. The State will work with the contracted MCOs to determine the methodology for sharing pharmacy and PCP lock-in information when members transition between MCOs, including potentially adding this element to the coordination of care form/data transfer.
28	RFP Appendix A, Contract	3.8.11.1	79	Is there a defined mechanism, system or process for sharing with other MCOs the results of its identification and assessment of Special Needs Children?	A coordination of care form must be completed if a member with special needs transitions to another MCO.
29	RFP Appendix A, Contract	3.7.1.3.3	101	When is the Pre-Admission Evaluation completed? To whom is it submitted? Is this part of the PASRR process?	The PAE is completed by the State as part of the DSHP Plus LTSS eligibility process and by the MCO prior to an HCBS member being admitted to a nursing facility. As required by section 3.7.2.5.21 of the contract, for HCBS members being admitted to a nursing facility, the MCO shall complete the PAE and submit it to the State. The PAE is not always part of the PASRR process. However, if a member will be admitted to a nursing facility, the MCO must ensure and document that a PAE and PASRR have been completed by the State prior to admission. If the State completes a PAE for a member, the State will provide the completed PAE to the member's MCO via secure email.

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30	RFP Appendix A, Contract	3.11.6.4	205	Please identify the provider categories that Delaware expects to be included in each of the example payment models (a) through (e) defined in Question 44: e.g., primary care physicians, specialty physicians, acute care hospitals	The payment model encompassed by design parameters (a) through (e) in question 44 is primarily focused on participation of primary care providers, whether independent or part of a broader legal entity. For example: 1) Primary care providers practicing in independent practices; 2) Primary care providers employed by a hospital or a multispecialty group practice; 3) Primary care providers who are part of an ACO or other structure. Rewards for primary care providers will reflect quality, utilization, and total cost of care across the care continuum (excluding other institutional and ambulance services) for the population attributable to those primary care providers (excluding DSHP Plus and dual eligibles).
31	RFP Appendix A, Contract	3.11.6.4	205	Please confirm that the payment models are not expected to be applicable to ancillary providers, IMDs, nursing facilities, assisted living facilities, other institutional long-term care services, and home and community-based services.	The payment model is focused on participation of primary care providers, as described in response to question #30. Rewards for primary care providers will reflect quality, utilization, and total cost of care across the care continuum for the population attributable to them.
32	RFP Appendix A, Contract	3.11.6.4	205	Does the State expect to reimburse the health plan for a portion or all of the incentives to be offered to providers through an incentive pool?	The State's intention is that any provider incentives flow through the MCO and that the MCO develops incentives that result in cost savings.
33	RFP Appendix A, Contract	4.7.3.1	302	What will be the total incentive pool of dollars that are available and potentially can be awarded to the Contractors as part of the Value-Based Purchasing Program?	The State's 2015 budget has not been finalized, but DMMA is targeting $2.5 million for the VBP incentive pool.
34	RFP Appendix A, Contract	3.2.6.3.1	39	Will the open enrollment period change now that the effective date will be January 1, 2015? In addition, will members be "locked in" to the MCO for the entire benefit year, January 1 - December 31?	Yes, the annual open enrollment period will change to the fall, mostly likely October instead of May. Section 3.2.6.3 of the contract will be revised to reflect the new annual open enrollment period. Yes, except as provided in section 3.2.7 of the contract, members are "locked in" to the MCO for the calendar year.
35	RFP Appendix A, Contract	3.4.2.2	49	Currently there is a 30 day inpatient limitation, with the new contract will there be any limitations to the number of inpatient behavioral services? Will the limitations be defined in the benefit grid?	No, the current 30 day inpatient limitation for adults is not included in the new contract.
36	RFP Appendix A, Contract	3.4.2.2	50	In Appendix A, section 3.4.2.2 there are limitations [on behavioral health crisis services] for members under age 18, are there any limitations for members ages 18 and over? If so, please provide those limitations	No, there is no limitation on medically necessary behavioral health crisis services for members age 18 and over.
37	RFP Appendix A, Contract	3.4.2.2	50	In Appendix A, section 3.4.2.2 there are limitations [on substance use disorder services] for members under age 18, are there any limitations for members ages 18 and over? If so, please provide those limitations.	No, there are no limitations on medically necessary substance use disorder services for members age 18 and over.

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38	RFP Appendix A, Contract	3.4.2.2	50	Are there any limitations [on licensed behavioral health practitioner services] for members age 18 and older? In Appendix A, section 3.4.2.2 there are limitations for members under age 18, are there any limitations for members ages 18 and over? If so, please provide those limitations.	No, there are no limitations on medically necessary licensed behavioral health practitioner services for members age 18 and over.
39	RFP Appendix A, Contract	3.14.1.4.1.5	225	Please clarify the statement "the contractor shall update member handbooks on the Contractor's member website daily". Will the expectation be to update all contents of the website version of the member handbooks daily? Is this requirement addressing the Contractor's capability to update the website daily?	If the content of the MCO's member handbook(s) changes, the MCO shall update the member handbook(s) on the member website within one business day.
40	RFP Appendix A, Contract	3.8.1.4.1	133	Will the enrollment file from the state indicate and identify a member that has transferred from another MCO? If so, what identifying information will be provided?	No, the enrollment file will not indicate if a member has transferred from another MCO. However, the State will work with the contractors to develop and implement an effective member transfer process.
41	RFP Appendix A, Contract	3.14.1.4.1.3	224	Please confirm the reference to 3.14.1.4.1.3 in the statement "The Contractor shall annually, within 30 calendar days of the end of the Annual Open Enrollment Period, send a letter to members who did not change enrollment during the Annual Open Enrollment Period(for new members see Section 3.14.1.4.1.3 above) notifying them of the availability of an updated DSHP/DSHP Plus member handbook (as applicable to the member) and summarizing any changes to the member handbook." is the appropriate referenced section.	The reference should be "3.14.1.4.1.2."
42	RFP Appendix A, Contract	3.16.4.5	225	Please provide the level of authorization required from the State and within what timeframe will the approval occur?	If a staff member of DMMA's Program Integrity Unit or MFCU responds in writing (including email) to the MCO's notification of suspected fraud, waste or abuse (see section 3.16.4.3) stating that the MCO is not prohibited from taking the actions specified in section 3.16.4.5.1 through 3.16.4.5.3, the MCO may take those actions. The State intends to provide this approval within two business days of receiving the notice specified in section 3.16.4.3.

