State of Oklahoma
OKLAHOMA HEALTH CARE AUTHORITY

Amendment of Solicitation

Date of Issuance: February 7, 2017 **Solicitation No.** 8070000933

Requisition No. 8070000933 **Amendment No.** 6

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:

Amendment Six to include the following:

Clarification of Questions and Answers from Round One Questions

Slides from Actuarial Bidder's Conference to be posted in Bidder's Library with the name, "Mercer Presentation – Actuarial Bidders' Conference (Feb. 1, 2017)"

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
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.
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 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: http://www.oar.state.ok.us
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?	Yes, the waiver enrollment will be contained in the member Health Program information. No, the OHCA will not indicate if members are on a waiver waitlist.
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 will be retroactively enrolled. Enrollment effective date on the 834 is date specific.
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. For ADvantage waiver members, the total cost of each individual member's service plan must be under the institutional cost cap. For OHCA's Medically Fragile waiver, the cost cap is considered in the aggregate across all enrollees. For the applicable waiver year, the cost of the member's services on average cannot exceed $256,573. Limits are set in the approved waivers, which may be extended or amended.
280	N/A	General	N/A	If there was a previous contract (pertaining to this RFP) what organization holds it?	No previous contract pertaining to this RFP exists.

Question Number	Section or Subsection Number	Section or Subsection Title	Solicitation Page	Question	Response
304	2.4.2.2	General Medical and Related Benefits	59	It is our understanding that Med Advantage and Medically frail members are authorized 7 generic and 3 brand drugs without PA. Could OHCA provide all of the exceptions for the 6 limit fill?	Waiver member prescriptions are unlimited so long as medically necessary. Extended State Plan prescribed drugs provided under the provisions of the Waivers are in addition to the State Plan Prescribed Drugs benefit and combined include up to 3 branded medications and 10 generic medications. If the member requires more than 3 brand name or 13 total prescriptions within a one month time frame, the member's pharmacy may submit a written request on behalf of the member to have additional prescription needs reviewed. In addition to making a determination of a medical necessity for the additional prescription product(s) being requested, this review could result in a recommendation that certain medication regimens be altered or discontinued. The initial request for additional medications must have a response within 24 hours.