State of Oklahoma
OKLAHOMA HEALTH CARE AUTHORITY

Amendment of Solicitation

Date of Issuance: December 22, 2016 **Solicitation No.** 8070000933

Requisition No. 8070000933 **Amendment No.** 2

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

Oklahoma City, OK 73105 -

or

Personal or Common Carrier Delivery:
Oklahoma Health Care Authority
4345 North Lincoln Boulevard

Oklahoma City,OK 73105 -

Sheila Killingsworth
Contracting Officer

(405) - 522 - 7846
Phone Number

sheila.killingsworth@okhca.org
E-Mail Address

Description of Amendment:

a. This is to incorporate the following:

Responses to Round One Technical Questions and Answers are attached.

Form O is revised and uploaded into the Bidder's Library.

b. All other terms and conditions remain unchanged.

Supplier Company Name (**PRINT**) Date

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

Solicitation No. 8070000933
Questions and Answers

Question Number	Section or Subsection Number	Section or Subsection Title	Solicitation Page	Question	Response
Example	2.1.1.1	Oklahoma Health Care Authority	#	Are Oklahoma's statutes available online?	Oklahoma statutes can be accessed online at the following address: http://www.oklegislature.gov/osstatuestitle.html
1	1.3	Solicitation Timeline	15	Will OHCA consider releasing the answers to the second round of questions from bidders earlier, possibly by February 15, 2017, so that MCO bidders can have enough time to factor in that guidance for their final proposals?	No.
2	1.3	Solicitation Timeline	15	Since a COA is required at contract date, will the OHCA provide a specific estimated award date?	Contract Award still remains in To Be Determined (TBD) status.
3	2	Model Contract	48, 50, 66, 67, 177	How can I view the 1915c Waivers?	Information is publicly available at: http://www.okhca.org/individuals.aspx?id=8137&terms=1915c%20Waiver
4	2	Model Contract	81, 82, 83, 97, 138, 147-148, 155, 159, 191, etc.	Does any information in the RFP relate to medical authorizations?	Numerous locations address authorizations including: Transition of Care General Provisions, Transition of Care Period, Member Handbook Content, Provider Services Call Center, Prior Authorization Timelines, Care Management Supervisor Responsibilities and Qualifications, Electronic Care Management System, etc.
5	2.11	Care and Disease Management	153	Is there a preference or a concern if responders offer a Special Needs Plan to coordinate the Medicare benefits for members seeing providers who do not participate in the CPC+ program?	Responders should highlight relevant expertise in their submission.
6	2.11	Care and Disease Management	153	Will there be an opportunity to meet with OHCA in person to further discuss key components of Care Coordination as it relates to the SoonerHealth+ program and contract requirements prior to the RFP response deadline?	No.

7	2.11	Care and Disease Management	153	There are a variety of programs and initiatives aimed at providing care coordination for the SoonerHealth+ population in addition to Care Coordination expected to be provided by the Contractor, including but not limited to, Health Management Program (HMP), Comprehensive Primary Care Plus (CPC+), Primary Care Case Management (PCCM) and Patient Centered Medical Home (PCMH). Will these programs carve out Care Coordination efforts on behalf of the Contractor and how does OHCA foresee these programs working together?	As noted in section 1.1.1, "SoonerCare Program Background," ABD members will discontinue receiving services through these initiatives when enrolled in the SoonerHealth+ Program. The SoonerCare Choice program and the OHCA care management initiatives will continue to operate for populations not enrolling in the SoonerHealth+ Program. Contractors will be responsible for performing care coordination for SoonerHealth+ members. (See section 2.11.10, "CPC+ Care Management Procedures" for details on the care management requirements for Contractors and CPC+ practices.)
8	2.5	Enrollment	71	Will there be a daily and/ or monthly enrollment file? Will the file have TPL and Waiver information?	The OHCA will collaborate with the awarded Contractors on enrollment file specifications.
9	2.8	Provider Network	109	Is OHCA's definition of a nursing facility limited to a specific type or does it include Outpatient, Inpatient, Rehab Centers, CORF/ORF, Nursing Homes, etc.	All.
10	2.5.2.6	Enrollment	73	Will a newborn be enrolled under its own Member Medicaid ID? Is the MCO expected to enroll the newborn prior to receiving the newborn on the 834 enrollment file?	Yes, a newborn will be enrolled under its own Member Medicaid ID. Yes, the eNB1 process generates a member ID for the newborn and adds to the existing case in near-real-time. If newborns are not added through eNB1, a manual enrollment and reconciliation are available. The newborn is the plan's responsibility for all needed services until data are reconciled and the newborn is included on the 834 file.
11	2.7.4.1	Enrollment	96	Contractor must provide member handbook within 15 days after receiving notification of member's enrollment and within seven days of member's request for a new handbook. Is this business or calendar days?	Calendar days. Per Appendix 1 - Definitions and Acronyms, "days is defined as calendar days unless otherwise specified."
12	1.1.1	SoonerCare Program Background	3	In the introduction, the word "holistic" is used to describe the systems of supports. That is a wonderful target, but this RFP seems to be missing several key, "value-added" components to ensure a holistic approach. For example, employment is not mentioned. When we assure this population has a real shot at meaningful employment, we work ourselves out of providing care for this population. Why is employment (as a goal, and in terms of true person-centered planning) not addressed in this bid?	Contractors are expected to develop a person-centered care planning approach that comprehensively addresses and supports all identified needs and goals, including meaningful employment, if applicable.

13	1.1.1	SoonerCare Program Background	3	There is no significant mention of the role of assistive technology. Again, a true holistic approach includes a significant investigation of low-, medium- and high tech assistive devices. This aides independent living, employment goals, educational attainment, and MANY other value-added, positive outcomes for persons with disabilities. Can Assistive Technology become a more major component of the contractors' work?	Contractors are expected to develop a person-centered care planning approach that comprehensively addresses and supports all identified needs and goals, including assistive technology, if applicable.
14	1.1.1/2.6.3.2	SoonerCare Program Background/Transitioning Members with an Existing Care or Treatment Plan	3, 85	Please provide a list of vendors mandated by OHCA for use pursuant to the RFP, identifying the administrative or delegated services they provide.	A list cannot be provided at this time.
15	1.1.3	Population Counts	7	Can the state provide the total number of dual eligible individuals in the population?	Available data on dual eligibles can be found in the research section of the OHCA website. Additional information will be included in the actuarial data book to be released in January.
16	1.1.3	Population Counts	7	What percentage of the 7,442 ID individuals on the waitlist are children vs. adults?	42% are children.
17	1.1.3	Population Counts	7	What percentage of the 154, 795 total members receive behavioral health services?	22.50%
18	1.1.3	Population Counts	8	The RFP mentions a waiver waiting list for children and adults. Is the IDD waiver the only waiver with a waiting list? The RFP also mentions that 65% of members on the waiting list are enrolled in SoonerCare and receiving State Plan benefits. What HCBS type services are covered under the State Plan Benefit?	Yes. Personal care HCBS type services are covered under the State Plan Benefit.
19	1.1.3, 1.2.4	Population Counts, Geographic Scope of Contracts	7, 10	Can the OHCA provide an eligibility map by county of enrollees?	The map cannot be provided at this time.

20	1.2.2	OHCA Sole Point of Contact	9	Please identify any agencies, departments or entities bidder is prohibited from communicating with during the procurement period.	Noted in 1.2.2, Page 9, there is to be no communication between potential Bidders and any employees of the OHCA during this RFP process. Any questions or concerns must be submitted via email to the Sole Point-of-Contact, Contract Coordinator identified within the RFP using the appropriate RFP document located on the OHCA's website. All RFP-related inquiries must be directed as such.
21	1.2.8 & 3.5.3	Bids Subject to Public Disclosure/ Proprietary Information	13 282	Bidders are required to identify what documents or portions of documents they consider to be confidential and submit redacted versions (one electronic and one hard copy). How would the OHCA prefer bidders to identify the confidential portions? Should this information be included in the Transmittal Letter?	Bidders are requested to include a listing of proposal page numbers with redacted material and the basis for the redaction. The listing should be inserted at the front of the redacted version of the proposal. The listing can be numbered separately from the proposal page numbering, so that redacted and non-redacted proposals have material on the same pages. Bidders should not include the information in the Transmittal Letter.
22	1.2.8, 3.1.5	Bids Subject to Public Disclosure/ Proprietary Information, Property of the State	13, 280	Can the OHCA provide guidelines or boundaries as to what it considers "proprietary information" given that it will make the final determination as to whether the documentation or information is confidential?	The bidder will decide how to best identify confidential portions of the submission with the knowledge that any proprietary and confidential information submitted will be available to the public if requested, under the Oklahoma Open Records Act.
23	2.1.1.1	Oklahoma Health Care Authority	#	Are Oklahoma's statutes available online?	Oklahoma statutes can be accessed online at the following address: http://www.oklegislature.gov/osstatuestitle.html
24	2.1.22 and 2.1.22.4	Insurance	33 - 34	The RFP states, "The Contractor shall obtain reinsurance coverage or self-reinsurance subject to the provisions of section 2.1.22.4, "Reinsurance," below. The Contractor shall be in compliance with all applicable insurance laws of the State and federal government throughout the duration of the Contract. The Contractor shall purchase reinsurance from a commercial reinsurer in accordance with State insurance requirements..."	Oklahoma Insurance Department (OID) regulatory language concerning allowable reinsurance arrangements is at Oklahoma Insurance Department Rules - Title 365, OAC 365:25-7-50. OID has no requirement is in place for commercial reinsurance as such. The OHCA is not requiring bidders to have it, if they self-reinsure. Title 365 can be viewed at: https://www.ok.gov/oid/Public_Information/Legal/Oklahoma_Insurance_Department_Rules_Title_365.html

25	2.10.2	Qualified Staff	146	RFP Section 2.10.2 states: "...decisions shall be made by an individual who has appropriate clinical expertise in treating a member's condition or disease." What does "appropriate clinical expertise" entail?	Appropriate clinical expertise is dictated by the matter being reviewed in the medical management Department.
26	2.10.4	Prior Authorization Process	147	Would our after hours nurse line satisfy pharmacy call center hours for times when the pharmacy call center is not available?	The purpose of the pharmacy call center is to assist members, prescribers, and pharmacies with both general and specific information. General information about the pharmacy benefit, drug coverage, copays, prior authorization, etc. Most calls, however, are about a specific pharmacy claim that needs to be answered in real time. IF the staff of the nurse line will have access to pharmacy claims in real time and have knowledge and authority to resolve claims issues in real time, then the after hours nurse line can also be used as a pharmacy call center. If they do not have access to real time claims or authority to resolve claims issues in real time, then no, there must be adequate pharmacy call center coverage outside of the nurse line.
27	2.10.9.1	General	149	Can the State confirm a licensed Pharmacist without an OK license can make a negative determination?	The pharmacist does not need to possess an Oklahoma license so long as they have a valid license in the state where they practice.
28	2.10.9.3	Pharmacy Benefit Manager	150	RFP section 2.10.9.3 states: "The pharmacy benefit manager shall employ a State liaison with whom the OHCA may communicate directly. The State liaison also must be available for direct communication with pharmacy providers to resolve issues and to work directly with the OHCA to resolve drug rebate disputes that arise from Contractor's claim files." Please confirm either the Contractor or PBM shall designate a State liaison.	The PBM shall designate a State liaison for direct communication with OHCA and pharmacy providers. The Contractor may desire to designate a pharmacy liaison as well, but the purpose of having a direct connection to the PBM is to decrease delays and misunderstanding and to improve communication.
29	2.10.9.4	Pharmacy Benefit Financial Disclosures	150	We propose the following change to this requirement: The Contractor shall disclose to the OHCA all financial arrangement between the Contractor or Subcontractor and all drug-related companies, including manufacturers, labelers, compounders and benefit managers, to the extent such arrangements pertain to Contractor's agreement with OHCA. The OHCA retains the right to request this information at any time and will treat it as confidential as required under State and federal law.	Yes, the requirement is hereby revised as requested.

30	2.10.9.5	Rebates and Financial Reports	151	If the OHCA is to collect rebates on MCO contractor diabetic testing supply claims, how will such supplies be listed on the OHCA PDL?	The supplies will be listed by NDC. Only the preferred products will be included. Preferred products are limited to blood glucose and ketone test strips, control solution and meters. Lancets, lancet devices, urine ketone strips, insulin syringes and pen needles do not have preferred products.
31	2.10.9.5	Rebates and Financial Reports	151	Given that diabetic testing supplies are not part of the Federal rebate program, does the OHCA's rebate contracts with diabetic supply manufacturers allow it to collect rebate on managed care claims? There are other state Medicaid programs where only Federal Rebate claims for drugs flow back to State Medicaid under the ACA.	Oklahoma's contracts for rebates on diabetic supplies do not restrict rebate collection to utilization by Fee for Service members.
32	2.11.10.5	Members Assigned to Risk Level 3	172	Does this means that the MCO is prohibited from contracting with CPC+ providers for the additional activity of doing HCBS service plans and HCBS management ?	No.
33	2.11.12.1	Pharmacy Lock-in	175	This appears to contradict the statement just proceeding it. Both statements include "shall" but the first states a member shall be locked into a single pharmacy and single prescriber while this statement excludes any mention of prescriber lock-in requirement. Is it up to the discretion of the plan or is it mandatory to have a prescriber lock-in program in excess of pharmacy lock-in?	The pharmacy lock-in program includes restrictions on both pharmacies and prescribers. The only claims affected are pharmacy claims for controlled substances. A member enrolled in the lock-in program should be limited to receiving controlled substance prescriptions from one pharmacy written by one prescriber.
34	2.11.12.1	Pharmacy Lock-in	175	Can OHCA define "program data and activity"? Is this the data that is referred to in the Pharmacy Lock-In Care Management Report requirement found in 2.11.15?	Lock-in program data and activity refers to any action or intervention performed related to the lock-in program. For example, if a member is referred for possible inclusion in the lock-in program, that should be recorded and reported. That member's claims would then be investigated. That is another reportable event. The decision to place the member into lock-in or not is another reportable event. These are examples of the activities included in 2.11.15.