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43	RFP Appendix A, Contract	3.9.6.6.3	171	This statement refers to the provider complaint system policies and procedures, including claims issues. Claims issues are a response to an action (the definition of appeal). So, is the complaint system actually referring to (or synonymous with) the provider appeal system? The terms appeals, grievance, and complaints seem to be used interchangeably and are not all defined in the definitions section. Please define: 1. provider complaint 2. provider appeal 3. provider grievance	The contract uses the term "provider complaint system" to distinguish it from the member "grievance and appeal system," and "complaint" is used to refer to any provider disputes. An MCO may use other terminology and include additional levels of review as long as the requirements in section 3.9.6.6, including the timeframes for resolving complaints/disputes, are met. Note that the State intends to revise section 3.9.6.6.4.7 to replace "15 calendar days" with "30 calendar days" in two places.
44	RFP Appendix A, Contract	3.20.2.1.4	278	Please clarify if the BH CMO should be an MD. In addition, is this position also expected to be an advanced practice nurse as well?	The BH CMO is not required to be a physician. If the BH CMO is a physician, he/she does not need to also be a nurse, but he/she must be a board certified psychiatrist licensed in Delaware with at least five years of combined experience in mental health and substance use services. See also response to question #86.
45	RFP	4.2.8	19	Section 4.2.8 instructs bidders to start each new question on a new page. Due to page limits, will the State allow bidders to start each section on a new page, rather than each question?	No, the page limit per section is based on estimated pages per question so it reflects the requirement to start each question on a new page.
46	RFP and RFP Appendix A, Contract	3.20	RFP page 33 & RFP Appendix A page 277	Please clarify this requirement. Please confirm if the state would like resumes in addition to job descriptions and to be counted outside of the page limits.	As part of its response to question 77, the bidder shall provide job descriptions (not resumes) for key personnel positions, and the job descriptions are included in the page limit for the section. In accordance with section 3.20.1.2, as part of readiness review the MCO will submit resumes for all key personnel.
47	RFP Appendix B, Data Book		Databook	Will the state, as part of the release of the databook, provide additional information about the actuarial assumptions the state made in the release of the data, so that all bidders have the same understanding?	The data book describes the adjustments reflected in the data book (see Section 4 of RFP Appendix B) and other adjustments that might be made as part of rate development (see Section 5 of RFP Appendix B).

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48	RFP	4.2.8.9, Q 38	26	Please confirm that the State is requesting only the number of participating providers by type and county served, and is not requesting the Bidder to submit provider participation agreements (that is, signed contract documents) or letters of intent. If the State does require provider contract agreements or LOIs to be submitted as part of the proposal, please identify the required submission format, as hardcopy submission in the required number of copies will total millions of pages. If the State does not want the provider contracts or LOIs, but does want identification of the providers in the network, would a list of providers or current printed provider directory be acceptable? If such a list or directory is required, please confirm that it will be exempt from the current page limit for the section. If a list is required, please specify the necessary data elements.	The State is requesting only the number of participating providers by type and county. The State is not requesting the bidder to submit provider participation agreements or letters of intent. However, the number of participating providers by type and county must be based on existing provider participation agreements or letters of intent. The State is not requesting the identification of the providers, just the number of providers by type and county. The response to question 38.a is exempt from the page limit for this section.
49	RFP Appendix A, Contract	3.20.2.1.11 to 3.20	279	Currently, DPCI has a full time employee for network development for all lines of business and a full time employee responsible for provider relations for all lines of business. Is the state's intention to be prescriptive with regard to the organization's structure and reporting relationships, or is it acceptable to continue with this or similar organizational structure as long as all contract and RFP requirements are met?	As specified in sections 3.20.2.1.10 and 3.20.2.1.11 of the contract, the State is requiring the MCO to have at least two staff persons for provider services and provider relations - one staff person for DSHP and another staff person for DSHP Plus, including DSHP Plus LTSS. The MCO can split the function of each staff person (so there is one person responsible for network development for DSHP and another person responsible for provider services for DSHP), but the same person cannot be responsible for both DSHP and DSHP Plus. Also, per section 3.20.1.9, key personnel must be dedicated to the contract (not work on other lines of business).
50	RFP	4.2.8.19, Q 75	31-32	For part (a) of Question 75 (page 31) Please specifically define what constitutes “cloud computing” and “remote hosting” for purposes of this RFP.	For the purposes of this RFP, any system that houses state owned confidential and/or HIPAA-regulated data that has a component resident in a cloud environment or in a remotely-hosted data center is considered to fall under these requirements.
51	RFP	4.2.8.19, Q 75	32	For part (b) of Question 75 (page 32), is the Bidder required only to provide attestation to the requirement, or a description of how the requirement will be fulfilled?	The bidder is required to provide an attestation of this requirement with a brief description of the generally accepted professional and technical policies and standards employed.
52	RFP	4.2.8.19, Q 75	32	For part (c) of Question 75 (page 32), if the Bidder’s information systems do not fall within the definition of “cloud computing” or “remote hosting,” is a response required to the elements of this question?	Yes, the bidder's information systems environment is considered remote to the State network, therefore this requirement holds if state owned confidential and/or HIPAA-regulated data is hosted by the bidder.
53	RFP			Given the new contract and program requirements, will bidders be provided with guidance on which items are not addressed in the data book? If yes, when will the additional guidance be available to bidders?	The data book contains information available at this time regarding the new contract and new requirements, including, for example, information on pharmacy and SBWCs.

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54	RFP Appendix A, Contract	3.18.4.4	268-269	Given the new requirements for encounter submissions, will the weekly submission limitations be removed? Will the frequency for the 835 response file and remit file increase?	There will be no adjustments to the weekly encounter limitations at this time, but the State will revisit this if necessary. Similarly, the 835 file will continue to be provided weekly. For additional information on MCO data exchanges with the State, see "Managed Care Data Exchanges" in the procurement library.
55	RFP Appendix A, Contract		282	Does Appendix A section 3.21.1.8 apply to general reporting only? Please confirm that the requirements in this section do not apply to financial reports and that the financial reports will continue with the current contract timeframes?	The reporting timeframes in section 3.21.1.8 apply unless otherwise requested by the State, and the State intends to continue the current timeframes for financial reporting (quarterly reports due 60 days after quarter end, annual reports 120 days after year end).
56	RFP Appendix A, Contract		298	How will the State provide information related to actuarial soundness and any related underlying assumptions? Please confirm this will be provided prior to contract negotiation.	The State has not decided what information regarding actuarial assumptions will be shared with bidders prior to price negotiations.
57	RFP Appendix B, Data Book	1	1	The databook shows historical DSP member counts (Exhibit 9). When will the State provide historical DSP claim costs? Please confirm that DSP claim costs are not reflected anywhere in the databook currently.	DSP-related claims were not included in any of the exhibits contained in the data book. Summarized DSP fee-for-service claims information for calendar year 2011 and 2012 is provided in Attachment 1. This attachment provides summarized CY 2011 and CY 2012 fee-for-service (FFS) data for DSP participants eligible to enroll in DSHP managed care by rate tier. Due to small population sizes, the data has been aggregated on a statewide basis by major category of service. The FFS claims data reflect payment run-out through October 2013. The only adjustments made to this data were exclusion of services not covered under managed care and removal of a small number of prisoners enrolled in the DSP program.
58	RFP Appendix A, Contract	3.4.2.2	51	The new requirement in Section 3.4.2.2 bottom of page 51, requires the MCO to coordinate benefits with Medicare up to 100% of the Medicare allowed. Current language and contracts support "lesser of" reimbursement for all coordination of benefits including Medicare. This new requirement would increase the cost of the program by requiring MCOs to coordinate with Medicare up to 100% of the Medicare allowable, rather than up to 100% of the Medicaid allowable, whichever is less. Please clarify if it is the State's expectation for the MCO to coordinate with Medicare to pay up to 100% of Medicare allowed.	The text in section 3.4.2.2 of the contract should read "Medicare deductible/co-insurance up to the Medicaid allowed amount." The intent is to continue the current policy of paying the lesser of (a) the Medicaid rate for the service minus the Medicare payment; and (b) the Medicare deductible/co-insurance.

