Addendum 3
ITN DOH17-026
CMS Managed Care Plan

DATE: March 16, 2018

TO: Prospective Vendors

FROM: Diana K. Trahan, Department of Health
Purchasing

SUBJECT: Addendum 3 to DOH17-026 CMS Managed Care Plan

This addendum serves as notice of the following change(s):

Deletions are indicated by "~~strikethrough~~" or reference. Additions, updates or replacements are indicated by underscore, reference or highlighting.

3. **Responses to Questions**

This is the final response to questions that were received on February 21, 2018 and the additional questions that were received on March 7, 2018.

Questions and Answers
ITN DOH17-026
Administration of the CMS Plan

Q54) Attachment D-3
Are pharmacy costs reported in the data book gross or net of rebates?
A54) REVISED ANSWER: Title XIX pharmacy costs are gross of rebates and Title XXI pharmacy costs are net of rebates.

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Q91) Criteria #18 – Additional Expanded Benefits
In the first paragraph do they mean to refer to Exhibit A-1-b rather than Exhibit A-1-c? Also do they mean to refer to Criteria #17 rather than #7?
A91) Criteria #18, Exhibit A-1-b is correct. Criteria #7 should be Criteria #17.

Q92) Criteria #32 – Utilization Management
Item 1. (h): Which UM staff are being referred to here - all levels or just management? What is the CMS Plan Medical Director's role? Who are the clinical oversight staff?

A92) The Respondent UM staff include the Medical Director, UM Manager, Dispute and Appeal Manager, BH Medical Director, and the following operational staff: UM, PA, and Concurrent Review. The Department employed CMS Plan Medical Director and clinical oversight staff include the Florida DOH CMS Plan Medical Director and Clinical Director and other clinical staff employed by the Florida DOH CMS Plan

Q93) Criteria #32 – Utilization Management
What is the role of the Liaison for Medically Complex Children? Which entities will this liaison be working with?

A93) The duties for the Liaison for Medically Complex Children include oversight of high-touch coordination for medically fragile children meeting top tier requirements for care management. It also includes being the direct Vendor contact for Care Coordinators/Case Managers and service providers for children who are medically fragile. The Liaison or his or her backup contact will be available during business hours to address issues from Care Coordinators/Case Managers regarding medically fragile enrollees. The Liaison will assist with enrollment, disenrollment, access to care, and facilitation of single case agreements. The liaison should have working knowledge of systems and agencies in Florida that serve children with medical complexity and application of that knowledge to assist in facilitating connecting families of children and youth with special health care needs to needed resources and services. Entities that the liaison will be working with include Care Coordinators/Case Managers, patient centered health homes, children's specialty hospitals and clinics and specialty providers responsible for addressing the healthcare needs of medically complex children.

Q94) Criteria #32 – Utilization Management
What is the role of the maternal health/EPSDT Coordinator?

A94) The Maternal Health/EPSDT Coordinator is responsible to: (a) Ensure receipt of EPSDT services. (b) Ensure receipt of maternal and postpartum care. (c) Promote family planning services. (d) Promote preventive health strategies. (e) Identify and coordinate assistance for identified member needs; and (f) Interface with community partners.

Q95) Criteria #24 – Provider Network Development
Page 88 - e. Where is the procurement library listing found?

A95 If available, the link is: http://www.floridahealth.gov/programs-and-services/childrens-health/cms-plan/cms-plan-invitation-to-negotiate/index.html

Q96) Criteria #39 – Vignette
Please confirm that CMS will still be responsible of eligiblity and enrollment, or will that function be part of the Contractor's responsibility.

A96) The Department of Health determines clinical eligibility for potential enrollment into the CMS Plan. The Department of Children and Families and Florida Healthy Kids Corporation determine all other components of eligiblity for Medicaid and KidCare, respectively. Medicaid Managed Care enrollment is administered by AHCA. KidCare enrollment is administered by Florida Healthy Kids Corporation. These responsibilities will continue upon the Department's contracting with a Respondent.

Q97) Criteria #40 – Vignette

Please confirm that CMS will still be responsible of eligiblity and enrollment, or will that function be part of the Contractor's responsibility.

A97) The Department of Health determines clinical eligibility for potential enrollment into the CMS Plan. The Department of Children and Families and Florida Healthy Kids Corporation determine all other components of eligibility for Medicaid and KidCare, respectively. Medicaid Managed Care enrollment is administered by AHCA. KidCare enrollment is administered by Florida Healthy Kids Corporation. These responsibilities will continue upon the Department's contracting with a Respondent.

Q98) Criteria #6 – Care Coordination and/or Case Management
How many CMS Care Coordinators are currently employed by CMS? What are the current caseload ratios for the NCC's?

A98) The CMS Plan has approximately 250 care coordinators and caseloads vary across the state, but a generally 200-300+ (As of 12/17).

Q99) Criteria #6 – Care Coordination and/or Case Management
Will the recertification/redetermination process be centralized by CMs or remain responsibility of NCC's?

A99) The clinical eligibility screening process authorized in 64C-2.002 and 2.003, Florida Administrative Code and referenced on the CMS Plan website will remain the responsibility of the Florida Department of Health CMS. Annual assessment and care plan redeterminations and the care plan requirements described currently in contract FP031 between AHCA and DOH and in the future contract will be the responsibility of the Respondent.

Q100) Please confirm Attachment A Evaluation Criteria and Instructions should be named Exhibit A Evaluation Criteria and Instructions.