35	2.11.12.1	Pharmacy Lock-in	175	Will the lock-in criteria be standardized across all lock-in programs? Does the current fee for service lock-in program include prescriber lock-in? Does OHCA intend to facilitate the transfer of member lock-in data and, if so, how (e.g., will lock-in data be transmitted on the 834 or an ancillary file; what data would be transmitted (i.e. NPI's, Medicaid ID, etc..))? Will OHCA provide a disenrollment file in order for us to be able to identify which members are transferring out that we would have to provide data for? If not, how would OHCA propose MCO's would transfer member lock-in data?	Q1: If a contractor has lock-in criteria of their own, they may use it, subject to OHCA review and approval during the readiness review. If they don't have criteria, they must follow the fee for service criteria. Q2: Yes. Members are restricted to one pharmacy and one prescriber for controlled substance prescriptions. Non-controlled drugs may be reimbursed to any contracted pharmacy and from any contracted prescriber. Q3: The OHCA will develop processes with the awarded Contractors. Q 4: The OHCA will develop processes with the awarded Contractors.
36	2.11.13.4	Authorized Representatives	178	Are there any restrictions on who the member can hire as the PSA or APSA within the CD-PASS program such as spouse, child, or parent?	Yes. A Power of Attorney, Guardian or Authorized Representative cannot be the paid caregiver (PSA or APSA). A spouse is only allowed to be the paid caregiver (PSA or APSA) if an exception is made by the Oklahoma DHS. See OAC 317:30-5-761.
37	2.11.13.5	Contractor Responsibilities (2.11.13 Self-Direction)	179	RFP Section 2.11.13.5 states that the Contractor shall "subcontract with the existing FMS entity that is currently under contract with Oklahoma DHS to perform payroll and other employment related functions." Will the Contractor participate in selection of future subcontractors? Is there only one FMS in Oklahoma serving all self-direction options?	There are currently three FMS entities. AD*vantage* uses Public Partnerships LLC (PPL). The OHCA Medically Fragile waiver uses Morning Sun Financial Services. OKDHS/DDS uses ACUMEN for IID waiver members, who will enroll starting in year two. Potential Contractor interest in participating in the selection of future FMS subcontractors is noted.
38	2.11.14	EVV System	189	"DHS contracts with an EVV vendor to monitor ADvantage waiver member utilization of HCBS and generate claims for payment of covered services." Please explain the current payment process in relation to the EVV vendor and the provider that is providing the service. Does the EVV vendor make the payment to the provider?	First question: That arrangement is currently between Oklahoma DHS and the EVV vendor. A new contract is in the process of being awarded so little can be shared about the current contractual arrangement. Second question: The EVV vendor does not make the payment to the provider. Payments are issued to the provider from OHCA.

39	2.11.3	Care Manager Staffing	157	The RFP states, "The Contractor shall offer a contract to the existing ADvantage waiver and Medically Fragile waiver case management agencies for the provision of care management services for at least the initial program Contract year." By "Case Management," does the OHCA mean the social service coordination activities that ADvantage Waiver providers typically provide or does this refer to the clinical case management that is typically performed by employees of the health plan?	Current CM is only in relation to current HCBS services, not medical treatment(s).
40	2.11.4	Electronic Care Management System	160	Please provide guidance as to how contractors will interface with the State's clinical information system.	Oklahoma DHS is currently developing a new waiver management information system and would expect contractors to interface with this system.
41	2.11.5	Initial Member Outreach for Health Risk Screenings	160	The RFP states that the Health Risk Screening shall be done by phone. Can other methods, such as in-person, mail or secure web be used?	In-person and secure web are acceptable methods for Health Risk Screening. No, mail is not an acceptable method of Health Risk Screening.
42	2.11.5	Member Outreach	159	Can health plans offer health risk assessment via methods other than telephonic outreach?	See response to question 41.
43	2.11.5	Initial Member Outreach for Health Risk Screenings	159	Can State clarify licensure requirements for staff members conducting initial health risk screenings?	There are no licensure requirements for staff members who conduct the initial health risk screenings.
44	2.11.6.1	Level 1 (Low Risk) Description and Care Management Requirements	162	It appears that Nursing Facility members would automatically fall into level 1 for care management assignments as they do not receive HCBS services and would not require a face-to-face assessment/visits. Please confirm this is correct. Please clarify if the Semi-annual and annual contacts by phone focusing on Disease Management apply to nursing facility/ICF ID facilities or will further detail be released in future amendments to the CRA?	Residents of long term care facilities are excluded from SoonerHealth+ until year three. Requirements for this population will be addressed in future amendments.

45	2.11.8.2, 2.11.8.4	Care Plan Requirements, Care Plan Approval	168	Will the OHCA allow an electronic member signature on a care plan? Will the OHCA allow the member to sign an electronic care plan?	The OHCA will allow the member to sign an electronic care plan and will allow an electronic member signature on a care plan via an electronic signature pad device. The biometric signature data must be saved in a database which can be used to verify the signature authentication.
46	2.11.8.3	Service Plans	170	Please clarify which providers are *responsible for implementation* and need to sign the service plan.	Providers who are providing care management services and those who will be providing direct care services such as a home health provider, are responsible for implementation and will need to sign the plan. Ancillary providers, such as DME and home-delivered meals, would not generally sign the plan.
47	2.11.8.6	Care Plan Reviews	170	The RFP states that members must be reassessed within 72 hours of a change with a follow-up visit within seven days. Would the OHCA allow this to be done through a form of video conferencing?	No.
48	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?	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.
49	2.12.3.4	Member Cost Sharing	7	Can the state provide membership numbers by region?	Numbers cannot be issued at this time.
50	2.12.4.1	IHCPS	193	Will contractor be able to assign members to IHCP providers at the group/clinic level, or will it be required to assign at the individual provider level?	AI/AN SoonerCare members are assigned to a facility not an individual provider. (See RFP 2.5.4.2.)
51	2.12.4.1	IHCPS	193	Will contractor be able to assign non-Tribal members to IHCPs, or will contractor be required to work through OHCA to assign non-Tribal members to IHCPs?	Contractors should not be able to assign non-tribal members to IHCP.
52	2.12.4.1	IHCPS	193	Will Contractor be able to assign Tribal members to IHCPs or will contractor be required to work through OHCA to assign the Tribal members to IHCPs?	Contractors should not be able to assign tribal members to IHCPs without their permission, since tribal members will have the option to opt out.

53	2.13.3.3	QAPI Program Documentation	198	RFP section 2.13.3.3 states: "The Contractor's QAPI program description, work plan and program evaluation shall be exclusive to Oklahoma Medicaid and shall not contain documentation from other state Medicaid programs." Is it okay to submit corporate policies that include exception language from other states?	Yes.
54	2.13.3.3	QAPI Program Documentation	198	Please clarify whether the contract requires that members and/or their representatives be represented on the Quality Improvement Committee (QIC). Is it sufficient for the member-majority advisory body to periodically report its recommendations to the QIC?	At a minimum, the participation on the QIC of a staff member from Member Care Support Staff demonstrates members' representation. The selected contractor must comply with the requirements at 2.2.2.3.
55	2.13.4	Accreditation	200	Can the state please confirm that Accreditation is required with 18 months of contract go-live, not contract award?	Accreditation is required within 18 months of Contract Award.
56	2.14.1.5	Receipt of Member Complaints and Appeals	212 213	What is the requirement to acknowledge the member's complaint and appeal?	The requirement is for the Contractor to have a process. The proposed process should be described in the response to RFP submission item 88.
57	2.14.1.8	Present Evidence	213	Does providing evidence in person include via phone?	A member can be offered the option of providing evidence by phone but must be permitted to offer evidence in person or in writing, if the member so elects.
58	2.14.3.2	Timeframes for Notice	215	RFP Section 2.14.3.2 states: "The Contractor shall provide members with written notice of an adverse benefit determination in as few as five days prior to the date of the action if the Contractor has verified information indicating probable member fraud." What is the maximum number of days in which the Contractor has to act?	Ten days.
59	2.14.5.5	Expedited Resolution Timeframe	219	What specific notification needs to be sent to the member when a expedited request has been denied by the Contractor and is transferring to a standard timeframe?	The Contractor must make reasonable efforts, as determined by the OHCA, to give the member prompt oral notice of the transfer, and within two days provide written notice to the member of the reason for the decision and inform the member of the right to file a complaint if the member disagrees with that decision. The OHCA will work with Contractors to develop model notices.

60	2.15.2	Communication with OCHA	224	This section seems to conflict with section 2.1.18.3. On page 225 the RFP indicates that our email server must support VPN "The Contractor shall operate a functional email server that is compatible with the systems maintained by the OHCA and its fiscal agent. This server should be capable of sending and receiving **confidential encrypted material over a virtual private network** specified by the OHCA." however section 2.1.18.3 (page 31) says that no VPN will be used for email "The Contractor shall provide encrypted e-mail communication when PHI is transmitted to the OHCA. **No direct connection or Virtual Private Network (VPN)** to the OHCA will be used for this purpose, nor will the OHCA use individual e-mail certificates for its staff. Such encrypted e-mail will require a X.509 certificate that can be collected by the existing OHCA e-mail encryption system, so that e-mails can be decrypted automatically by the OHCA."	Contractors will not be required to use VPN for email exchanges with the OHCA.
61	2.15.3.2	Timely Submission and Reconciliation	224	Does the OHCA intend to adjudicate encounter data submitted by participating health plans through the MMIS edits utilized to adjudicate Fee-for-Service claims?	Yes. However, edits that would not be appropriate to determine that an encounter is invalid would be disabled.
62	2.15.3.2	Timely Submission and Reconciliation	225	Please advise which NCPDP version will be utilized for pharmacy submissions.	Currently the OHCA processes claims using D.0 for NCPDP transactions and the OHCA does not plan on changing this process at this time.
63	2.15.3.2	Timely Submission and Reconciliation	224	RFP Section 2.15.3.2 states: "The Contractor shall submit encounter data to the OHCA by the 10th day of the month for encounters adjudicated in the previous month. The Contractor shall submit encounter data for 99% of encounters within 30 days of adjudication (whether paid or denied)." Please confirm that OHCA will accept submission of encounters more frequently than on a monthly basis.	Yes. The OHCA will collaborate with the awarded Contractors and will accept encounter data more frequently.
64	2.16.2.4	Timely Payment Requirements	230	Please confirm that the denominator used to measure timeliness of clean claims is claim count.	Yes.

65	2.16.2.5	Claims Payment	231	Interest rate starts on day 45, yet timely payment is between 14 - 30 days. Please confirm that interest does not begin accruing until day 45.	Interest rate begins accruing on day 45. The State Fiscal Year (SFY) 2017 interest rate applicable to late payments to vendors has been set at 0.11% per annum, or $0.0003 per $100 per day, which will be in effect July 1, 2016, through June 30, 2017. This interest rate is provided by the State Treasurer based on the average interest rate for thirty day time deposits of state funds during the last calendar quarter of the last preceding fiscal year. (62 O.S. § 34.71 & 34.72 and 74 O.S. § 500.16A and Office of Management and Enterprise Services (OMES) Prompt Payment Rules/Regulations) (Oklahoma's Prompt-Pay law, 36 O.S. § 1219)
66	2.16.5	Member Cost Sharing	194	Can OHCA confirm, MCO's interpretation that charging premiums is a decision the contractor can make?	No. The interpretation is incorrect. All premium and cost sharing policies will be determined by the OHCA, per section 2.16.5. The page number referenced should be 231, not 194.
67	2.16.5	Claims Payment	231	The premium and cost sharing will be capped at 5% of family income. Does public assistance or SSDI count as income?	For families whose eligibility is determined under the MAGI rules, neither public assistance nor SSDI are countable income. OHCA will set the monthly five percent household cap.
68	2.16.5	Member Cost Sharing Limitations	231	Can the OHCA describe the process for determining that a SoonerCare FFS or SoonerCare Choice member cost sharing has reached five percent of family income?	The OHCA will work with Contractors to develop a detailed reporting and notification process.
69	2.18.2	Coordination of Benefits	246	Will there be member notification/outreach requirements (i.e. sending a letter asking member about other coverage)?	Contractor should inquire about other coverage as part of routine verification and updating of member information.
70	2.18.2	Coordination of Benefits	247	The RFP indicates that the Contractor will receive known member third party resources via the enrollment file. For members with Medicare, will the enrollment file include the member's Medicare Health Insurance Claim (HIC) number?	Yes.
71	2.18.3	3rd party liability	245	What state specific reporting is required to provide adds/changes related to TPL to the state (not claims related, but rather related to TPL record accuracy)?	The OHCA will work with Contractors to develop a detailed reporting and notification process.
72	2.18.3	3rd party liability	245	Will there be separate TPL data files for Pharmacy and Medical?	Yes, the TPL data file for Pharmacy is differentiated from Medical.

73	2.18.3	Third Party Liability	248	Please confirm that the Contractor can cost avoid claims for a known casualty.	Yes, per 2.18.3 of the RFP, "The Contractor shall make every reasonable effort to: Determine the liability of third parties to pay for services rendered to members; Avoid costs which may be the responsibility of third parties; and Recover any liability from responsible third party sources." The Contractor's TPL payment and recovery activities are for non-Subrogation claims. For Third Party Subrogation and Recovery please see 2.18.3.7.
74	2.18.3.3	Determination of Third Party Payment	248	Please confirm that the Contractor can bill the provider directly when we discover third party liability after claim payment.	See response to question 73.
75	2.18.3.5 and 2.18.3.7	2.18.3.5 Third Party Payment Recovery, 2.18.3.7 Third Party Subrogation and Recovery	249	The RFP indicates that the Contractor retains third party payment recoveries except as otherwise specified. In our markets where the states retain subrogation recoveries, they do allow the MCO to pursue Workers Compensation Recoveries. Will the OHCA allow the Contractor to pursue Workers Compensation cases they identify?	No.
76	2.18.3.7	Third Party Subrogation and Third Party	249	Will OHCA be responsible for sending the Subrogation questionnaire to identified members?	Yes.
77	2.2.1	Licensure	41	Will the OHCA consider accepting the Contract of Award (COA) by readiness review or prior to member enrollment?	No. The Certificate of Authority must be furnished at time of Contract award to assure that the program will have sufficient capacity.
78	2.2.1	Licensure	42	Can the State please clarify if the term "Contract award" refers to the date the contract execution date.	The Contract Award is identified as the date the fully executed Contract and Purchase Order are finalized and issued to the awarded Vendor.