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59	RFP Appendix A, Contract	3.11.6.4.1	205	The model contract states that at the end of 2015, contractors will be paying 80% of participating providers using Pay 4 Value or total cost of care models (with at least 20% in total cost of care). Previous conversations in the state around the SIM Grant have targeted 80% of the state's population receiving care through value-based payment within 5 years. Given the alignment and aggregation needed in the market, we suggest that the requirements in the RFP be aligned to the SIM requirements. Will the model contract be modified?	The contract will reflect the SIM requirements that contractors will have 80% of the population receiving care through value-based payment at the end of five years.
60	RFP Appendix A, Contract	3.5.6	78	The contract states that contractors will ensure that members will continue treatment of medications prior authorized or not prior authorized by the State according to certain protocols. In order to appropriately administer this for Delawareans, we will need utilization history and files from the State. We will need the details of electronic delivery of this information.	The State will provide each contractor with an electronic file of pharmacy prior authorizations for its members.
61	RFP Appendix A, Contract	3.5.2.2	75	The contract states that the formulary will follow the States Preferred Drug List which has been made available. Can the State further provide an NDC file of PDL drugs and devices? Based on our experience, we recommend that the State allow the Contractor to maintain a specific number of products within a therapeutic class rather than the specific NDCs currently in a given class.	The State will provide a list of NDCs and their associated status on preferred or non preferred to the contractors.
62	RFP Appendix A, Contract	3.14.2.10.2, 3.20.1.14-16	278	Section 3.14.2.10.2. requires that member advocates have job responsibility for appeals and grievances. Are the member advocates required in section 3.20.1.14 and 3.20.1.15 inclusive of the grievances and appeals staff person required per contract section 3.20.1.16?	No, the DSHP and DSHP Plus Member Advocates are separate from the staff person responsible for managing member grievances and appeals. The responsibilities of the DSHP and DSHP Plus Member Advocates include helping members navigate the grievance and appeal process and may participate in the process, but they are not responsible for managing the grievance and appeals process.
63	RFP Appendix A, Contract	5.1.2.1.2	308	The State has set forth a vision in the State Health Care Innovation Plan to employ care coordinators (at all levels of member risk strata) as part of healthy neighborhoods or accountable care communities. However, Section 5.1.2.1.2 prohibits MCOs from subcontracting this function. This requirement will restrict local community/provider based support entities from performing this function, many of which do so today. We recommend modifying the language to ensure that MCOs oversee, monitor and audit these activities and that the use of any subcontractors would be subject to the approval of the state. This would mitigate disruption to current care providing organizations.	The intent of section 5.1.2.1.2 of the contract is to require the MCO to have its employees (versus subcontracted staff) provide DSHP Plus LTSS case management and Level 2 care coordination, both of which require regular, face-to-face contact with members. Consistent with the State Health Care Innovation Plan, section 3.6.7.2 of the contract requires the MCO to work with DMMA to develop capacity to support provider level care coordination activities. As part of this requirement, the MCO may fund provider investments in care coordination (either embedded with or dedicated to provider sites). In addition, the MCO may subcontract for community health workers.

Question Number	Pertinent Document	Section Number	Page # in Ref. Doc.	Question	Response
64	RFP	4.2.8.20, Q 77	33	The question asks for job descriptions of Key Personnel Positions within the Bidder's organization. Can you provide some guidance as to whether DHSS is looking for separate detailed traditional job descriptions submitted for each position? Or, would DHSS like to see a single document that summarizes the general description of the primary job functions to be performed.	The State is looking for a one to two page job description for each of the listed key personnel positions.
65	RFP	4.2.8.7, Q 31	25	Some states only require that HCBS be covered until the daily cost is equal to or greater than the average cost of a SNF stay. Does Delaware have such provisions? If so, what is the average daily (or monthly) cost of a SNF stay?	No, Delaware does not have an individual cost cap for HCBS.
66	RFP	4.2.8.8, Q 34	25	Does DHSS have preferred agencies for the provision of Self Directed Attendant Care services inclusive of financial management and support brokerage? If yes, will the State share a list of agencies with the MCO?	The current MCOs contract with Easter Seals and JEVS Supports for Independence, and the State encourages MCOs to contract with both of those vendors.
67	RFP	4.2.8.8	25	Are 'specialized services' those that go beyond the care generally offered in nursing facilities e.g., 24 hour supervision, medical care, room & board, nutrition/meals, medication, needed treatments/therapies, access to a physician and social services? If so, please provide examples.	Specialized services are defined in section 1 of the contract (page 21). They are highly individualized services that are necessary to support an individual with mental illness or intellectual disability over and above those services a nursing facility must provide under reimbursement as nursing facility services. An example of a specialized service that is included in the DSHP benefit package is licensed behavioral health practitioner services.
68	RFP Appendix B, Data Book		Exhibits 1-4	Is the experience in Exhibits 1-4 (DSHP Financials 2010, 2011, 2012 and DSHP Plus Financials 2012) able to be split into cost and utilization components? If so, could you provide this additional information?	The data book contains the information the State is able to share at this time.
69	RFP Appendix B, Data Book		Exhibits 1-3	Can the maternity experience in Exhibits 1-3 (DSHP Financials 2010, 2011 and 2012) be split out so that the maternity rate tier payment can be evaluated?	Attachment 2 provides summarized calendar year (CY) 2012 maternity delivery events and maternity-related expenses as reported by the two existing MCOs pursuant to DMMA's financial reporting requirements. Data from both MCOs were combined for display purposes. No adjustments have been made to this data.
70	RFP Appendix B, Data Book		Exhibits 10a-10b	Would you be able to provide the average pharmacy discounts split for each year (2010, 2011 and 2012) for brand, generic, and specialty?	No, the State will not provide the requested information.
71	RFP Appendix C, Procurement Library, MFP Protocol	3	11	Does the State expect each plan chosen to meet a proportionate number of these benchmark goals?	Yes.
72	RFP Appendix B, Data Book			Could you please provide the rate setting documents for DSHP and DSHP Plus (data book and other rate setting documents) for the last three rate years?	No, this information will not be provided at this time.

Question Number	Pertinent Document	Section Number	Page # in Ref. Doc.	Question	Response
73	RFP Appendix B, Data Book			Could you provide the actual 2014 enrollment by month for the three ACA Expansion Rate Tiers, as well as the state's projected 2015 enrollment for these three groups?	Actual member months for newly eligible individuals is provided in Attachment 3. However, given enrollment challenges, the State believes these numbers should be viewed with caution.
74	RFP Appendix B, Data Book			Does the state have any information available regarding expected claim cost levels of the three ACA Expansion Rate Tiers?	The State will not provide the requested information at this time.
75	N/A	N/A	N/A	Per the DOJ Settlement Agreement: Crisis stabilization services are short-term acute inpatient care intended to stabilize an individual and avoid long-term psychiatric hospitalization. Lengths of stay shall be limited to no longer than 14 days. ii. Prior to admitting an individual for crisis stabilization services, the State shall, to the extent permitted by law, determine that such services are required and that admission of the individual could not be avoided through the use of other services. Can the State provide the number and names of the existing facilities that meet the DOJ compliance expectations? For persons enrolled in MCOs and in the PROMISE program are there to be two distinct processes regarding the need for admission to such settings---one managed by the MCOs and one managed by the PROMISE contractor?	The reference to crisis stabilization in the DOJ Settlement Agreement is to short-term stays in an inpatient psychiatric unit, which are already the responsibility of the MCOs. The State is developing mobile crisis and site-based crisis intervention services, which will be covered under the new contract using state certified crisis intervention providers. The State is in the process of certifying these providers, and a list of certified providers will be available on DSAMH's website. Information on providers currently certified as crisis providers can be found on DSAMH's website at http://dhss.delaware.gov/dhss/dsamh/crisis_intervention.html. The MCO will be responsible for both admission to behavioral health inpatient care and access to crisis intervention services for its members, regardless of the member's participation in PROMISE.
76	N/A	N/A	N/A	Per the DOJ Settlement Agreement: When an individual is admitted for acute care, intensive support service providers will engage with the individual within 24 hours of admission in order to facilitate a quick return to the community with necessary supports Could the State articulate its expectations regarding the roles of the MCOs in contrast to the intensive support service providers when an "individual is admitted for acute care"?	For members in PROMISE, the MCO shall collaborate with the member's DSAMH care manager as needed to ensure that intensive support service providers engage with the member within 24 hours of admission. For members not participating in PROMISE, the MCO is responsible for initiation of discharge planning, including coordination with a community-based behavioral health provider, within 24 hours of admission.

Question Number	Pertinent Document	Section Number	Page # in Ref. Doc.	Question	Response
77	N/A	N/A	N/A	Per the DOJ Settlement Agreement: Crisis apartments are apartments where individuals experiencing a psychiatric crisis can stay for up to seven days to receive support and stabilization services in the community before returning home. Could the State provide us with the names/locations of the existing Crisis apartments which would be available to MCO members also enrolled in the PROMISE program?	The State will provide information on existing crisis apartments to the selected contractors. At this time crisis apartments will be covered by PROMISE, so members participating in PROMISE will have access to crisis apartments through the PROMISE program.
78	N/A	N/A	N/A	Per the DOJ Settlement Agreement: By July 1, 2014 the number of annual State-funded patient days in acute inpatient settings in the State will be reduced by 30% from the State's baseline on the Effective Date of the Settlement Agreement as determined by the Monitor and the Parties It appears that "State funded patient days" will be a mixture of MCO-funded days and State-funded days (e.g., Delaware Psychiatric Center) ---is this correct? If yes, could State please provide us the most current report on this DOJ metric and the percentage of total days represented by each psychiatric inpatient facility? (General Psychiatric Hospital, IMD and Delaware Psychiatric Center).	Please see the DHSS website (http://dhss.delaware.gov/dhss/dsamh/repstats.html) for the court monitor's reports and the State's progress reports. The State has not completed the methodology for counting "State-funded patient days," so this information is not currently available. This information will be provided to the selected contractors.
79	N/A	N/A	N/A	Will the State be providing historical claims data on all assigned members to each MCO? And do you have the ability to provide such data from prior MCO and FFS databases as well as the pharmacy database which they currently manage?	The State does not intend to provide historical claims data on all assigned members but will work closely with the contractors to implement an effective member transition process.
80	RFP Appendix A, Contract	N/A	50	RFP notes that Substance abuse benefits for those not in PROMISE are the responsibility of the MCO. State refers to covering "all levels" of the American Society of Addiction Medicine. Please confirm this includes ALL residential levels, including levels 3.1, 3.3, 3.5 and 3.7? And please confirm if all these levels are currently available in the State of Delaware?	This includes all ASAM residential levels of care including 3.1, 3.2D, 3.3, 3.5, 3.7 and 3.7D. Yes, all levels of care are currently available in Delaware. Please see the State's Medicaid behavioral health certification and reimbursement manual for a complete description of each level of care. If the MCO would like to utilize DSAMH SAPT block grant funds for room and board, the provider must obtain prior authorization through DSAMH.

Question Number	Pertinent Document	Section Number	Page # in Ref. Doc.	Question	Response
81	RFP	4.2.8.1, Q 7	20	Section 4.2.8.1(7) of the RFP asks for pending or recent (last 7 years) civil, criminal or administrative litigation against the Bidder (including parent, affiliated and/or related business entities) where the amount in controversy is $1 million or more or is related to a public sector contract (including but not limited to Medicaid, Medicare, CHIP and public employees). Bidder is a subsidiary of a large publicly traded insurance company which has subsidiary health plans nationwide, including numerous commercial health plans, as well as a number of service companies and international organizations, most of which conduct absolutely no Medicaid business and do not provide services in support of Medicaid business. As responding to this question with respect to Bidder's parent, affiliated and/or related business entities would result in the provision of a voluminous amount of information which would consist primarily of information that is immaterial to the Bidder's abilities or applicable subcontractor affiliates' abilities to support the DHSP and DHSP Plus programs, please confirm that the information requested in this question pertaining to litigation where the amount in controversy is $1 million is limited to the Bidder's and its parent, affiliated and/or related business entities' Medicaid line of business only.	Question 7 in Section 4.2.8.1 of the RFP is revised to read as follows: State whether there is any pending or recent (i.e., in the last seven years) civil, criminal or administrative litigation against the Bidder (including parent, affiliated and/or related business entities). If the litigation is related to the Bidder's Medicaid line of business, provide the contract that is being litigated (if applicable), the damages being sought or awarded and the extent to which adverse judgment is/would be covered by insurance or reserves set aside for this purpose. Also include any outcomes, deferred prosecution agreements (or agreements whose effect is the same) and settlement agreements. For litigation that is not related to the Bidder's Medicaid line of business, provide a statement as to whether there is any material, pending litigation against the Bidder that the Bidder should reasonably believe could adversely affect its ability to meet contract requirements pursuant to this RFP or is likely to have a material adverse effect on the Bidder's financial condition. If such exists, list each separately, explain the relevant details, and attach the opinion of counsel addressing whether and to what extent it would impair the Bidder's performance in a contract pursuant to this RFP. Also include any Securities and Exchange Commission (SEC) filings discussing any pending or recent litigation. The Bidder does not need to divulge workers' compensation litigation, real estate litigation, internal contractual litigation (including labor litigation), or employment litigation if there is no Equal Employment Opportunity Commission (EEOC) cause finding (or state/local agency equivalent of cause finding).

Question Number	Pertinent Document	Section Number	Page # in Ref. Doc.	Question	Response
82	RFP	4.2.8.1, Q 9	21	Section 4.2.8.1(9) of the RFP asks to identify and describe any debarment or suspension, regulatory action or sanction (monetary or non-monetary sanctions) imposed by any federal or state regulatory entity against the Bidder, its parent, affiliated and/or related business entities within the last 7 years. Bidder is a subsidiary of a large publicly traded insurance company which has subsidiary health plans nationwide, including numerous commercial health plans, as well as a number of service companies and international organizations, most of which conduct absolutely no Medicaid business and do not provide services in support of Medicaid business. As responding to this question with respect to Bidder's parent, affiliated and/or related business entities would result in the provision of a voluminous amount of information which would consist primarily of information that is immaterial to the Bidder's abilities or applicable subcontractor affiliates' abilities to support the DHSP and DHSP Plus programs, please confirm that the information requested in this question is limited to the Bidder's and its parent, affiliated and/or related business entities' Medicaid line of business only.	This question is not limited to the bidder's Medicaid line of business. However, it is only asking for actions by federal and state regulatory entities, not employers or other non-governmental entities.