79	2.2.2.2 / Form 8070000933-H-Major Subcontractors	Subcontractors	41	On this form, in the row titled "Dollar Value," is this the estimated amount paid to the subcontractor over a 12-month period or some other measurement, e.g., over the life of the contract?	"Dollar Value" means the amount expected to be paid to the subcontractor over the first full year of the Contract.
80	2.2.2.2; Appendix 1	Subcontractors; Appendix 1: Definitions and Acronyms: Definition of Major Subcontractor	42; 345	The definition of a major administrative subcontractor in RFP Section 2.2.2.2 does not provide the time period for which the threshold dollar amount of $2 million is to be estimated, but the definition provided in Appendix 1 limits the time period to "the year one Contract period." Please confirm that throughout the RFP, both "major administrative subcontractors" and "major health service subcontractors," are entities anticipated to be paid the specified dollar thresholds "during the year one Contract period" described in Appendix 1 at page 345.	Yes, this amount refers to what the Contractor expects to pay the subcontractor over the first full year of the Contract.
81	2.2.3.1	Board of Directors/ Executive Management	44	Please confirm that a health plan that has separate COO and CEO, and that the COO position is full-time dedicated to SoonerHealth+ and a resident of Oklahoma, has met the requirements of Section 2.2.3.1 and the CEO does not need to be an Oklahoma resident.	Yes. The described structure meets the requirements of Section 2.2.3.1.
82	2.20	Program Integrity/ Compliance	256	Please provide the State's definition of Program Integrity.	Program integrity is the administrative and management arrangements or procedures for detecting and preventing fraud, waste and abuse.
83	2.20.1.2	Referral to the OHCA's Program Integrity and Accountability Unit	257	Can the OHCA specify a timeframe related to the use of "Promptly;" is there a calendar or business day expectation?	The OHCA will work with Contractors to define expectations for timely referral of potential fraud, waste and abuse.
84	2.20.2	Model Contract: Program Integrity/Compliance; Compliance Program	259	The model contract requires a "monthly check for exclusions of the Contractor's employers, owners and agents and database to capture identifiable information" as part of the Compliance Program. Does "agent" in this context mean a non-employee subcontractor who provides health or administrative services for a member?	Yes.

85	2.20.7	Reporting Improper Payments	262	Can the OHCA specify a timeframe related to the use of “Promptly;” is there a calendar or business day expectation?	See response to question 83.
86	2.22.4.11	Schedule of Actions	273	Please provide definition or error rate with regards to encounter data submissions. This section indicates schedule of penalties for error rates of 5.1 to 7%, 7.1 to 10%, and > 10.1%. Is error rate based on the number of rejected/denied encounters (failing OHCA edits) divided by the total number of encounters submitted? If the encounter is rejected/denied and then resubmitted and accepted within 30 days (Section 2.15.3.2) is it counted toward the error rate calculation?	Q1: Yes, the error rate is based on the rejected/denied encounters divided by the total number of encounters submitted. Q2: No, if the claim is resubmitted and successfully pays, it will not be included in the error rate. (See O.A.C. 317:30-3-2.1 regarding "Error Rate" http://www.oar.state.ok.us/oar/codedoc02.nsf/frmMain?OpenFrameSet&Frame=Main&Src=_75tnm2shfcdnm8pb4dthj0chedppmcbq8dtmmak31ctijujrgcln50ob7ckj42tbkdt374obdcli00_) (See O.A.C. 317:2-1-7 regarding Program Integrity http://www.oar.state.ok.us/oar/codedoc02.nsf/frmMain?OpenFrameSet&Frame=Main&Src=_75tnm2shfcdnm8pb4dthj0chedppmcbq8dtmmak31ctijujrgcln50ob7ckj42tbkdt374obdcli00_)
87	2.3.4.2	Members Enrolled in Behavioral Health Homes	49	Does the OHCA envision that participating health plans would need to contract with the Behavioral Health Homes to support continuity of care for SMI/SED members who elect to remain in the contractors health plan?	No. Members will have a choice of either being in a Health Home or enrolled in an MCO.
88	2.3.4.2	Members Enrolled in a Behavioral Health Home	50	In reading the RFP, a member with SMI/SED can choose to participate in the behavioral health home model or stay with the MCO. If the member chooses to stay with the MCO, providing the appropriate level of services may be impacted by the benefit structure outlined in the RFP where certain levels of behavioral health services are not available to adult members. Please advise what options MCOs would have in this case where they may need to provide a full range of services to a member with SMI/SED.	The State needs more clarification as to which services the question is referring to in order to completely respond to the question. However, for adults with SMI that opt to enroll in a plan instead of staying with a Health Home, Programs for Assertive Community Treatment (PACT) is designed to meet the needs of this population.

89	2.3.4.5	Living Choice/ Money Follows the Person	50	The RFP indicates that individuals utilizing MFP are excluded from the SoonerHealth+ program. How will these members access waiver services during their 365 days in the MFP Program? In Contract year 3, would SoonerHealth+ members transitioning from a nursing facility into a home setting and who need access to the MFP be disenrolled from SoonerCare+ while they access MFP and then be re-enrolled after the 365 days?	Members will receive MFP services in their first year. OHCA will transition members out until December 31, 2018. Most services are in the waivers.
90	2.3.4.5	Living Choice/Money Follows the Person	50	Does OHCA intend that persons using the My Life/My Choice and Sooner Seniors waivers will be managed within SoonerHealth+ post MFP demonstration period? If yes, in what timeframe will these waivers be included in the Sooner Health+ program?	MLMC and Sooner Senior waivers have been terminated. These members are now enrolled in AD*vantage*.
91	2.3.4.6	Individuals with ID Who Receive Services through an HCBS Waiver	51	Will the IID waiver members lose the waiver services upon enrollment with the MCO, or will the array of waiver services be covered under the MCO contract?	IID waiver services will be covered when IID waiver members are enrolled.
92	2.4.2.1	General	53	The RFP states, "The Contractor may require prior authorization of benefits to the extent these are required under the OHCA's policies and rules." Do the OHCA's authorization rules support the utilization of evidence-based clinical criteria such as Milliman or Interqual?	Authorizations are based on medical necessity, not proprietary clinical criteria.
93	2.4.2.1	Capitated SoonerHealth+ Benefits; General	54	Please provide access to the list of services requiring prior authorization under this RFP.	The OHCA will provide awarded Contractors with additional information on current prior authorization policies.
94	2.4.2.1	General	53	Will the contractor be able to waive (remove) any of the prior authorization requirements on services that currently require a prior authorization under the OHCA's standards?	Yes, Contractors may waive prior authorization requirements.

95	2.4.2.2	General Medical and Related Benefits	55	Does the plan have the flexibility to waive copayments?	No. Page number pertaining is 54.
96	2.4.2.2	General Medical and Related Benefits	55	Can the Contractor waive copays? Based on our experience with this population in other states, we feel it may be a better member experience.	See response to question 95. Page number pertaining is 54.
97	2.4.2.2	General Medical and Related Benefits	58	Are Pregnancy Tests meant to be covered under the pharmacy benefit? If so can the contractor have preferred tests and include quantity limits?	Pregnancy tests are not covered in the FFS pharmacy benefit.
98	2.4.2.2	General Medical and Related Benefits	59	Incontinence Supplies, are these meant to be covered under the pharmacy benefit? If so can the contractor have preferred tests and include quantity limits?	Incontinence Supplies are covered under the Durable Medical Equipment (DME) Benefit for diapers, pull-ons, and underpads for children under EPSDT coverage requirements or for members in an HCBS waiver. ***Please restate and clarify the second portion of the question for Round Two, "If so, can the contractor have preferred tests and include quantity limits?"
99	2.4.2.2	General Medical and Related Benefits	60	Is enteral nutrition meant to be covered under the pharmacy benefit? If so, please confirm that contractor is permitted to have preferred tests and include quantity limits.	Enteral nutrition is covered under the DME benefit under EPSDT. Please restate and clarify the second question for Round Two, "If so, please confirm that the contractor is permitted to have preferred tests and include quantity limits?"

100	2.4.2.2	General Medical and Related Benefits	59	Limit of 6 Rxs per month including 2 brand Rxs. Does OK have specific criteria? Is there an upper limit of prescriptions per month and brand name Rxs per month?	For adult members who are Title XIX only with no waiver eligibility, 6 prescriptions is the upper limit per month. There are some drug classes that don't count including antineoplastics, anti-retroviral agents for persons diagnosed with Acquired Immune Deficiency Syndrome (AIDS) or who have tested positive for the Human Immunodeficiency Virus (HIV), certain prescriptions that require frequent laboratory monitoring, birth control prescriptions, over the counter contraceptives, hemophilia drugs, compensable smoking cessation products, low-phenylalanine formula and amino acid bars for persons with a diagnosis of PKU, certain carrier or diluent solutions used in compounds (i.e. sodium chloride, sterile water, etc.), and drugs used for the treatment of tuberculosis. Within the 6 prescriptions per month, two may be brand name drugs. A third brand name drug may be prior authorized if it is found to be medically necessary and the member has not used all 6 of the monthly prescriptions.
101	2.4.2.2	General Medical and Related Benefits	54	The Care/case management service benefit states that adults must pay a $4.00 copayment. What's the state's expectation for collection when MCO is using internal staff for this function? With each touchpoint, annually, etc.?	The OHCA does not expect collection of the copayment when internal staff are providing care management. See also response to question 104.
102	2.4.2.2	General Medical and Related Benefits	54	Implementation is scheduled to start in April. How will annual benefit limits apply in Year 1 since they are tracked on a calendar year basis?	The OHCA will provide Contractors with member-specific utilization information for January through March.
103	2.4.2.2	General Medical and Related Benefits	54	Please clarify if short-term Nursing Facility stays will be covered by the Contractor in Years 1 and 2.	Yes.
104	2.4.2.2	General Medical and Related Benefits	54	How does the Care/case management copayment apply for Adults? Per visit or per month?	Adults in HCBS waivers are not assessed a copayment for waiver case management services. For Behavioral Health Targeted Case Management, the copay is assessed for each date of service on the claim.

105	2.4.2.2	General Medical and Related Benefits	54	Does the requirement for a $4.00 copayment for care/case management services apply when those services are provided by employees or subcontractors of the health plan?	See response to question 101.
106	2.4.2.2	General Medical and Related Benefits	54	This section states that adults have "No Coverage" for Independently Contracted Licensed Behavioral Health Provider. Does this mean that the OHCA prohibits participating health plans from contracting or utilizing those providers to provide services to adult members? Are all of those members expected to be seen through Community Mental Health Centers? Does the same rule apply for Independently Contracted Psychologists?	Under current SoonerCare State Plan and coverage guidelines, there is no coverage for independently contracted LBHPs or Psychologists for adults. In order for adults to receive services through a licensed clinician, they must be seen through an outpatient behavioral health agency provider, which includes but is not limited to Community Mental Health Centers. However, pursuant to Section 2.4.2.8 of the Solicitation, the Contractor may cover services or settings that are in lieu of services or settings covered under the State Plan in accordance with 42 CFR § 438.3(e).
107	2.4.2.2	General Medical and Related Benefits	54	Is the intent that member co-pays be collected by the providers or are they to be deducted from the reimbursement made by the MCO to the providers?	MCOs have the option of deducting copayment amounts from provider reimbursement.
108	2.4.2.2	General Medical and Related Benefits	54	Are the benefits listed in the RFP all inclusive, or are additional services also identified in Chapter 30, OHCA Policies and rules?	Benefits listed in the RFP are all inclusive.
109	2.4.2.2	General Medical and Related Benefits	55	In the General Medical and Related Benefits grid on page 55, "Care and Case Management" is listed as a covered service requiring a $4 copay. Please provide additional details as to when the copay applies and to whom the member is expected to pay.	The copay applies per day of service. See also responses to questions 101, 104 and 107.
110	2.4.2.2	General Medical and Related Benefits	55-64	Does the Contractor have the option to waive the copay requirements?	See response to question 95.

111	2.4.2.2	General Medical and Related Benefits	55	Must case management services be encountered using CPT code T1016r or is case management categorized as an administrative expense with no encounter required? If CM is encountered using CPT Code T1016, does the copayment apply each time the code is encountered, or is there some other time frame, e.g., weekly, monthly, where the copayment would apply?	No. The copayment applies per visit.
112	2.4.2.2	General Medical and Related Benefits	56	For members under age 21, what is the State's expectation for covered preventive services? Can any of these preventative services be provided and reimbursable by a PCP as well as a dentist, such as fluoride varnish application?	Q1: The State's expectation for covered preventive services includes EPSDT and immunizations. Q2: Yes.
113	2.4.2.2	General Medical and Related Benefits	56	Aside from the RFP requirement to provide emergency extractions and related services to adults, are there any ancillary services or annual monetary benefits available to ABD or other Medicaid populations? If so, please identify what those services and/or benefits would include and their expected duration. Additionally, what are the restrictions, limitations, and exclusions, if any?	Q1: No. Q2: All covered services are found in the dental program policy. Q3: These are also explained in the current dental policy.
114	2.4.2.2	General Medical and Related Benefits	56	Please confirm that the dental benefit requiring coverage for "[e]mergency extractions and services related to extraction" includes coverage in any appropriate and medically necessary setting.	The OHCA expects all SoonerCare members to be treated in a manner that addresses any medically necessary service. It is anticipated this service will be delivered in the most appropriate setting.
115	2.4.2.2	General Medical and Related Benefits	54	Are home care benefits available if the member exceeds the 36 visit threshold? Does OHCA follow CMS guidelines on face-to-face physician consultations for continued home health services?	Q1: Yes, home care benefits are available if the member exceeds the 36 visit threshold with the PA for children. Q2: Yes.
116	2.4.2.2	General Medical and Related Benefits	58	Which visit types do not count toward the monthly specialist provider visit limit?	All specialist provider visits count.