Question Number	Pertinent Document	Section Number	Page # in Ref. Doc.	Question	Response
83	Not provided	Not provided	Not provided	Please confirm the length and dates of the initial contract.	As provided in section 2.1 of the RFP (page 9), the State expects the contract start date to be July 1, 2014, with operations and payment starting effective January 1, 2015. The initial contract period shall be through December 31, 2017 (three years from the start date of operations). Section 5.2.3 of the contract (page 313), will be revised accordingly.
84	Not provided	Not provided	Not provided	In section 3.6.3.2.1.3.1, there is a reference to 3.6.8.2, but that section does not exist. Can you please provide the correct reference?	The reference should be deleted, and the last clause of the sentence should read “the Contractor shall hire a proportionate number of additional field-based staff for that county.”
85	Not provided	Not provided	Not provided	Does the Bidder have to hold a HMO license from the Delaware Department of Insurance (DOI) at the time of submitting an RFP response, or by the “go live” date? Is it sufficient for the Bidder to have an HMO license application pending with DOI at the time of submitting the RFP response? Alternatively, is it sufficient if the Bidder operates a subsidiary that is licensed in another state?	As provided in sections 3.4 (page 10) and 4.2.3 (page 17) of the RFP, the bidder must be licensed as an HMO or HSC in Delaware OR be licensed as an HMO in another state. Having a subsidiary that is licensed as an HMO in another state meets that requirement. As provided in the contract (see, e.g., section 2.2 on page 31), before the start date of operations the contractor must be licensed by Delaware DOI as an HMO or an HSC or certified by DHSS.

Question Number	Pertinent Document	Section Number	Page # in Ref. Doc.	Question	Response
86	Not provided	Not provided	Not provided	For the required key personnel – the Behavioral Health CMO, the credentials for the position are narrowly tailored. Given the licensure structure in Delaware, where most of the advanced practice nurses with Behavioral Health certification are licensed as Clinical Nurse Specialists, not NPs, may an MCO deviate without penalty from the prescribed credentials if that deviation does not diminish the ability of the BH CMO? And should Delaware adopt the NCSBN consensus model, will DMMA accept the APRN license?	Yes, the BH CMO may be a board certified Psychiatric Mental Health Clinical Nurse Specialist with an APN license, and Section 3.20.2.1.4 will be revised to reflect that.
87	Not provided	Not provided	Not provided	What percentage of new members come over (from the HBM to the MCO) with a completed HRA in each eligibility category? Can we get a copy of the HRA, so we can program it/map it to our system?	The HRA is conducted by the MCO, not the HBM, and the HRAs are proprietary tools of each MCO.
88	Not provided	Not provided	Not provided	Data Book_List2, Tab 5a-5g: Please advise which Category of Service line items apply to Behavioral Health services besides just the Behavioral Health line item, and what portion of those additional line items apply to Behavioral Health services?	Services identified as behavioral health services were mapped to the Behavioral Health line item. They were not included in other line items.
89	Not provided	Not provided	Not provided	How will the membership be split among the two to three MCOs that are selected to manage the plans? Will there be an equal distribution of members from the DSHP and DSHP Plus plans to be covered by the selected MCOs or will there be some other methodology used for distributing the membership among the selected plans?	See response to question #7.
90	Not provided	Not provided	Not provided	How will individuals that are enrolled in PROMISE be identified in advance? How will the PROMISE members be recognized on the eligibility feed? How quickly will the MCO be notified of the member's acceptance into that Waiver?	It is anticipated that individuals enrolled in the PROMISE program will be identified using one of two demonstration indicators on the HIPAA 834 eligibility roster provided to the MCOs. Once the MCO refers an MCO member to DSAMH, the State is anticipating a 30-45 day process to assess the member, determine program eligibility, and develop a recovery plan under this new HCBS program.
91	Not provided	Not provided	Not provided	Please confirm whether services like in-home behavioral health treatment is considered an enhanced or non-enhanced service under PROMISE.	The State is not familiar with the terminology "enhanced service". Please see the concept paper for PROMISE included in the procurement library for a description of the services covered by PROMISE.

Question Number	Pertinent Document	Section Number	Page # in Ref. Doc.	Question	Response
92	Not provided	Not provided	Not provided	Please provide guidance on the rate presentation requirements – including if possible a template and PMPM expectations (e.g., separate rates for DSHP and DSHP Plus).	Additional information on the requirements for price negotiations will be provided to the bidders selected for price negotiations. However, the State anticipates using the current rate tier structure identified in RFP Appendix B, Data Book.
93	Not provided	Not provided	Not provided	Under the PROMISE program, how will services that are considered HCBS, for example vocational, or day habilitation, be managed? Will they be the responsibility of the MCO to case manage and cover or will they be managed by the PROMISE CM and covered by that program?	In general, PROMISE services will be the responsibility of the State and primarily managed by DSAMH care managers (see section 3.4.10.8.2 of the contract). However, for DSHP Plus LTSS members, the MCO is responsible for providing and managing all LTSS services in the MCO benefit package that are medically necessary per the MCO's UM criteria, including services that are similar to those covered by PROMISE (e.g., chore, personal care and respite). In addition, the MCO's DSHP Plus LTSS case manager is responsible for ongoing coordination and collaboration with the member's DSAMH care manager to ensure the development and implementation of a comprehensive plan of care that addresses the member's needs, including PROMISE services that are not available or exceed the MCO benefit through the DSHP or DSHP Plus LTSS benefit packages, as authorized by DSAMH. See section 3.7 of the contract for related requirements. See also response to question #9.
94	Not provided	Not provided	Not provided	Is the MCO responsible for any other data submissions or reports related to QI that are not delineated in Appendix A?	The QM/QI reporting requirements in the contract, including DSHP QCMMR and DSHP Plus-QCMMR, are the anticipated QM/QI reporting requirements for the new contract. However, as provided in section 3.21.1.5 of the contract, the State may changes these requirements as needed.
95	RFP	4.2.8.9, Q 38	26	Section 4.2.8.9, #38 of RFP states that "letters of intent (LOIs)" are acceptable for this proposal. Will the MCO bidder be penalized if providers refuse to sign an LOI after the MCO makes a reasonable attempt to obtain the LOI?	The information provided in response to question #38, particularly #38.a, must be supported by provider participation agreements or letters of intent (LOI). However, the State realizes that providers might not be willing to sign LOIs (or provider agreements) at this stage of the process and does not expect bidders to have a complete provider network at the time of proposal submission. The intent of question #38.a is for the bidder to document the current status of the bidder's provider network (as supported by LOIs or provider participation agreements). The bidder should describe its approach to building a complete provider network in its response to other sub-parts of question 38. The contractor must have a complete network before the start date of operations.

Question Number	Pertinent Document	Section Number	Page # in Ref. Doc.	Question	Response
96	RFP Appendix A, Contract	3.2.2	35	Section 3.2.2 of Appendix A states that "the State will implement an automatic assignment mechanism…such that all contracting MCOs achieve minimum membership levels as determined by the State." Can DHSS please identify what the minimum membership level will be in the event of a new MCO?	See response to question #7.
97	RFP Appendix A, Contract	3.2.2	35	What is the mechanism to ensure that each MCO achieves the minimum membership levels as determined by the DHSS?	See response to question #7.
98	RFP Appendix A, Contract	3.2.2	35	Will enrollment mix be a factor in the automatic assignment process and minimum membership levels?	See response to question #7.
99	RFP Appendix A, Contract	3.2.2.3.1	35	Section 3.2.2.1 of Appendix A states that "members who are already enrolled in an MCO as of the Start Date of Operations shall have 90 days to select an MCO." What are the start and end dates of this 90-day period?	See response to question #6.
100	RFP Appendix A, Contract	3.20	277-280	What staff positions are required to be physically located in Delaware?	The State's expectation, as reflected in section 3.20.1.9 of the contract, is that all key personnel be physically located in the State of Delaware. However, the State will consider limited, case by case exceptions.
101	RFP Appendix B, Data Book	2	6	Will DHSS provide data to support ACA Expansion capitation rates? If so, when will the data be released to potential bidders?	The State will not provide the requested information at this time.
102	RFP Appendix B, Data Book	6	26-27	Not all of the programmatic changes are shown with a cost/financial impact. What is the impact of fee schedule and benefit changes in the base periods 2010 through 2012?	The State will not provide the requested information at this time.
103	RFP Appendix B, Data Book	6	26-27	What is the cost impact for each of the anticipated fee schedule and benefit changes from the base period to the projected contract periods?	The State will not provide the requested information at this time.
104	RFP Appendix B, Data Book	HSS_14019 Medicaid_ LIST2.xlsx	Exhibits 1-3	The service types and/or service distribution categories for 2012 do not align with the ones used for 2010 and 2011, prohibiting bidders from properly analyzing the data. Can the State please clarify how the 2010 and 2011 data maps to the 2012 data?	With the implementation of DSHP Plus in 2012 the State collapsed and modified categories and cannot provide a mapping from the 2010 and 2011 data to the 2012 data.
105	General	General		What is the most recent distribution of eligibles by rate cell and geographic area?	Please see Attachment 4.
106	General	General		What are the current and historical capitation rates for DSHP and DSHP Plus by rate cell, geographic area, and contract period?	This information will not be provided at this time.
107	General	General		How will the PPACA Health Insurer Fee be recognized in the capitation rates?	The State is continuing to evaluate options for how to compensate MCOs for the applicable costs of the ACA health insurer fee. Additional information is not available at this time.

Question Number	Pertinent Document	Section Number	Page # in Ref. Doc.	Question	Response
108	RFP Appendix A, Contract	3.10.2.1.26	190	Given Appendix A Section 3.10.2.1.26, please confirm that current MCO contracts with providers which require stricter timely filing requirements than one year are still appropriate, as long as exceptions are made for coordination of benefits?	Section 3.10.2.1.26 of the contract should read "120 calendar" days instead of "one year."
109	RFP Appendix A, Contract	3.9.18.4.1.2 and 3.9.7.4.1.2	173 & 185	Please confirm that the hearing or review referred to in this section is the hearing afforded upon denial of re-credentialing specified in section 3.9.7.12. We are not aware of a requirement or standards for a hearing or review upon termination of a provider agreement for other reasons.	The MCO must offer a hearing or review to any provider that is terminated, whether part of re-credentialing or otherwise.
110	RFP	2.1	9	Please confirm the date of Oral Presentations is Monday, May 26, 2014.	No, May 26 was the estimated end date for the oral presentations, and State offices will be closed that day (Memorial Day). The State anticipates that during the week of May 5 it will contact selected bidders to notify them that they have been selected for an oral presentation and to schedule the oral presentation sometime the week of May 12 or May 19 (before May 22).
111	RFP Appendix C, Procurement Library, QMS		41	We have reviewed the materials on the disk and did not find the “Draft of the Delaware’s Quality Management Strategy (QMS)”. Can you please tell me where I can locate this document?	The draft QMS was unintentionally omitted from the procurement library DVDs. The State will post the draft QMS to the State of Delaware Procurement website at http://bids.delaware.gov/bids_detail.asp?i=2357&DOT=N.

Question Number	Pertinent Document	Section Number	Page # in Ref. Doc.	Question	Response
112	RFP and RFP Appendix A, Contract	3.4 and 2.2.2.2	10 & 31	RFP Appendix A, Section 2.2.1, pg. 31 states that prior to the Start Date of Operations and prior to accepting DSHP or DSHP Plus members, the Contractor shall be licensed by the Delaware DOI as an HMO or Health Service Corporation or certified by DHSS; however, Section 3.4 on page 10 of the RFP states that to submit a proposal, the Bidder must be licensed by the Delaware DOI as an HMO or Health Services Corporation, or be licensed by another state as an HMO. Please confirm that a health plan that holds a Certificate of Authority from the DHSS for a Medicaid HMO is not only eligible to accept DSHP or DSHP Plus members on January 1, 2015 in accordance with Section 2.2.1 of Appendix A, but is also eligible to submit a proposal in accordance with Section 3.4 of the RFP.	Yes, an MCO certified by DHSS both satisfies the licensure/certification requirement in section 2.2.1 of the contract and is eligible to bid on this RFP. Section 3.4 of the RFP (page 10) is revised to read "In order to submit a proposal, the Bidder must be certified by DHSS, licensed by the Delaware Department of Insurance as a Health Maintenance Organization (HMO) or Health Service Corporation, or be licensed by another state as an HMO." In addition, section 4.2.3.3 of the RFP is revised to read "A statement certifying that, as applicable, the Bidder is (a) certified by DHSS; (b) licensed by the Delaware Department of Insurance (DOI) as a Health Maintenance Organization, (c) licensed by DOI as a Health Service Corporation (HSC) or (d) licensed by a state other than Delaware as a health maintenance organization. If the bidder is licensed as an HMO or HSC include the license type and number, and, if licensed by a state other than Delaware, contact information for the state insurance agency (name of agency, contact name, contact phone and email address)."

TANF Newborns						
	CY 2011			CY 2012		
Major Category of Service	MMs	Dollars	PMPM	MMs	Dollars	PMPM
Inpatient	1,962	$ 1,015,668.88	$ 517.67	1,245	$ 296,895.24	$ 238.47
Outpatient/Clinic	1,962	$ 115,649.92	$ 58.94	1,245	$ 75,130.21	$ 60.35
Physician/Professional	1,962	$ 245,146.26	$ 124.95	1,245	$ 138,566.31	$ 111.30
Pharmacy	1,962	$ 53,848.18	$ 27.45	1,245	$ 51,862.32	$ 41.66
Other	1,962	$ 22,194.59	$ 11.31	1,245	$ 23,489.85	$ 18.87
Total	**1,962**	**$ 1,452,507.83**	**$ 740.32**	**1,245**	**$ 585,943.92**	**$ 470.64**

TANF Children						
	CY 2011			CY 2012		
Major Category of Service	MMs	Dollars	PMPM	MMs	Dollars	PMPM
Inpatient	36,135	$ 559,832.45	$ 15.49	21,545	$ 258,716.86	$ 12.01
Outpatient/Clinic	36,135	$ 2,257,543.98	$ 62.48	21,545	$ 1,503,563.04	$ 69.79
Physician/Professional	36,135	$ 1,381,303.70	$ 38.23	21,545	$ 814,688.96	$ 37.81
Pharmacy	36,135	$ 1,110,781.21	$ 30.74	21,545	$ 809,667.42	$ 37.58
Other	36,135	$ 543,066.56	$ 15.03	21,545	$ 197,895.46	$ 9.19
Total	**36,135**	**$ 5,852,527.90**	**$ 161.96**	**21,545**	**$ 3,584,531.74**	**$ 166.37**