117	2.4.2.2 2.4.2.3	Care/Case Management	54	There are copay requirements for 2.4.2.2 “Care/case management” and 2.4.2.3 “Care/case management.” Are these copays due when CPC+ providers provide the covered benefit or general case management provided by internal Health Plan Staff? Would a physical in-person visit with a care manager be the triggering event to cause a copay to be due?	CPC+ providers do not bill Care/Case Management.
118	2.4.2.2; 2.4.2.3	Medical/Behavioral Health Benefits	55; 63	The RFP identifies two different copays for "care/case management" provided under general medical benefits ($4 copay, p. 55) and behavioral health benefits ($3 copay, p. 63). How are we to handle that in the context of Mental Health Parity regulations?	Contractors are required to apply the correct copay.
119	2.4.2.2; 2.8.3.3; 2.11.7.2	General Medical and Related Benefits	63, 116, 165	Oklahoma is one of six states funded with a federal grant on “supporting families.” One of the major components of this work has been the realization that eligibility-based services are only a small piece of the puzzle. That being said, it is very often the sole focus of an individual or family. One of the major MISSING components of Oklahoma’s current system is a lack of peer support – both for the individual with a disability and those who support him/her. Where is the role of peer-to-peer support/counseling in this RFP? This is an important goal we must attain in Oklahoma.	The OHCA's intent is to promote flexible service delivery to achieve person-centered care. Contractors will be expected to offer a full array of services to best meet individual needs. Peer recovery support is included in the schedule of covered benefits. The OHCA anticipates that Contractors will develop and support enhanced use of peer-based services as appropriate.
120	2.4.2.3	Behavioral Health Benefits	62-65	Do the services provided under the "Psychiatrist" service include medication-assisted therapies?	The medical management/prescriber component would all fall under the "Psychiatrist" service, while the counseling and support services would fall under outpatient services through certified alcohol and drug treatment programs.
121	2.4.2.3	Behavioral Health Benefits	63-65	Section 2.4.2.3, describing behavioral health benefits for children and adults, includes prior authorization requirements for children to obtain behavioral health benefits. Please confirm that an MCO may adjust these prior authorization requirements to comply with the Mental Health Parity and Addiction Equity Act.	Yes. An MCO may adhere to existing requirements.

122	2.4.2.3	Pharmacy Program	61	Can the State confirm that if a drug product is administered under the drug benefit, it can be denied if requested again under the medical benefit?	It can be denied for the same date of service. A member may initially receive a drug under the medical benefit and then switch to the pharmacy benefit or vice versa. There is not a hard line, but a duplicate claim for same date of service should be denied. In this specific case, date of service would most likely be the date of administration by a health care professional, not necessarily the date of pharmacy dispensing.
123	2.4.2.3, 2.4.2.8. & 2.8.3.3	Behavioral Health Benefits, Services or Settings…, & Behavioral Health Providers	62-65, 68, & 117	The Behavioral Health Benefits grid on pgs. 62-65, 68 and 117 does not list crisis services and furthermore, crisis residential services are indicated as a less restrictive/in lieu of a covered benefit service, however, the behavioral health network indicates the inclusion of crisis intervention and crisis stabilization facilities. What crisis services, if any, are in scope for the health plan to provide?	Crisis services are covered through the outpatient behavioral health agency benefit (317:30-5-241.4) which is included on the benefits grid on Page 63. Crisis services include onsite and mobile crisis intervention services as well as facility based crisis stabilization and urgent recovery clinics (URC).
124	2.4.2.4	Pharmacy Program	64	Drug products available under pharmacy and medical benefits: Does Oklahoma have a list of drugs considered to be billable under both pharmacy and medical benefits?	The state will provide to Contractors a current list of drugs that may only be billed under the medical benefit. J code drugs not on this list may be billed either under medical or pharmacy. Due to the use of "junk codes" it is difficult to provide a complete list of drugs that could be billable under both medical and pharmacy benefits.
125	2.4.2.4	Pharmacy Program	64	Diabetic supplies are covered, specific products are listed but alcohol swabs are not. Is this list exclusive? If so, please confirm that alcohol swabs are not covered.	Diabetic supplies are covered partially under the pharmacy benefit and partially under the DME benefit. In addition to the listed products covered by the pharmacy benefit, the following codes are covered under DME: A4233, A4234, A4235, A4236, and A4245 (alcohol swabs).
126	2.4.2.4	Pharmacy Program	64	In regard to the requirement that MCOs must allow drugs to be available in both pharmacy heath care practitioner settings: a. Does that extend to oral drugs (e.g., oncology providers using in-office dispensing of drugs normally available through retail or specialty pharmacies)? b. For provider-administered drugs that are billed to the contractor under this requirement, is the contractor allowed to use its own Utilization Management policies/criteria or is there OHCA PDL criteria that extends to this setting?	a. Oral drugs may not be dispensed in-office. They may be administered for immediate use, but not dispensed for future use. b. The contractor must use the OHCA utilization management/prior authorization criteria.

127	2.4.2.4	Pharmacy Program	page 65	Please clarify which drugs or classes OHCA requires plans to provide under both pharmacy and medical benefits per the following language in section 2.4.2.4 Pharmacy Program of the Model Contract: If a drug product either can reasonably be dispensed by a pharmacy or administered by a health care practitioner, the Contractor shall follow the SoonerCare pharmacy program policy by making the drug product available through both settings.	See response to question 124.
128	2.4.2.4, 2.4.2.5, and Item 55	Pharmacy Program, Medicare Crossover Claims, and Medical Management: Pharmacy Benefit Management	64, 64, and 306	How are 340B pharmacy claims currently managed and adjudicated under FFS? For FFS, are there currently special 340B claims billing requirements and/or special reimbursements in place? Is it the OHCA's desire for MCO contractors to manage these drugs the same way, or differently?	340B covered entities submit their usual price to OHCA. OHCA pays the lower of the Medicaid allowable or the submitted charge. At the end of each calendar quarter, OHCA recoups an amount equal to what would have been collected in federal drug rebates. Most of the 340B activity is billed under medical claims for outpatient hospital or clinic administered drugs. Pharmacies owned by a covered entity are subject to the same process. Contract pharmacies must enter a three-way agreement that includes the covered entity and OHCA. They must obtain a second NPI if they are going to dispense both 340B and non-340B drugs to Medicaid members. OHCA would prefer to manage these drugs in the same way as this arrangement is beneficial for the covered entity, the state and the members. If the Contractor wishes to deviate from this arrangement, OHCA will review the proposed process during readiness review.
129	2.4.2.5	Medicare Crossover Claims	66	Would the plan also be responsible for Medicare Part D copayments for dual eligible members?	No. OHCA provides no assistance to dual eligible members for their Part D copayments.
130	2.4.2.8	Services or Settings In Lieu Of…	67	The RFP states that the Contractor may cover services or settings in lieu of services or settings covered under the State Plan. How will the Contractor submit encounters for these services/settings?	The OHCA will coordinate with Contractors to develop a process for submitting encounter data relating to "in lieu of" services, to the extent such services fall outside of the conventional coding practices.
131	2.4.3.1	Non-Emergency Transportation (NEMT)	68	Will MCO be required to contract with OHCA to ensure services managed by OHCA are paid for such as non-emergency transportation?	The meaning of the question is unclear. If the intent is to inquire as to whether Contractors must separately contract with the OHCA's NEMT provider, the answer is no.

132	2.4.3.1	Non-Emergency Transportation (NEMT)	68	Under Non-Capitated SoonerHealth+ Benefits, it states, "NEMT, other than transportation covered through an HCBS waiver, is provided through a separate OHCA contract with a transportation vendor." Will contractors be responsible for NEMT for HCBS waiver members? Will contractors have to use the state's NEMT vendor for these populations as well?	Q1: Yes. Q2: No.
133	2.4.4	Value-Added Benefits and Services	68	Can bidders propose descriptions of value-added services that they intend to offer in years 2-5 of the agreement or must the value-added services be implemented year 1?	Descriptions must be for year one services.
134	2.5.1.3	Nursing Facility Level of Care and Special Health Care Needs	70	Please confirm if the specific waiver type will be listed for members on the 834 file. In addition, will OCHA indicate if members are on a waiver waitlist?	No, the specific waiver type will not be listed for members on the 834 file. No, the OHCA will not indicate if members are on a waiver waitlist.
135	2.5.2.1	Enrollment Choice Counseling	72	Will historical data be included in the 834 enrollment files?	The OHCA does not anticipate using historical data.
136	2.5.2.1	Enrollment Process	73	42 CFR § 438.54. 42 CFR § 438.56. Looks like there will be an RFP for a choice counselor. Is that already in the works?	Yes, an RFP for Choice Counselor will occur. The RFP is not yet in process.
137	2.5.2.5	Auto-Assignment	72	Is the contractor maximum on member enrollment on a per region basis or state-wide?	Region.
138	2.5.2.5	Auto-Assignment	72	What is the next available window for bidders to sign a memorandum of understanding to serve as a CPC+ payer partner in Oklahoma?	The OHCA does not have this information. Bidders are encouraged to monitor CMS communications regarding CPC+ payer partners. Link to CPC+ : https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus
139	2.5.2.6	Enrollment	73	Contract states newborns eligible for the SoonerHealth + Program shall be enrolled effective as of the date of birth. For example, if the newborn date of birth is 6/15/18, will the enrollment effective date on the 834 be 6/15/18 or will it be retroactive back to 6/1/18?	Yes, if notified by the OHCA. Note that this would only occur in circumstance where both the mother and child (at time of birth) are SoonerHealth+ eligible, which should be a very rare occurrence.

140	2.5.2.6	Enrollment	73	RFP states members enrolling in a plan at time of discharge from a nursing facility, if known to the OHCA, shall be enrolled effective as the date of discharge. For example, if the member's date of discharge from the nursing facility is 5/15/18, will the enrollment effective date on the 834 be 5/15/18 or will the enrollment date be retroactive back to 5/1/18 ?	No members other than newborns will be retroactively enrolled. Enrollment effective date on the 834 is date specific.
141	2.5.3.1	Initial Contact	74	RFP section 2.5.3.1 states that the reasonable efforts to contact new members can be “in person, by telephone or through the use of other mechanisms.” This appears to conflict with RFP section 2.11.5.4 that indicates the Contractor “shall make at least three call attempts to contact members by telephone.” Please verify the methods that can be used to conduct Health Risk Screenings.	Per Section 2.11.5.4, the Contractor must make at least three call attempts to contact the member by telephone to perform the health risk screening but also may use other methods if unable to reach the member by phone. Section 2.5.3.1 refers to making initial contact with new members. Contractors may, but are not required, to combine the initial contact and health risk screening activities.
142	2.5.3.3	Failure to Contact	75	How far in advance will the format requirements for Failure to Contact be available?	The OHCA anticipates that this format will be available at least 90 days prior to the effective enrollment date.
143	2.5.4.3	Initial PCMH Selection or Assignment Process	75	Will OHCA provide an algorithm for PCMH assignment? OR is the expectation for the MCO to develop one? IF so, can OHCA elaborate on requirements?	The Contractor will be expected to make PCMH assignments in accordance with the requirements specified in section 2.5.4.3. The OHCA will not provide an algorithm.
144	2.5.5	2.5.5 Primary Care Dentist (PCD) Selection and Assignment	76	Does the OHCA currently offer primary care dental services to its members?	No, this service is not presently offered.
145	2.5.7.4	Disenrollment Effective Date	79	Will capitation payments to Contractor be adjusted if a member is only enrolled for a partial month? Will they be prorated based on the number of days the member is enrolled?	Q1: Yes. Q2: Yes.
146	2.6.3	Transition of Care Period	82	Will the State send us the pre-authorization information in advance of the member enrolling? Do all transitioned pre-authorizations expire after the 90 day transition period? Does this include only maintenance medications or all medications? Does this fall under the 6 prescription limit per month?	Q1: The OHCA will coordinate with awarded Contractors to provide this information. Q2: Authorizations would expire after the person is transitioned, or after 90 days. Q3: Please clarify the question for Round Two as it is unclear. Q 4: Please clarify the question for Round Two as it is unclear.

147	2.6.5.2	Nursing Facility to Home	86	"The estimated cost of the HCBS shall not exceed the limit established by the OHCA." Can you please provide the current limits as well as information on the methodology of how these limits will be set in the future and the frequency of updates?	Currently, the ADvantage Cost Cap is annualized on a Fiscal Year schedule. The FY17 ADvantage Cost Cap is $53,464.00, effective July 1, 2016. OHCA determines the annual cost of NF residents. Oklahoma DHS uses annual NF costs provided by OHCA, estimates full year average length of stay, adds acute care costs for NF residents and subtracts acute care costs for ADvantage recipients.
148	2.6.5.4	Transition of Care	88	Has or will OHCA define standardized protocols and data exchange formats to facilitate transfer of information between health plans with disparate systems?	The OHCA will collaborate with Contractors to specify formats and protocols.
149	2.6.5.5	Transition of Care	88	Has OHCA defined any standards or targets for providing claims history for transitioning members between surrendering and receiving health plans?	The OHCA will collaborate with Contractors to specify standards.
150	2.7.1.1	Prior Approval of Member materials	93	OHCA must review and approve all member materials. Please confirm that this includes member materials only and not provider materials.	Materials that require the OHCA's review and approval are specified throughout the RFP. For example, section 2.7.9.3 requires the OHCA's approval of the provider directory.
151	2.7.1.1	Prior Approval Process for Member Materials	91	Is there a similar requirement relative to member materials that provider materials (i.e., newsletters, etc.) also be submitted for OHCA approval?	See response to question 150.
152	2.7.1.4	Language/Accessibility	92	Could the State please clarify which languages are considered prevalent by OHCA?	English and Spanish.

153	2.7.1.4	Language/ Accessibility	91	Section 2.7.1.4 states that “The Contractor shall make its member materials available in the prevalent non-English languages as specified by the OHCA.” This section also states: “When the Contractor learns that the member requires information in a non-English language, all essential member materials shall be sent to the member in that non-English language within three days if the language is considered by the OHCA to be prevalent or 15 days if the language is considered non-prevalent.” Given the requirement that oral interpreters must be available to speakers of all languages, regardless of prevalence, and that plans must provide members with information on how to access them, would OHCA consider revising the requirements to limit written translation to prevalent non-English languages as long as plans provide oral translation of all materials in all non-prevalent languages upon request.	No.
154	2.7.1.4	Language/ Accessibility	91	Will the State provide us with the language indicator or is this dependent on the MCO?	Yes.
155	2.7.1.4	Language/ Accessibility	91	Will OHCA provide the Contractor with the members' preferred language on the 834 file?	Yes.
156	2.7.1.4	Language/ Accessibility	91	RFP section 2.7.1.4 states: "When the Contractor learns that the member requires information in a non-English language, all essential member materials shall be sent to the member in that non-English language " Question: Which member materials are considered essential?	All member materials are considered essential.
157	2.7.1.4	Language/ Accessibility	91	RFP section 2.7.1.4 states: "When the Contractor learns that the member requires information in a non-English language, a note shall be made in the member record and all Contractor correspondence thereafter shall be provided in both English and the required non-English language." **Question:** Does "and the required language" mean that this requirement only applies to prevalent languages or are proactive translations required for all documents in a given language as soon as 1 member notifies the contractor he/she prefers it?	Contractor must translate all documents into a member's preferred language after the member has notified Contractor of his or her preference.

158	2.7.1.4	Language/ Accessibility	91	Can the State please provide its methodology for determining if a language is deemed prevalent or non-prevalent? For example, in many other markets, there is a standard of language prevalence in which populations 5% or greater result in translated communications (electronic and paper).	The OHCA employs the 5% threshold.
159	2.7.3.3	Guidelines for Email	95	Section 2.7.3.3 states: “The Contractor shall attempt to contact members through email unless the member does not have access to email or opts out of email.” Can the State please provide some additional guidance on how member email addresses will be obtained (i.e. received on the member 834 file, etc.)? Also, what is the expected process for returned emails?	It is expected that Contractors will collect email addresses as part of initial outreach efforts.
160	2.7.6	Enrollment	101	Contractor shall distribute member identifications cards to members and replacement/reissued cards to members within seven days. Is this business or calendar days?	Calendar days. Per Appendix 1 - Definitions and Acronyms, "days is defined as calendar days unless otherwise specified."
161	2.7.6	Member Identification Card	101	Will the MCO be required to list the Primary Care Dentist (PCD) on the member identification card?	The required elements are listed in section 2.7.6. PCD is not a required element but Contractors are welcome to include the PCD on the card.
162	2.7.7.4	Website Translation	103	Please confirm that posting key plan documents in identified, prevalent non-English language(s) on the publicly available website (e.g. no login required) meets the translation requirement in RFP section 2.7.7.4.	Per section 2.7.7.4, all website content must be available in prevalent non-English languages.
163	2.7.8.1	Member Services Call Center Availability	104-105	What is the required timeframe for call retention?	Seven years.
164	2.7.8.1	Member Services Call Center Availability	103	Typically, care management calls are not recorded (PHI concerns) nor are IVR calls, such as those used for disease management for controlled chronic diseases. Is it the intent of OHCA that these are also required to be recorded?	The OHCA's intent is that calls to member services call center are recorded.

165	2.7.9	Provider Directory	105	Please confirm that Contractor is permitted to direct members to Subcontractor websites to search for applicable participating providers (i.e., PMB Subcontractor website who provides pharmacy network).	Contractor may provide a link from the provider directory portion of its website to the provider directory portion of the PBM website, as long as members are not required to login separately to the PBM site.
166	2.7.9	Provider Directory	106	When the OHCA defines requirements for a provider directory, can they ensure requirements for listing PCMH's don't result in having to list specialists or general practitioners serving as PCMHs twice? In e.g.: If a Specialist is listed under a respective specialist category and then again on a separate page as a potential PCMH.	The OHCA will review provider directory format and content as specified in section 2.7.9.3.
167	2.7.9.4	Updates	106	Would OHCA consider following CMS standard of electronic updates for online version of a provider directory every 30 days?	No.
168	2.7.9.4	Provider Directory; Updates	107	To reduce administrative costs of printing monthly directories, may a printed directory be produced from the web site upon a member's request?	Yes.
169	2.8.1.1	Adequate Network	110	Will OHCA provide contracting lists (e.g. Significant Traditional Providers) to assist in network build?	No.
170	2.8.1.3 & 2.9.3.6	Providers Prohibited from Network Participation / Database Checks/Screenings and Criminal Background Checks	110;127	Please confirm the background check is waived for any provider if the provider is confirmed as an approved Medicaid provider and is not listed on any of the State and/or federal registries as being excluded from participation in Medicaid/Medicare.	The OHCA will review Contractor credentialing and recredentialing policies and procedures during readiness review. See section 2.9.3.6 for provisions related to waiver of background checks.
171	2.8.1.5	Monthly Network Provider Listing	111	If available, will OHCA provide the data fields that will be required for the Monthly Provider Directory listing?	This information will be shared with Contractors upon award.

172	2.8.3	Network Access Standards	113	In our experience, states typically have differing access standards across urban and rural areas. You have provided different access standards for hospitals across urban and rural regions in Section 2.8.3.1. Would the State consider doing the same for PCMHs and other Provider types?	No. The OHCA believes the standards as they are currently set are achievable throughout the State. The Contractor's network must be adequate to ensure that the care is available timely and geographically accessible and be based on the needs of members.
173	2.8.3.1	PCMH Providers	114	Can a Nurse Practitioner be assigned as a PCMH? If yes, does the Nurse Practitioner need a PCMH number?	Q1: Yes. Q2: Yes, the Nurse Practitioner needs a Contract ID.
174	2.8.3.3	Behavior Health Providers	117	What percentage of PACT program adults are currently receiving through Health Homes?	Approximately 60%.
175	2.8.3.3	Behavioral Health Providers	116	The stated distance standard for behavioral health providers is within 30 miles of a member's residence. Would the OHCA allow participating health plans to utilize independent behavioral health providers or tele-behavioral health capabilities to meet those standards or should plans utilize only CMHC providers to fulfill the requirements?	Under current SoonerCare State Plan and coverage guidelines, there is no coverage for independently contracted LBHPs or Psychologists for adults. Pursuant to the State Plan, in order for adults to receive services through a licensed clinician, they must be seen through an outpatient behavioral health agency provider, which includes but is not limited to Community Mental Health Centers. However, pursuant to Section 2.4.2.8 of the Solicitation, the Contractor may cover services or settings that are in lieu of services or settings covered under the State Plan in accordance with 42 CFR § 438.3(e). Services can be provided via telemedicine, but this does not absolve the plan of having contracted provider sites within 30 miles of the member's residence for outpatient office visits.
176	2.8.3.5	HCBS Providers	118	What is OHCA's desired way for MCO's to measure HCBS Network Adequacy (75 Mile Radius) as most Home and Community Based Services are provided in home?	HCBS Network Adequacy is measured as the distance from provider to member's home.
177	2.8.3.5	HCBS Providers	117	As referenced in RFP section 2.8.3.5, will OHCA be providing a listing of current contracted HCBS providers?	A listing of ADvantage providers by county is available at advantage.ok.gov.
178	2.8.3.5	HCBS Providers	119	Please provide the HCBS provider schedules, or in the alternative, please provide the applicable fee schedules.	The current ADvantage rate schedule can be found at: http://www.okdhs.org/services/aging/Pages/RRS.aspx.

179	2.8.3.6	Pharmacies	120	Are there any additional Oklahoma specific registration or credentialing requirements for pharmacies included in the SoonerHealth+ network?	Out of state pharmacies should become familiar with the non-resident provisions of the Oklahoma Board of Pharmacy regulations. They require out of state pharmacies to obtain an Oklahoma pharmacy license and to employ an Oklahoma-licensed pharmacist as the Pharmacist in Charge.
180	2.8.3.8	Hospitals and Essential Community Providers	121	The document states that in rural areas, the distance can be greater than 30 miles but must be the "community standard". What exactly is that standard and where might we locate that?	The community standard means the distance residents typically must travel for care. The actual standard is community-specific, based on where the nearest providers are located.
181	2.9.2.1	Provider Network Participation & Database Checks/Screenings and Criminal Background Checks	123	Will OHCA notify the contractor of providers that register to participate in Soonercare?	Yes, notification will be provided when contract is completed.
182	2.9.2.1	Application for SoonerCare Participation	123	Do the requirements of RFP section 2.9.2.1 apply the pharmacies/pharmacy benefit management? If so, will OHCA provide a listing of pharmacy providers who have enrolled with FFS? If so, please clarify the following: a. How will the MCO/PBM receive the file? b. How often will the MCO/PBM receive updates? c. Does this FFS enrollment requirement apply to both dispensing pharmacies, prescribers, or both?	Q1: Available information on providers can be found on the OHCA website. Q2 and Clarifications: The OHCA will collaborate with awarded Contractors on these items.
183	2.9.3	Credentialing	123	Will DME, Ambulance, Pharmacies, IHCP Individual, IHCP Clinics, IHCP Hospitals, FQHC and RHC clinics be required to credential?	Yes, at the provider level. The OHCA will review the Contractor's credentialing and recredentialing policies and procedures as part of readiness review.

184	2.9.3	Credentialing	124	Will the credentialing be required at the clinic level for FQHC/RHC/IHCP, or for each individual providers providing services for each clinic?	See response to question 183.
185	2.9.3	Credentialing	124	Will Registered Nurses be required to credential?	Yes.
186	2.9.3	Credentialing	124	Can Contractor utilize CAQH in lieu of State Uniform Credentialing application?	The OHCA will review the Contractor's credentialing and recredentialing policies and procedures as part of readiness review.
187	2.9.3.1	Credentialing and Recredentialing Timeframes	125	Please confirm that the timeline noted in this section is applicable to credentialing for providers "applying for network provider status" and not to recredentialing timelines.	Correct.
188	2.9.3.1	Credentialing and Recredentialing Timeframes	124	Can the state clarify the wording of the timeframes specified in this section? Please confirm that the timeframes would begin "from the time that a complete application has been received by the Contractor from the provider."	Correct.
189	2.9.3.1	Credentialing and Recredentialing Timeframes	124	How often are providers required to be re-credentialed? Are there different timeframes based on provider types? If so, please provide the timeframes for each provider type.	See response to question 186.
190	2.9.3.4	Credentialing and Recredentialing Verification	126	Please confirm the insurance coverage of $1 Million/$3 Million meets OHCA minimum requirements for Medicaid participation for malpractice/liability insurance. If not, please provide the minimum insurance requirements.	Insurance coverage of $1 Million/$3 Million meets OHCA's minimum requirements for Medicaid participation.
191	2.9.3.5	On-Site Review	125	Will all facilities, and sole-practice clinics, IHCP clinics, IHCP Hospitals, FQHC and RHC, Rural County Health Departments, Oklahoma City and Tulsa County Health Department sites be required to have on-site reviews?	The requirement for on-site reviews specified in Section 2.9.3.5 is hereby revised to apply only to PCMH providers and any other provider types that may be mandated in the future by CMS. If on-site reviews are required in the future for the provider types identified in the question, the OHCA will coordinate a single, joint on-site review with SoonerHealth+ Contractors.

192	2.9.3.5	Onsite Review	125	Due to the anticipated large number of sites and burden on providers to review "all facilities and service delivery site to be utilized by the Contractor's providers," would the OHCA consider focusing onsite visits solely to PCPs?	See response to Question 191.
193	2.9.3.5	Onsite Review	126	As the language is written, site reviews and medical records would need to be conducted for every provider type and associated practice locations. It is our understanding that site and medical record reviews would only apply to PCP and OB/Gyn provider types. It is also our understanding that this would apply to newly credentialed providers submitting applications as of this contract effective date and that this would apply to those groups that are not delegated for credentialing. Please confirm that our interpretation is in line with the States expectation.	See response to Question 191.
194	2.9.3.5	Onsite Review	126	Please identify the types of "Contractor's providers" requiring onsite reviews as prescribed by Section 2.9.3.5.	See response to Question 191.
195	2.9.3.5	Onsite Review	125	Can the State confirm the requirement for onsite reviews does not apply to pharmacy credentialing?	See response to Question 191.
196	2.9.3.6	Database Checks/ Screenings and Criminal Background Checks	126	Will the contractor be expected to conduct disclosure of ownership and control screening as detailed in 42 CFR 455.104-106 if the network provider's/subcontractor's Medicaid enrollment as a SoonerCare provider is verified during credentialing?	Contractors must collect and report ownership and control information for every subcontractor, regardless of whether subcontractor also is enrolled as a SoonerCare provider or otherwise has an agreement with OHCA. Network providers that are not subcontractors, based on the definition in RFP Appendix 1, Item A.1.2 - Subcontractor and 42 CFR § 438.2), are excluded from this provision. Their ownership and control information will be collected solely by the State.
197	2.9.3.6	Database Checks/ Screenings and Criminal Background Checks	126	Since there is no mentioned of Medicaid, in paragraph 1 it can be inferred as non-government sponsored insurance programs, compared to paragraph 2 granting a waiver for Medicaid providers by OHCA. Please clarify the directive regarding Database Checks/Screenings and Criminal Background Checks for Medicaid programs?	See response to question 170.