TANF Adults						
	CY 2011			CY 2012		
Major Category of Service	MMs	Dollars	PMPM	MMs	Dollars	PMPM
Inpatient	12,330	$ 1,735,680.14	$ 140.77	6,906	$ 931,107.65	$ 134.83
Outpatient/Clinic	12,330	$ 1,433,456.01	$ 116.26	6,906	$ 877,372.21	$ 127.04
Physician/Professional	12,330	$ 1,501,316.12	$ 121.76	6,906	$ 743,300.65	$ 107.63
Pharmacy	12,330	$ 1,145,206.59	$ 92.88	6,906	$ 844,742.82	$ 122.32
Other	12,330	$ 94,818.00	$ 7.69	6,906	$ 84,899.49	$ 12.29
Total	**12,330**	**$ 5,910,476.86**	**$ 479.36**	**6,906**	**$ 3,481,422.82**	**$ 504.12**

Waiver Expanded (≤ 100% FPL)						
	CY 2011			CY 2012		
Major Category of Service	MMs	Dollars	PMPM	MMs	Dollars	PMPM
Inpatient	17,990	$ 6,687,675.17	$ 371.74	10,732	$ 6,021,429.12	$ 561.07
Outpatient/Clinic	17,990	$ 4,058,937.89	$ 225.62	10,732	$ 2,297,296.58	$ 214.06
Physician/Professional	17,990	$ 3,511,899.95	$ 195.21	10,732	$ 2,028,959.58	$ 189.06
Pharmacy	17,990	$ 3,056,723.39	$ 169.91	10,732	$ 2,045,571.48	$ 190.60
Other	17,990	$ 361,797.29	$ 20.11	10,732	$ 273,881.65	$ 25.52
Total	**17,990**	**$ 17,677,033.69**	**$ 982.60**	**10,732**	**$ 12,667,138.42**	**$ 1,180.31**

SSI						
	CY 2011			CY 2012		
Major Category of Service	MMs	Dollars	PMPM	MMs	Dollars	PMPM
Inpatient	9,155	$ 5,248,291.59	$ 573.27	7,889	$ 3,676,963.93	$ 466.09
Outpatient/Clinic	9,155	$ 3,182,339.96	$ 347.61	7,889	$ 2,447,615.32	$ 310.26
Physician/Professional	9,155	$ 1,732,863.81	$ 189.28	7,889	$ 1,370,346.74	$ 173.70
Pharmacy	9,155	$ 2,925,408.73	$ 319.54	7,889	$ 2,497,454.92	$ 316.57
Other	9,155	$ 3,223,620.62	$ 352.12	7,889	$ 2,809,765.98	$ 356.16
Total	**9,155**	**$ 16,312,524.71**	**$ 1,781.82**	**7,889**	**$ 12,802,146.88**	**$ 1,622.78**

CHIP						
	CY 2011			CY 2012		
Major Category of Service	MMs	Dollars	PMPM	MMs	Dollars	PMPM
Inpatient	4,555	$ 139,111.88	$ 30.54	2,254	$ 200,653.70	$ 89.02
Outpatient/Clinic	4,555	$ 385,652.67	$ 84.67	2,254	$ 182,572.90	$ 81.00
Physician/Professional	4,555	$ 229,667.92	$ 50.42	2,254	$ 116,483.71	$ 51.68
Pharmacy	4,555	$ 229,547.59	$ 50.39	2,254	$ 121,553.25	$ 53.93
Other	4,555	$ 69,291.95	$ 15.21	2,254	$ 18,166.67	$ 8.06
Total	**4,555**	**$ 1,053,272.00**	**$ 231.23**	**2,254**	**$ 639,430.23**	**$ 283.69**

DSHP Total						
	CY 2011			CY 2012		
Major Category of Service	MMs	Dollars	PMPM	MMs	Dollars	PMPM
Inpatient	82,127	$ 15,386,260.10	$ 187.35	50,571	$ 11,385,766.50	$ 225.14
Outpatient/Clinic	82,127	$ 11,433,580.42	$ 139.22	50,571	$ 7,383,550.26	$ 146.00
Physician/Professional	82,127	$ 8,602,197.78	$ 104.74	50,571	$ 5,212,345.95	$ 103.07
Pharmacy	82,127	$ 8,521,515.69	$ 103.76	50,571	$ 6,370,852.22	$ 125.98
Other	82,127	$ 4,314,789.01	$ 52.54	50,571	$ 3,408,099.09	$ 67.39
Total	**82,127**	**$ 48,258,342.99**	**$ 587.61**	**50,571**	**$ 33,760,614.01**	**$ 667.59**

Notes:
1. Prisoners have been removed from this data.
2. All non-managed care categories of service have been removed.
3. No adjustments have been made to the data other than the exclusions listed above. (Examples: no completion factors, no smoothing)
4. Paid dollars reflect runout through October 2013.

Number of Live Births by Rate Tier	Kent County		New Castle County		Sussex County		Statewide	
CY 2012	**C-section**	**Vaginal**	**C-section**	**Vaginal**	**C-section**	**Vaginal**	**C-section**	**Vaginal**
TANF Newborn	0	0	0	0	0	0	0	0
TANF Children	4	24	15	83	2	29	21	136
TANF Adults	268	656	681	1,642	295	619	1,244	2,917
Waiver Expanded (≤ 100% FPL)	8	17	20	58	12	16	40	91
SSI	6	14	19	30	8	3	33	47
CHIP	0	0	1	3	0	0	1	3
NF/HCBS Dual	0	0	0	0	0	0	0	0
NF/HCBS Non-Dual	0	0	0	0	0	0	0	0
Community Well	0	1	8	8	2	0	10	9
Total	**286**	**712**	**744**	**1,824**	**319**	**667**	**1,349**	**3,203**