198	2.9.4.4	Specific Requirements for PCD's	132	Can all general care dentists (e.g. Pedodontics, Periodontics) be considered as Primary Care Dentists?	General care dentists would include Pedodontist and general practice dentists only. Excluded due to specialty would be, e.g., oral surgeons, periodontist, endodontist and oral surgeons.
199	2.9.5.1 2.9.5.7 2.9.5.8	Rate Setting, Payments to FQHCs and RHCs, Payments to Pharmacy Providers	133-135	Please provide additional information about the payment rates and price types (AWP, MAC, etc.) employed by the OHCA for this program.	Beginning 1-3-2017, OHCA will move to an Actual Acquisition Cost (AAC) based reimbursement system. The ingredient price will be based on the lower of Wholesale Acquisition Cost (WAC), National Average Drug Acquisition Cost (NADAC), or State Maximum Allowable Cost (SMAC). Additionally, for drugs not typically dispensed at retail pharmacies, OHCA will set a Specialty Pharmaceutical Allowable Cost (SPAC). In setting the SPAC rate, Part B pricing, WAC and NADAC will be considered. The Professional Dispensing Fee is $10.55 per prescription.
200	2.9.5.8	Payments to Pharmacy Providers	135	Can contractors use an alternative pricing model for MAC pricing instead of the pricing models noted on the Oklahoma website?	Contractors can use their own pricing models so long as the total reimbursement to pharmacies is not less than what would be paid for the same claim under FFS rates.
201	2.9.5.8	Payments to Pharmacy Providers	135	If MCO contractors are to reimburse pharmacies no less than the FFS rates, how will the OHCA provide contractors with regular update files of its Fee for Service (FFS) MAC list?	The OHCA will collaborate with the awarded Contractors on the updating process.
202	2.9.5.8	Payments to Pharmacy Providers	135	What is the current pharmacy reimbursement rate formula for Medicaid FFS, as it relates to brand and generic drugs? Will the rate change during the contract period?	See response to question 199. Brand drugs are reimbursed at the lower of the Medicaid allowable or the submitted usual and customary charge. The Medicaid allowable for branded drugs is the lower of WAC, NADAC, or SPAC plus $10.55 professional dispensing fee. The Medicaid allowable for generic drugs is the lower of WAC, NADAC, or SMAC plus $10.55 professional dispensing fee. The rate may change during the contract period.

203	2.9.5.8	Payments to Pharmacy Providers	135	Does the FFS rate requirement for pharmacies extend to specialty pharmacies or are MCO contractors free to negotiate any rate with those pharmacies?	Contractors may negotiate rates with specialty pharmacies, but must follow the OHCA definition of a specialty drug. A specialty drug is one that is not typically dispensed by a community pharmacy and has at least one of the following characteristics: (1) covered by Medicare Part B, (2) 5i drug (injected, infused, instilled, inhaled, or implanted), (3) cost greater than $1,000.00 per claim, (4) licensed by the FDA under a Biological License Application, (5) special storage, shipping, or handling requirements, or (6) does not have a NADAC price from CMS.
204	2.9.5.9	Performance-Based Provider Payments	136	Regarding "Provider whose payment methodology is prescribed by the OHCA will be excluded from the calculation.": Please provide which providers have payments that would fit into this criteria.	The provider types in question are identified in sections 2.9.5.6 through 2.9.5.8. If directed or pass through payments are required in accordance with section 2.9.5.1, these also will be excluded from the calculation.
205	2.9.5.9	Performance-Based Provider Payments	135	Please clarify whether the 80 percent threshold for performance-based provider contracting will be calculated using a numerator that is the total claims spend “tied to” performance based contracts, or “total payment to these providers?"	If any portion of a provider's payment methodology is performance-based, the provider's total payments may be included in the numerator.
206	2.9.5.9	Performance-Based Provider Payments	135	Please confirm that the term “performance-based component” used in the RFP section 2.9.5.9 is inclusive of the HCP LAN APM Framework Categories 2, 3, and 4.	Yes. The contracts with a performance-based component include those delineated in section 2.9.5.9 as well as those described in the Healthcare Payment Learning and Action Network Framework.
207	2.9.6.2	Provider Services Call Center	138	Can the State confirm the pharmacy call center is intended for provider calls only? Would our after hours nurse line satisfy pharmacy call center hours for times when the pharmacy call center is not available?	The pharmacy call center is not limited to providers. Members may call with questions as well. See question 26 for further discussion.
208	2.9.6.3	Provider Website	139	The list of required website items includes sample provider agreements. Due to its proprietary content, would the OHCA consider the request that our standard process of listing contact information for providers wishing to contract be deemed sufficient?	No.
209	3.5.2	Electronic Proposals	281	Can USB flash drives be submitted in lieu of CD ROMs?	No. CD-ROMs are the method of virus-free submission required by the OHCA's Information Technology (IT) Department as noted in 3.5.2 and Page 281.

210	3.5.2	Electronic Proposals	281	Can bidders provide flash drives in lieu of CD ROMS?	No. CD-ROMs are the method of virus-free submission required by the OHCA's Information Technology (IT) Department as noted in 3.5.2 and Page 281.
211	3.5.6	Opening of Proposals	284	Will there be a public bid opening that MCOs can attend? If yes, what is the date, time, and location of the public bid opening?	No, a public bid opening will not occur with this RFP.
212	3.6.1	Format	284	Should forms and attachments include consecutive page numbering ? For example, if a question has a 3 page limit and a four page form, do we number the documents pages 1 – 7 and start the next question on page 8, or do we start the next question on page 4.	All pages should be sequentially numbered. In the example, number the pages 1 - 7 and begin the next question on page 8.
213	3.6.1	Technical Proposal Requirements: Format	N/A	We would like to customize our proposal document by including the OHCA logo on the cover and within the document. Do you give us permission to do so? If yes, can you please provide a high resolution jpeg file of your logo?	No, the OHCA logo is not to be used with the RFP proposal.
214	3.6.1	Format	283	Can the OHCA confirm that the font size for the headers/footers and the tables within the proposal can be 8 point or greater?	Yes.
215	3.6.1	Format	283	RFP section 3.6.1 states: "Wording in any exhibits included or attached to proposal narrative must be in 8-point or greater font." Does this specification apply to tables, captions, and graphics within the bidder's response?	Yes.
216	3.6.1	Format	283	RFP section 3.6.1 states: "Proposals must be on standard-sized 8 1/2 by 11-inch paper and printed on one side only." Will the state allow for the use of fold out 11x17 paper for maps, charts, and spreadsheets?	No.
217	3.6.1	Format	283	RFP section 3.6.1 states: "Proposals must be on standard-sized 8 1/2 by 11-inch paper and printed on one side only." In the interest of being environmentally-friendly, reducing waste and providing lighter and more easily manageable binders to the State, will the State consider two-sided printing of proposals?	The proposals are to be one-sided printing only.
218	3.6.2	Technical Proposal Contents - Question #49	304	Please confirm question 49 is looking to determine whether the MCO has/will delegate care management?	One component of the question relates to subcontracting for care management.

219	3.6.2	Technical Proposal Contents	284	Opening paragraph references Appendix 4.4, please share this document or advise where this can be found, it doesn't currently appear in the bidder's library.	There is no Appendix 4.4. Instead, all forms have been included in the bidder's library.
220	3.6.2	Technical Proposal Contents	305	When will the data for Technical Proposal items 52 and 53 be made available?	Historical utilization data will be included in the data book scheduled to be released January 18, 2017. Bidders are free to use other data from the research section of the OHCA website or other sources in making an assessment of the potential for reducing utilization under SoonerHealth+.
221	3.6.2	Technical Proposal Contents, Item 7: Oklahoma Experience	288	Please confirm the extent to which OHCA will allocate additional points for existing Oklahoma experience.	This information will not be shared at this time.
222	3.6.2	Technical Proposal Contents, Item 10: Benchmark Contracts	289	In this question, the RFP allows bidders that have existing commercial managed care business in OK to use those programs as benchmark plans. In many cases, populations served by Medicaid and Medicare plans have different challenges and patterns of care than populations enrolled in commercial health plans. As a result, it can be difficult to adequately compare health plan experience and performance. For example, commercial health plan performance on HEDIS and CAHPS measures is often higher than Medicaid health plan performance. These and other issues may limit OHCA's ability to accurately determine a bidder's future success in the SoonerCare+ Program. We encourage OHCA to require that bidders select Benchmark plans that serve populations similar to those covered by the SoonerHealth+ RFP (e.g. Medicaid/Medicare). We also encourage OHCA to require bidders to justify their selection of each Benchmark plan, including their experience serving populations covered by the SoonerHealth+ RFP?	Section 3.6.2 will not be modified in the manner requested.

223	3.6.2	Technical Proposal Contents, Item 30: Enrollment: PCD Selection and Assignment	296	Please confirm that within the first sentence of this question the term 'PCMH' should be changed to 'PCD'.	Correct. The reference in the first sentence should be to PCD rather than PCMH.
224	3.6.2	Technical Proposal Contents	page 307	Please clarify Question 55 on page 307 of the Technical Proposal, "Describe any direct and indirect remuneration fees to be charged to pharmacies for SoonerHealth+ member prescriptions, your process and timing for collecting fees, including through reconciliations, and your process for providing detailed disclosure of the fees to pharmacies at time of collection". Our understanding is that direct and indirect remuneration activity typically relates to Medicare and is not applicable to Medicaid. Should this language be changed or removed?	OHCA defines direct and indirect remuneration fees as any monetary payment from the provider pharmacy back to the PBM or Contractor or any discount taken from a payment to the pharmacy by the PBM or Contractor. Any fees charged to the provider pharmacy should be listed in Technical Proposal 55.
225	3.6.2	Technical Proposal Contents	285	Section 3.6.2 refers to Appendix 4.4. Appendix 4.4 was not included with the solicitation or RFP Library. Please advise when Appendix 4.4 will be released.	See response to question 219.
226	3.6.2	Technical Proposal Contents	291	**Organizational Charts/RFP Item 16** - Consistent with the types of Oklahoma Experience the OHCA requests in Form E, please confirm that the Oklahoma lines of business bidders are to include in their Organizational Charts are limited to those serving the following populations: Insure OK, Medicare Advantage, Medicare SNP, Commercial Group, and Commercial Individual (exchange and non-exchange).	Correct. Correct RFP page should be 290.
227	3.6.2	Technical Proposal Contents	291	**Organizational Charts/RFP Item 16** - Please confirm that the requirement to "[i]dentify functions....performed by Subcontractors" is limited to those functions performed by those entities that meet the definition of "major subcontractor" as defined in Appendix 1--Definitions and Acronyms. (Page 345)	Correct. Correct RFP page should be 290.

228	3.6.2	Technical Proposal Contents	306	**Medical Management: Emergency Room Utilization (Item 53)** - If data is available, would the State want ER utilization rates related to non-traumatic dental services for both adult and under age 21 populations?	Yes.
229	3.6.2	Technical Proposal Contents	284	For questions where the State is not specifically asking for benchmark state examples, are we able use other state examples and data to support our response if they are the best examples to demonstrate our capabilities?	Yes.
230	3.6.2 (10)	Benchmark Contracts (Programs)	288	Item 10 asks bidders to select up to three contracts to serve as benchmark programs for the remainder of the proposal, for which performance data is available and can be shared. For Commercial-Group and Commercial-Individual contract categories, the RFP states that selection of one (or both) as benchmark means all contracts of that type are to be included together for data reporting purposes. While this direction is specific to Commercial-Group and Commercial-Individual contract categories, many states, such as Texas, also issue Medicaid managed care contracts on a service area basis, or by program/population. As a result, bidders may hold multiple contracts for the Medicaid program in a single state that include populations or services that are similar to those proposed under SoonerHealth+. Where appropriate, will the State allow bidders to aggregate performance data for such contracts to be treated as one benchmark program for a bidder's response?	Yes.

231	3.6.2 (11)	References	289	Item 10 asks bidders to identify up to three benchmark programs for their proposal and to share performance data from those programs in their responses. “Inability to provide data may negatively affect a bidder’s evaluation results, [and] bidders are encouraged to select benchmarks for which data is available and can be shared.” At least thirty five items follow, requiring bidders to provide specific examples from the identified benchmark programs, for topics such as Quality Improvement, Care and Disease Management, and many others. Item 11 also requires bidders to identify an individual from a contracting agency within each benchmark program to serve as reference for this RFP. However, contracting agencies in several states bidders may strongly consider as their leading benchmark programs, as a matter of policy, do not give out references. Similarly, states that are in an imminent or active procurement stage with their respective managed care programs may also be unable to provide a reference. Inability to obtain references from those states, may cause bidders to list as their benchmarks, programs that are either not most similar to SoonerHealth+, or for which performance data may not be available, simply because contracting agencies in those states do provide references. Therefore, to ensure compliance with Item 10’s instructions to “select contracts from other states that are most similar to SoonerHealth+ in terms of populations serviced and capitated benefits” so OHCA can most effectively evaluate a bidder’s experience and innovations that are most applicable and relevant to the SoonerHealth+ program (and therefore most indicative of a bidder’s potential performance), would the State consider amending Item 11 to not require that all references come from benchmark programs?	No.

232	3.6.2 (12)	Reinsurance for Contractors	288	Can the State elaborate on what arrangements and underlying assumptions, beyond statements on Contractor's ability (size and financial reserves included), are expected to satisfactorily respond to Item 12 as it pertains to model Contract section 2.1.22.4, "Reinsurance," for Contractors who may consider self-funding the risk?	Oklahoma Insurance Department (OID) regulatory language concerning allowable reinsurance arrangements is at Oklahoma Insurance Department Rules - Title 365, OAC 365:25-7-50. OID has no requirement is in place for commercial reinsurance as such. The OHCA is not requiring bidders to have it, if they self-reinsure. Title 365 can be viewed at: https://www.ok.gov/oid/Public_Information/Legal/Oklahoma_Insurance_Department_Rules_Title_365.html
233	3.6.2 (55)	Technical Proposal Contents #55 - Medical Management: Pharmacy Benefit Management	306	As we understand DIR, it is used by CMS related to the Medicare Part D benefit, and we do not receive DIR payments from retail pharmacies for Medicaid members. Can the State please advise how it defines "direct and indirect remuneration fees"?	See response to question 224.
234	3.6.2 (84)	3.6.2 Technical Proposal Contents, #84 - Quality Improvement: Quality Performance Measures	320	In reference to Item 84, will OHCA consider revising the timeframe by which accreditation must be achieved from 'within 18 months of contract award' to 'within 18 months of contract go-live' so that the policies and procedures developed at the time of readiness review will have the opportunity to be approved by OHCA prior to submission to the accrediting body?	See response to question 55.

235	3.6.2 (86)	3.6.2 Technical Proposal Contents, #86 - Quality Improvement: Member Satisfaction, Appendix 2 - Quality Performance Measures, Section A.2.2.3 - HCBS Performance Measures	320	The National Core Indicators Aging and Disabilities consumer survey is designed to be fielded by state agencies to obtain a system-wide perspective on consumer outcomes. Their website clearly indicates, "States are responsible for the actual administration of the NCI-AD survey in their state." (See http://nci-ad.org/upload/files/NCI-AD_Overview.pdf) Please confirm that OHCA will be the lead entity for administering the NCI-AD and responsible for associated participation costs.	OHCA will work with awarded contractors to evaluate the best scenario in which the readily-available NCI-AD tool can possibly be used for this program for evaluative purposes.
236	3.6.2 Technical Proposal Contents/Benchmark Plan Reference, and subsequent Benchmark Plan Examples	Member Services	290	If one of the benchmark plans selected is “Oklahoma-Commercial”, BCBSOK understands it must select one of the three largest (in terms of covered lives) commercial customers as a reference. However, in subsequent questions when asked to provide examples from one of the benchmark programs, is the bidder allowed to reference a Commercial Customer product that was not selected for a reference (due to the size of product not one of our three largest)? Examples of a specific commercial customer outside of the one chosen for a reference would be provided only in instances where the specific commercial customer example best fits the context/requirement of the question.	Yes.

237	3.6.2 Technical Proposal Contents/Benchmark Plan Reference, and subsequent Benchmark Plan Examples	Member Services	288	Can OHCA please clarify what is meant by "all contracts by that type"? For example, if one of the benchmark plans selected is “Oklahoma-Commercial”, under an ASO agreement, would the aggregate for data reporting purposes be all ASO Commercial Groups?	Yes.
238	3.6.2 Technical Proposal Contents/Benchmark Plan Reference, and subsequent Benchmark Plan Examples	Member Services	288	Just to clarify OHCA's expectations, If one of the benchmark plans selected is “Oklahoma-Commercial”, when asked in a subsequent form to provide data examples (in e.g.: Form N asks for average speed to answer) is contractor expected to provider aggregate across all commercial groups? Or just the benchmark group?	If the benchmark plan is defined as "Oklahoma-Commercial" then aggregated data would be provided for all "Oklahoma-Commercial" groups.
239	3.6.2 Technical Proposal Contents/Question 24	Benefits: Capitated Benefits	294	Can OHCA clarify what is being asked here? Is the intention to ask how/if MCO has experience accepting risk for capitated and non capitated benefits? Also, is this referring to risk between the state and MCO, or the provider and MCO?	Capitated benefits refers to the MCO-covered services under the Contract. Bidder is asked to identify any services described in RFP section 2.4.2 for which the bidder does not have experience providing such services under a risk contract.

240	A.1.2	Appendix 1-Definitions and Acronyms/Person-Centered Care	348	While very excited to see many times the phrase “person-centered care,” I would like to better understand the expectation of the OHCA in terms of this practice. There are several training sources and sets of training materials related to “person-centered care,” and, of course, this is a term already in policy of DHS Developmental Disabilities Services. However, there is not consistent practice of this meaningful work. What will be the standards and expectations? Who is the “person” at the center of the planning process (too often, this seems to be the case manager and not the individual)? Who will be trained? Who will train the trainers? How will self-determination and informed decision-making be assured? I believe very strongly that true person-centered planning and implementation of these plans assure cost-containment and better outcomes for both individuals and their families, as well as “the system.”	The OHCA has developed Contract requirements with the intention of ensuring person-centered care. The individual (or the individual's family) will be at the center of care planning activities. Contractors will be required to demonstrate through policies and procedures, training materials and performance metrics that care planning is person-centered and that appropriate self-determination and informed decision making occurs.
241	A.1.2	Oklahoma SoonerHealth+ Program - Contract Definitions	330	The definitions for urgent care and emergency medical condition appear to be almost the same, with the exception of psychiatric disturbances and/or symptoms of substance use disorder not included in the emergency medical condition definition. As the requirements for urgent care and emergent care differ within the RFP, could additional clarification in the definitions be provided?	The distinction between "urgent care" and an "emergency medical condition" reflects a need for medical attention within 24 hours (for urgent care) and an immediate need for medical attention, as determined by a prudent layperson (for an emergency medical condition).

242	Appendix 1, A.1.1 and A.1.2	Definition of Subcontractor	330 and 353	The term "Subcontractor" is defined very broadly in the RFP, Appendix 1, page 354: "An individual or entity that has a contract with the Contractor **that relates directly or indirectly to** the performance of the Contractor's obligations under its contract with the State. A network provider is not a subcontractor by virtue of the network provider agreement with the Contractor." However, the RFP also states in Appendix 1, section A.1.1: "The following terms shall have the same meaning as those terms in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) rules: […] Subcontractor[.]" The term Subcontractor is defined under HIPAA regulations at 45 CFR 16.103 as follows: "Subcontractor means a person to whom a business associate **delegates a function, activity, or service**, other than in the capacity of a member of the workforce of such business associate." **When read together we interpret these provisions of the RFP to mean that a Subcontractor is an individual or entity (other than a provider) that contracts with the Contractor to perform one of Contractor's obligations under its contract with the State. Please confirm.**	Correct.
243	Appendix 2, A.2.2	Appendix 2 - Quality Performance Measures, Section A.2.2 - SoonerHealth+ Program Performance Measures	357	Appendix 2 lists numerous performance measures for which the Contractor must report data. Will the State be supplying technical specifications for the non-HEDIS measures to ensure uniformity of reporting across participating health plans? Moreover, several of the measures were designed for facility-level or clinician-level analysis, requiring data that is not available to health plans. Will there be an opportunity for collaboration between health plans and the state to ensure that the required measures are feasible to implement without undue reporting burden being placed on providers?	The OHCA and Contractors will collaborate to develop specifications for the non-HEDIS measures.
244	Form 80700000933-C-B.12			Please confirm that the information requested on Form 80700000933-C-B.12 only pertains to responsive information for the Bidder. If the answer to this question is not affirmative, please confirm that the requested information is for matters involving contracts and organizations listed in Items 9.	The reference to "your organization" under Tab C-B.12 refers to the managed care organization, institution, business or agency that is submitting a proposal.

245	Form 8070000933-E	klahoma Experien	2 - 5	Form 8070000933-E requires bidders to provide enrollment by county for members enrolled in Insure Oklahoma. OHCA does not currently provide information to health plans on their Insure Oklahoma patients by county; OHCA only provides total number of employer groups participating and the total number of employees participating. However, OHCA has requested that health plans provide that very information and level of detail on pages 2-5 of Form E. Since the health plans do not have this information and would need to request OHCA to provide the information in order to populate the field, can the health plans leave this particular field blank? If OHCA requires the health plans to populate this particular information, can OHCA provide enrollment by county for Insure Oklahoma members to each health plan separately, and only for its population, in order for the plan to populate the form completely?	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.
246	Form 8070000933-V-Contract Performance			Please confirm that “Description of Action Taken by Regulatory Body” is asking for bidders to categorize if the reported action was either a monetary sanction, contract deficiency or corrective action.	The categories are listed in the bullets above the table, beginning with Access Standards.
247	Form 8070000933-V-Contract Performance			Please confirm that the form should reference contracts listed in Items 9 and 10 rather than Items 6 and 8. Please clarify that bidders should provide the information on all contracts, not solely the contracts listed in proposal submission Items 9 and 10, as there appears to be conflicting direction between paragraphs one and two.	The correct reference is contracts listed in submission items 7 (Oklahoma Experience) and 9 (Other State Medicaid and Medicare Experience). Information should be provided for all managed care contracts held by the bidder, an affiliate plan or parent organization in calendar year 2012 or later.
248	Form 807000933 - J	Plan Staffing	1	For Form J Staffing Plan, did OHCA leave customer service staff managing claims out of this form? Or is it rolled up under a different definition? IF so, can OHCA clarify?	Customer (Member) Services staff should be reported either on the Call Center line or Member Services Staff (non-Call Center) line, as appropriate.
249	Form C	License/Certification	Part 5	Please confirm that the term "certifications" is limited to NCQA and URAC accreditations. If not, please provide a listing of the specific certifications for which the OHCA seeks information in response to this question.	"Certification" is used as a synonym for "License", as some states (e.g., Oklahoma) issue "Certificates of Authority". Accreditation status is to be reported through forms 8070000933-D and 8070000933-F.

250	Form C	Disclosure of Ownership and Control Interest Information--Social Security Numbers	Section B	Consistent with the OHCA's concern about maintaining the confidentiality and security of SSNs and DOBs provided in response to Section B of Form C, Disclosure of Ownership and Control Interest Information, may bidders exclude this information from all copies of their bids, including the original, and instead submit this information under separate cover in an envelope marked appropriately or as instructed by the OHCA?	No, the process suggested will not be used.
251	Form C	License/Certification	Tab A.5b	Please confirm the term "HMO licenses" is limited to Certificates of Authority to operate as an HMO specifically, and does not include other types of licensure, such as TPA, UR, PPO, or pharmacy licenses. If this interpretation of the term "HMO licenses" is incorrect, please provide a listing of the specific types of licenses bidders are to include in response to Tab A.5a of Form C (Bidder's Representations and Certifications).	Correct.
252	Form C	License/Certification	Tab A.5a	Please confirm that the Organizational Chart referenced in this question is the Organizational Chart that will be provided in response to RFP Item 16, titled "Organizational Charts," and not RFP Item 14, which is titled "Major Subcontractors."	Correct.
253	Form C	Board of Directors	Tab C.1	Please confirm that the individuals that should be listed in response to Form C, Tab C.1 are the same as those we list in response to RFP Item 17, titled "Board of Directors," and not RPF Item 15, titled "Policies and Procedures."	Correct.
254	Form C	Subcontractor Ownership or Control Interest--Related Party Identification	Tab B.4	Please confirm that the instructions for Form C (Bidder Representations and Certifications) Tab B.4 should read, "Identify the following information for any individuals with ownership interests in any subcontractor identified in B.3..."	Correct.

255	Form C	Ownership in Other Entities	Tab B.6	Section B(6) of Form C requests certain information for "any other entity" in which a person who has an ownership or control interest in the Bidder also has an ownership or control interest. This RFP provision is related to 42 CFR 455.104(b)(3), which requires the following disclosure: (3) The name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the disclosing entity (or fiscal agent or managed care entity) has an ownership or control interest. (cont. in cell below and includes Lines 253-254-255)	(Tab B.6 Question includes three lines of Information.) As required under 42 CFR § 438.604(a)(6) for responding MCOs, PIHPs, PAHPs, PCCMs, PCCM entities and their subcontractors (as governed by 42 CFR § 438.230), Tab C-B.6 should be read to direct bidders to identify any ownership and control information from any "other disclosing entity" in which a person with an ownership or control interest in the bidder also has an ownership or control interest described in 42 CFR § 455.104.
256	Form C	Ownership in Other Entities	Tab B.6	"Other disclosing entity" is defined in 42 CFR 455.101 and is restricted to certain types of entities. The requirement in 42 CFR 455.104 is much narrower than the RFP requirement in that the CFR is limited to "other disclosing entities" in which a person with an ownership or control interest in the bidder also has an ownership or control interest. The RFP requirement is far broader in that it requests information from "any other entity" in which a person with an ownership or control interest in the (cont. in cell below and includes Lines 253-254-255)	(Tab B.6 Question includes three lines of Information.)
257	Form C	Ownership in Other Entities	Tab B.6	bidder also has an ownership or control interest. Broadening the CFR requirement to "any other entity" would require bidders to provide the requested information for each and every one of its subsidiaries owned by a parent company, which also has an ownership or control interest in the bidder. For large organizations, this could result in voluminous amounts of information, some, or even most, of which is not contemplated by 42 CFR 455.104. Please confirm that Tab B(6) of Form C is not intended to deviate from 42 CFR 455.104, and instead, consistent with the federal requirement, is limited to information from any "other disclosing entity" in which a person with an ownership or control interest in the bidder also an an ownership or control interest. (includes Lines 253-254-255)	(Tab B.6 Question includes three lines of Information.)

258	Form C, Section B(12)	Form C, Legal Actions	Form C, page 5	Please confirm that for purposes of completing tab B.12 of Form C related to Legal Actions that "your organization" refers to the Bidder but not its affiliates.	See Response to Question 244.
259	Form C, Tab B.4	Form C, Subcontractor Ownership or Control Interest	Form C, Tab B.4	Please confirm that the instructions in the top of this tab should read "Identify the following information for any individuals with ownership interests in any subcontractor identified in B.3 ... " As currently states, the request relates to individuals identified in B.4, which is circular.	See Response to Question 254.
260	Form G-1; Form G-2; RFP Item 11: References	Form G-1; Form G-2; Proposal Submission Item 11: References	Form G-1; Form G-2; p. 290	Several states in which we currently do business have informed us that they will not provide references for RFPs issued by other state Medicaid agencies because they do not want to unfairly advantage or disadvantage competing MCOs. This position hinders us, and other MCOs, from using high-performing plans in these states as benchmark programs for this RFP. For benchmark plans within a state that will not provide a reference, will OHCA accept a reference from a large provider group or other key stakeholders?	No, the OHCA will not accept other references in lieu of references by other state Medicaid agencies.
261	Form O	Network Summary	Page 1	During stakeholder meetings that occurred prior to the issuing of the RFP, potential bidders and providers were informed that a contracted provider network would neither be required for bid submission nor that bidders may be negatively affected during the evaluation period for lack of a contracted provider network. Based on this information, providers have been reluctant to begin the contracting process with bidders until awards are made. There are no requirements within the Technical Proposal that a provider network is either required for bid submission or that bidders may be negatively affected during the evaluation period for lack of a contracted provider network. Please confirm that a contracted provider network is not required for bid submission and that bidders will not be negatively affected during the evaluation period for lack of a contracted provider network, but rather will be evaluated based on the submitted Network Development plan as outlined in Section 2.8.3.	The OHCA will review networks as part of the evaluation process but is not requiring submission of complete provider networks.