Medical Expenses (All Rate Tiers)	Kent County		New Castle County		Sussex County		Statewide	
CY 2012	**C-section**	**Vaginal**	**C-section**	**Vaginal**	**C-section**	**Vaginal**	**C-section**	**Vaginal**
Inpatient Hospital Services								
Medical/surgical/rehabilitation	$ 1,331,611	$ 3,215,145	$ 4,011,386	$ 9,447,271	$ 1,576,294	$ 2,751,816	$ 6,919,291	$ 15,414,232
Intensive care (NICU/ICU/CCU)	$ 16,871	$ 8,436	$ 134,970	$ 183,817	$ 963	$ 34,589	$ 152,804	$ 226,842
Psych/detox (non-IMD)	$ -	$ -	$ -	$ 8,759	$ -	$ -	$ -	$ 8,759
IMD (including ancillary treatment)	$ 1,520	$ -	$ 1,670	$ 2,005	$ -	$ -	$ 3,190	$ 2,005
Total Inpatient Hospital Services	**$ 1,350,002**	**$ 3,223,581**	**$ 4,148,026**	**$ 9,641,852**	**$ 1,577,257**	**$ 2,786,405**	**$ 7,075,285**	**$ 15,651,838**
Other Institutional Services								
Nursing facility – public facilities	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Nursing facility – private facilities	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other institution	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Other Institutional Services	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Home/Community Services								
Assisted living	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Adult day care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Day habilitation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Personal care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Respite	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Cognitive services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Homemaker/chore services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Emergency response system	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Support for consumer direction	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Nutritional supplements	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Specialized DME	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Home modifications	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Home delivered meals	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
MFP transition services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other home/community services or supports	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Home/Community Services	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Outpatient Facility Services								
Emergency room	$ 36,230	$ 106,105	$ 337,502	$ 794,025	$ 30,394	$ 59,369	$ 404,126	$ 959,499
Surgery	$ 101,283	$ 174,084	$ 33,395	$ 91,745	$ 69,654	$ 168,335	$ 204,332	$ 434,164
Family planning/sterilization	$ 63	$ 274	$ 240	$ 351	$ 184	$ 46	$ 487	$ 671
Behavioral health	$ 1,408	$ 253	$ 558	$ 5,580	$ 27	$ 972	$ 1,993	$ 6,805
FQHC	$ 2,039	$ 3,453	$ 97,576	$ 222,361	$ 10,022	$ 24,024	$ 109,637	$ 249,838
Dialysis clinic	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Ambulatory surgical center	$ 460	$ -	$ -	$ -	$ -	$ -	$ 460	$ -
Community mental health clinic	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Division of Public Health clinic	$ 288	$ 1,088	$ 6,123	$ 13,860	$ 336	$ 1,033	$ 6,747	$ 15,981
Methadone clinic	$ 574	$ 1,393	$ 3,509	$ 7,215	$ 441	$ 660	$ 4,524	$ 9,268
Freestanding emergency room	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other outpatient services	$ 182,300	$ 297,001	$ 155,878	$ 330,042	$ 99,947	$ 181,845	$ 438,125	$ 808,888
Total Outpatient Facility Services	**$ 324,645**	**$ 583,651**	**$ 634,781**	**$ 1,465,179**	**$ 211,005**	**$ 436,284**	**$ 1,170,431**	**$ 2,485,114**
Physician/Professional Services								
Primary care physician	$ 11,714	$ 15,166	$ 77,268	$ 145,901	$ 23,579	$ 68,120	$ 112,561	$ 229,187
Physician specialists	$ 547,000	$ 1,024,083	$ 1,330,922	$ 2,508,282	$ 536,558	$ 757,247	$ 2,414,480	$ 4,289,612
Emergency room	$ 4,662	$ 15,774	$ 32,173	$ 80,855	$ 8,027	$ 12,643	$ 44,862	$ 109,272
Family planning	$ 12,564	$ 3,065	$ 11,957	$ 2,301	$ 11,382	$ 3,890	$ 35,903	$ 9,256
Behavioral health	$ 9,907	$ 16,625	$ 16,135	$ 29,434	$ 6,615	$ 18,241	$ 32,657	$ 64,300
Other professional services	$ 5,930	$ 45,216	$ 10,552	$ 84,704	$ 26,063	$ 147,002	$ 42,545	$ 276,922
Total Physician/Professional Services	**$ 591,777**	**$ 1,119,929**	**$ 1,479,007**	**$ 2,851,477**	**$ 612,224**	**$ 1,007,143**	**$ 2,683,008**	**$ 4,978,549**
Other Medical Services								
DME/prosthetics/orthotics	$ 157	$ 1,170	$ 3,770	$ 2,795	$ 1,073	$ 4,758	$ 5,000	$ 8,723
Lab and pathology	$ 50,486	$ 110,423	$ 94,274	$ 192,781	$ 53,654	$ 101,972	$ 198,414	$ 405,176
Radiology	$ 100,294	$ 142,936	$ 302,112	$ 494,113	$ 104,005	$ 143,282	$ 506,411	$ 780,331
Pharmaceuticals	$ 1,536	$ 5,619	$ 1,972	$ 18,704	$ 2,618	$ 11,796	$ 6,126	$ 36,119
Ambulance	$ 1,519	$ 3,854	$ 16,473	$ 50,088	$ 9,427	$ 8,112	$ 27,419	$ 62,054
Therapies (physical, speech, occupational)	$ 3,229	$ 4,233	$ 5,870	$ 6,103	$ 1,145	$ 3,583	$ 10,244	$ 13,919
Private duty nursing	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Hospice	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Home health care	$ 2,058	$ 3,640	$ 15,422	$ 35,907	$ 765	$ 2,991	$ 18,245	$ 42,538
Miscellaneous other medical	$ 11,689	$ 26,453	$ 7,490	$ 21,832	$ 11,589	$ 14,145	$ 30,768	$ 62,430
Total Other Medical Services	**$ 170,968**	**$ 298,328**	**$ 447,383**	**$ 822,323**	**$ 184,276**	**$ 290,639**	**$ 802,627**	**$ 1,411,290**
Case Management Expenses	$ 275	$ 625	$ 525	$ 1,050	$ 550	$ 1,300	$ 1,350	$ 2,975
TOTAL MEDICAL EXPENSES	**$ 2,437,667**	**$ 5,226,114**	**$ 6,709,722**	**$ 14,781,881**	**$ 2,585,312**	**$ 4,521,771**	**$ 11,732,701**	**$ 24,529,766**
Reinsurance premiums	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Reinsurance recoveries	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Post payment recoveries (see instructions)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL NET MEDICAL EXPENSES	**$ 2,437,667**	**$ 5,226,114**	**$ 6,709,722**	**$ 14,781,881**	**$ 2,585,312**	**$ 4,521,771**	**$ 11,732,701**	**$ 24,529,766**
Cost Per Birth	**$ 8,523**	**$ 7,340**	**$ 9,018**	**$ 8,104**	**$ 8,104**	**$ 6,779**	**$ 8,697**	**$ 7,658**

Attachment 3 (Question #73)

	Jan-14	Feb-14	Mar-14
19-49 Females	326	718	1,156
19-49 Males	139	306	500
50-64	170	349	528
Total	635	1,373	2,184

Actual member months for newly eligible individuals under the Affordable Care Act.

Attachment 4 (Question #105)

Rate Tier	County/Subgroup	Member Months
TANF Newborns	New Castle	3,044
TANF Newborns	Kent	1,074
TANF Newborns	Sussex	1,292
TANF Children	New Castle	38,889
TANF Children	Kent	13,450
TANF Children	Sussex	17,331
TANF Adults	New Castle	20,532
TANF Adults	Kent	7,855
TANF Adults	Sussex	8,737
Waiver Expanded	New Castle	22,455
Waiver Expanded	Kent	7,673
Waiver Expanded	Sussex	9,294
SSI	New Castle	7,491
SSI	Kent	2,229
SSI	Sussex	1,983
CHIP	New Castle	5,162
CHIP	Kent	1,637
CHIP	Sussex	2,296
ACA Expansion	19-49 Females	1,156
ACA Expansion	19-49 Males	500
ACA Expansion	Ages 50-64	528
Maternity Care Payment	New Castle	205
Maternity Care Payment	Kent	97
Maternity Care Payment	Sussex	93
NF/HCBS Dual	Statewide	4,610
NF/HCBS Non-Dual	Statewide	905
Community Well	Statewide	5,610
Grand Total		**186,128**

Actual member months for March 2014