262	Form V	Form V, Contract Performance	Form V	Please clarify which proposal submission items should be referenced in paragraphs 1 and 2 of the instructions for Form V.	See response to question 247.
263	Form V	Contract Performance	N/A	Please confirm the RFP Items the OHCA requests data for on Form V include RFP Item 8, titled "Oklahoma Medicare Advantage Expansion," and RFP Item 10, titled "Benchmark Contracts" and that RFP Item 6, titled "Regions," was referenced in Form V in error.	See response to question 247.
264	Form V	Contract Performance	N/A	For data regarding any regulatory action or sanction imposed by a Federal or state government entity with respect to managed care contracts held by affiliate plans or parent organizations of the bidder, please confirm that the information sought by affiliate and parent organization entities are limited to those entities that fall within the scope of Form E, Oklahoma Experience, and Form F, Medicaid & Medicare (Dual-Eligible) Experience (Non-Oklahoma), in addition to any information provided in response to the RFP items related or referenced in Form V.	Correct.
265	Form-8070000933-N-Call Center Performance			Clarification needed on the definition of the following metrics: o Average speed to answer- Is this a blended rate (IVR and live-agent)? It references live voice. o Average wait time- Is this alluding to member hold time after call is initially answered? o Blocked call rate- Need enhanced definition.	Q1: No, the average speed to answer is not a blended rate. Q2: No. Q3: Blocked call refers to calls that cannot be connected because all lines or trunks are in use.
266	Form-8070000933-O			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.”	(Form 8070000933-O Question includes two lines of Information.) The OHCA will review networks as part of the evaluation process but is not requiring submission of complete provider networks.

267	Form-8070000933-O			According to Section 2.8.3.3 of the RFP, in comparison to Form-O-8070000933, tab Form-O-8070000933-BH, there appears to be additional specialties. Can the OHCA please provide clarification on which specialty listing supersedes?	(Form 8070000933-O Question includes two lines of Information.) 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.
268	Item 41 / Form 8070000933-O-Network Summary and Rosters	Provider Network: Network Development / Form 8070000933-O-Network Summary and Rosters	300	The instructions specify that only providers contracted to “serve SoonerHealth+ members” should be included on Form O. Does this mean that contracted providers for commercial members should be excluded?	Yes, if not also contracted for SoonerHealth+.
269	Item 41 / Form O	Provider Network: Network Development / Form 8070000933-O-Network Summary and Rosters	300	Given that the transcript of the OHCA November 2016 meeting states, "And so beginning with the reminder that OHCA is not requiring the bidders, the health plan bidders, the respondents to the RFP, to submit complete, fully formed provider networks when their proposals come in. Instead, when health plans have been awarded. contracts, they'll then be a period between the contract award and when we conduct readiness review activities for those network development activities to be completed….” Would the OHCA consider including signed Letters of Intent in lieu of contracted providers to significantly reduce administrative overhead for Oklahoma providers during the bid submission timeframe?	No.

270	Item 41 / Form O	Provider Network: Network Development / Form 8070000933-O-Network Summary and Rosters	300	Form O requires the submission of a network contracted to provide services to SoonerHealth+ members. The transcript of OHCA November 2016 meeting states "…and so beginning with the reminder that OHCA is not requiring the bidders, the health plan bidders, the respondents to the RFP, to submit complete, fully formed provider networks when their proposals come in. Instead, when health plans have been awarded contracts, they'll then be a period between the contract award and when we conduct readiness review activities for those network development activities to be completed." Is it still the OHCA's intent to allow completed network submission of a fully contracted network at readiness review?	Yes.
271	Item 52	Medical Management: Hospital Utilization	305	Will the OHCA confirm that the page limit excludes the copy of Form 8070000933-P-Hospital Utilization?	Yes.
272	Item 53	Medical Management: Emergency Room Utilization	305	Will the OHCA confirm that the page limit excludes the copy of Form 8070000933-Q-Emergency Room Utilization?	Yes.
273	Item 6 / Form 8070000933-D-SoonerHealth+ Regions	Regions / Form 8070000933-D-SoonerHealth+ Regions	286	Form D requires bidders to identify whether licensure is possessed in each county of the state. How should a bidder complete this form if licensure is pending?	If an application has been submitted and is under review for a county, the bidder may enter "Pending" for that county in the No column.
274	N/A	General	N/A	Is it possible that you can send me the (RFP) document in a Word file?	We are unable to release the RFP in a Word document as it is the instruction piece. The documents for submission requirements and with which you will need to work, are on the website under the hyperlink "RFP Library" as Microsoft Word or Excel: http://www.okhca.org/about.aspx?id=19878

275	N/A	General	N/A	When the date of bid opening occurs, is the (bid) opening open to the public?	No.
276	N/A	General	N/A	Can I view the DMHSAS Assessment Tool?	ODMHSAS utilizes the Client Assessment Record coupled with Prior Authorization Level Assessment Criteria found in the ODMHSAS Services Manual which is found at http://www.odmhsas.org/picis/Documents/Manuals/FY2017%20ODMHSAS%20Services%20Manual.pdf
277	N/A	General	N/A	Can I view the OHCA Billing and Procedure Manual?	Yes. The Billing and Procedure Manual is publically posted and viewable at this site: http://www.okhca.org/providers.aspx?id=100&terms=OHCA%20Billing
278	N/A	General	N/A	Can I view the Electronic Visit Verification (EVV) service monitoring tool Contract?	The EVV is not available at this time.
279	N/A	General	N/A	Has the ABD population previously been enrolled in managed care? Or is this procurement the first?	A portion of the ABD population is enrolled in the SoonerCare Choice program, which includes components of managed care under a non-capitated system (e.g., patient centered medical homes). A portion of the ABD population was enrolled in capitated health plans under the SoonerCare Plus program.
280	N/A	General	N/A	If there was a previous contract (pertaining to this RFP) what organization holds it?	This information will not be shared at this time.
281	N/A	General	N/A	How many ABD beneficiaries will be affected?	The RFP includes this information.
282	N/A	General	N/A	Could you please send the RFP number related to medical authorizations?	RFP Number and Solicitation Number are the same: 8070000933. All RFP information is posted on the publicly viewed site: http://www.okhca.org/about.aspx?id=3217
283	N/A	N/A		Can OHCA provide the Model Contract / RFP in a version where bidders can copy and paste content from the document? This will ensure awardees can lift model contract language quicker and input into business requirements.	We are unable to release the RFP in a Word document as it is the instruction piece. The documents for submission requirements and with which you will need to work, are on the website under the hyperlink “RFP Library” as Microsoft Word or Excel: http://www.okhca.org/about.aspx?id=19878
284	N/A	Fee Schedule	N/A	What is the proposed structure of the capitation rate cells? How will they be divided by population? Will there be separate capitation rates by major service category, such as drug, behavioral health, long term care services, etc.?	This information will not be shared at this time.

285	N/A	Fee Schedule	N/A	Will the capitation for ALL populations be delivered in January, or just that population that is moving to managed care in the first year? If the populations entering the managed care programs in subsequent years are not included in the January release, what is the expected timeline for that rate development (and meetings with the state/its actuaries)?	This information is not available at this time.
286	N/A	Fee Schedule	N/A	Will the base capitation (net of any risk adjustment) be the same across all MCOs for a particular service area/rate cell or will it be specific to an MCO? If specific to an MCO, how will the draft capitation rates presented in January represent the final capitation rates to be assigned to each MCO?	Rates will not be MCO-specific.
287	N/A	Fee Schedule	N/A	What risk mitigation measures will OHCA incorporate into the capitation payments? If there will be risk adjustment, will the model be just for acute services, for long term services, or both? Will there be any corridors around any particular population or item?	Rate cell capitation rates will be developed by population risk group and region, aligning payment with risk. Other than 2.1.22.4 Reinsurance, and 2.21.2 Medical and Administrative Expense (medical expense ratio of at least 85 percent), there are no risk mitigation provisions within the contract. Beyond the capitation rates, OHCA will not share in any adverse financial risk with those SoonerHealth+ MCOs selected. Hence State-sponsored reinsurance, risk pools, or risk corridors, etc. are not part of the contract. Risk adjustment between MCOs is currently not part of the contract.
288	N/A	Fee Schedule	N/A	We ask for some detail around what to expect with the data book: Will the data book be comprised of detailed claims data (de-identified) couple with a (de-identified) enrollment file of sorts, or will the data book be more like aggregated cost and utilization by certain service categories, regions, etc. with no specific claims detail? What is the file format to expect and how many files? This information is incredibly useful when preparing internally to receive the data.	The Data Book will include regional population/rate cell aggregated cost and utilization data by multiple consolidated service categories (no sub-totals included). No de-identified individual/specific claims detail will be provided. The data will be summarized in a single Microsoft Excel (.xlsx) workbook.

289	N/A	Fee Schedule	N/A	Will the draft capitation rates released in January be just capitation rates, or will it be accompanied by a rate certification narrative that details data adjustments, program adjustments, base data, trend assumptions, etc.? Preference is that a draft rate certification narrative is delivered alongside the capitation rates to make capitation development transparent and the conversation at the Actuarial Bidder's meeting as effective as possible.	With the start of services April 1, 2018, 2019, and 2020 for respective populations, CMS will not approve capitation rates with currently available data (most recent complete is Calendar Year 2015) being as "old" as it is. Hence a formal rate certification will not be provided in January given that the capitation rates will need to be rebased/updated at a later point in time. However, the draft/modeled capitation rates released will include significant rate cell and service category detail around base data, base data adjustments, program/policy change impacts, claim cost trends, managed care model adjustment factors, MCO administration and underwriting gain loads, premium taxes, rebalancing assumptions, etc. Bidders will have a clear understanding of the capitation rate development process and individual components.
290	N/A	Fee Schedule	N/A	Will OHCA consider adjusting rates to account for implementation costs MCOs incur in the initial capitation rate development?	The data will be summarized in a single Microsoft Excel (.xlsx) workbook.
291	N/A	General	N/A	As an advocate who works closely with families, I am aware of a whitepaper submitted by a group of parents and advocates related to this solicitation. This was submitted to OHCA some months ago, and OHCA promised to provide a crosswalk of that paper's issues within the RFP. Will this be forthcoming?	The crosswalk referred to was presented at the July 2015 stakeholder meeting PowerPoint, slides 14-21 – this includes information on select model contract sections, stakeholder recommendations received at the time and how those recommendations translated into requirements for MCO's. In addition, Sept, Oct & Nov 2015 presentations to stakeholders further elaborated on approaches taken in the RFP in response to stakeholder input. Here is the link to the SoonerHealth+ webpage archive: http://www.okhca.org/about.aspx?id=18413
292	N/A	General	N/A	Will OHCA release a member zip code file? This file would benefit GEO Access mapping member to provider distance for all services.	No.

293	N/A	General	N/A	There may be a significant duals population within this ABD segment. Duals obtain their drug coverage through their Medicare D program. The MCO contractor in many cases will not be the member's Part D provider. Please provide clarification that for duals enrolled in this program, that the primary RFP Pharmacy Requirements do not apply as the pharmacy benefit is managed by the member's Part D provider under CMS rules for Part D drug coverage and utilization management. Can the OHCA provide clarification for Part D excluded drugs that it will provide guidance for in regard to contractor MCO responsibility for Medicaid coverage (e.g., which Part D excluded drugs must be covered and in what manner)?	The primary RFP Pharmacy Requirements do not apply to members who are dually eligible for Medicare and Medicaid. OHCA will provide clarification to Contractors as to which Part D excluded drugs must be covered by the Contractor and in what manner they should be covered.
294	N/A	N/A	N/A	Will the State release a link or access to the most recent companion guide and fee schedule?	See link: http://okhca.org/providers.aspx?id=102&menu=60&parts=7773
295	N/A	N/A	N/A	Please provide more information about Targeted Case Management for individuals eligible for part B of Medicare (under 317:30-5-1011) in the context of the SoonerHealth+ program, specifically addressing the role of MCOs, duplication concerns, and any contracting requirements.	All Targeted Case Management services described in referenced section are rendered by the Oklahoma Department of Human Services. DHS Developmental Disabilities Case Managers will retain Targeted Case Management functions for individuals with intellectual disabilities who may be enrolled in Sooner Health+. Contractors should coordinate plans of care with DHS case managers such that no duplication of services occurs for members with intellectual disabilities, both those who are eligible for Medicare Part B and for those not eligible.
296	N/A	N/A	N/A	Will OHCA be providing a historical claims utilization report inclusive of two (2) years worth of utilization?	Yes, this data/information will be provided within the Data Book.
297	N/A	N/A	N/A	Will OHCA be providing a membership data report indicating member demographics (inclusive of address, zip code and county)?	No.
298	N/A	N/A	N/A	Is there a definition or listing of State vs. Non-State employed providers?	No.

299	N/A	N/A	N/A	If an existing State of Oklahoma Provider or Vendor is approached by managed care plans to subcontract, can the existing State of Oklahoma Vendor entertain the conversation with the MCO without violating procurement requirements?	The stance regarding communications with managed care plans who have contacted subcontractors remains the same as noted in the ABD Provider Communications. When the RFP is awarded, SoonerCare ABD members will be enrolled in a Managed Care Organization (MCO). Until the RFP(s) is/are awarded, the OHCA is not working with or endorsing any health care company(s) to be the chosen MCO. Health care companies may contact Providers or Vendors to determine a provider network to serve the ABD enrolled members when the RFP is awarded. The information is publicly posted at this site: http://okhca.org/providers.aspx?id=45&parts=7437_7439_7443_7455 * What's New **ABD Provider Communication ** ABD FAQs for Providers
300		Provider Network Contracting	8	While the Stakeholder document specifically states that "Health Plans awarded contracts will have a period between award and readiness review to meet network requirements" page 301, Question 41 requires that we provide a completed form, 8070000933-O Network Summary and Rosters, denoting our current provider and case management agency contracts by provider/agency type. Please clarify that we should only submit providers that are contracted for SoonerHealth+ with this RFP per the question # referenced above and we will be able to submit an updated form 8070000933-O closer to readiness review per the reference in the Stakeholder meeting deck dated November 8, 2016.	Correct.