A100) No. Attachment A is correct.

Q101) Please confirm Attachment A-1 Evaluation Criteria should be named Exhibit A-1 Evaluation Criteria.

A101) No. Attachment A-1 is correct.

Q102) Please confirm Exhibit 5 should only be submitted once within the response following Exhibit A-1. Exhibit 5 should NOT be supplied again as part of Attachment D Cost Reply Part 4 per instructions on page 171 of 196.

A102) Please submit Exhibit 5 as part of the response to Exhibit A-1 and complete the Managed care savings adjustments in the cost reply template as requested on page 171.

Q103) For Section 4.10.1, please confirm reference to Attachment C should be Attachment B (not C).

A103) Correct, it should be Attachment B.

Q104) Please advise where in the reply Attachment B should be located within the hard copy and electronic copy.

A104) Refer to section 4.5.2.3(b) of revised ITN document included in Addendum 1.

Q105) Section 2.14 indicates the performance bond must be submitted 30 days after notification of award ($1M for each regional cluster). However Section 4.5.2.3(b)(3) and 4.6.3(3) reflect it should be included in the reply. Can you please clarify your intention related to the performance bond?

A105) The bond shall be furnished to the Procurement Officer within thirty (30) calendar days after execution of the resulting Contract and prior to commencement of any work under this Contract.

Q106) Section 4.12 states If the Respondent considers any portion of its Reply to be confidential, exempt, trade secret, or otherwise not subject to disclosure pursuant to Chapter 119, Florida Statues, The Florida Constitution or other authority, the Respondent must segregate and clearly mark the document(s) as "CONFIDENTIAL".
Please clarify if the State wants whole sections containing confidential information segregated or individual pages. Does the State want this for both the paper copy and electronic copy?

A106) The redacted copy must be provided to the Department at the same time the Respondent submits its Reply and must only exclude or redact those exact portions which are claimed confidential, proprietary, or trade secret.

Q107) 4.6.3.1 In addition to the PDF submission, the following attachments and exhibits will be submitted in Microsoft Excel 2016, utilizing the CMS Plan provided templates and will be saved on the USB flash drive.

- Exhibit A-1-a Criteria #9 - General Performance Measurement Tool;
- Exhibit A-1-b Criteria #17 Expanded Benefits Template;
- Exhibit A-1-c Criteria #18 – Additional Expanded Benefits Template;
- Exhibit A-1-d Criteria #22 - Standard CAHPS Measurement Tool;
- Exhibit A-1-e Criteria #54 – Provider Network Agreements/Contracts;
- Exhibit A-1-f Criteria #55 – Provider Network; Agreements/Contracts Statewide Essential Providers; and
- Exhibit 5, Summary of Managed Care Savings.

Please confirm if Mentioned Exhibits A-1-a through A-1-b are actually files named attachment-a-1-a through a-1-f. Also a-1-a, a-1-b, a-1-c and a-1-d are word templates, if excel files are required, will the State provide those templates?

A107) Exhibits A-1-a through A-1-f should be named Attachments which are provided in Excel at the following link: http://www.floridahealth.gov/programs-and-services/childrens-health/cms-plan/cms-plan-invitation-to-negotiate/index.html

Q108) Should plans who manage Florida Healthy Kids (CHIP) members report specific results for FL FHK as one of the three Medicaid or CHIP contracts, even if the number of FHK enrollees is less than the number of enrollees for a non-Florida Medicaid contract?

A108) For Criteria #9 and 22, if the respondent has a Florida Healthy Kids or Medicaid contract, please include those responses and note that it is for the FHK or Medicaid population. The Respondent should next utilize results from 3 non-Florida Medicaid contracts, if available. If the respondent does not have 3 Medicaid/Florida Healthy Kids contracts, the Respondent should utilize results from CHIP contracts in other states to the extent necessary to have results from three contracts. Only if the Respondent does not have HEDIS results for at least three Medicaid or CHIP contract, should the Respondent provide

commercial HEDIS measures for the Respondents largest contracts and then that data should not supplant the reporting of Medicaid and CHIP data available.

Q109) The instructions ask plans to report all 4 rates for the Children's Access to Primary care, however there is only one line. How should Plans report all rates?

A109) The Department has provided a revised attachment A-1-a. F21 at http://www.floridahealth.gov/programs-and-services/childrens-health/cms-plan/cms-plan-invitation-to-negotiate/index.html

Q110) Which Prenatal and Postpartum Care (PPC) measure should be reported -- Prenatal or Postpartum?

A110) Refer to Criteria #9 - There are two prenatal measures that should be reported. Timeliness of prenatal care and Frequency of Ongoing Prenatal Care (>= 81% of expected visits).

Q111) Can you please clarify the requirements regarding frequency of face-to-face visits? Item (f) of Criteria #6 references "at least one face-to-face visit must be conducted in the home annually". Item (g) references "at a minimum, all children should have quarterly face-to-face visits".

A111) Item (f) is clarifying that at least one face-to-face visit needs to be physically in the child's home. Item (g) is stating that face-to-face visits need to be done quarterly at a minimum, (but may take place physically outside of the child's home.

Q112) Can DOH offer additional information on the volume of Care Managers currently working with the defined volume of CMS children to assist in building a hiring plan of the qualified CM staff?

A112) CMS has approximately 250 care coordinators and caseloads vary across the state, but a generally 200-300+.

Q113) Will DOH provide specific requirements for inclusion in provider contracts, or can we assume they will be same as the existing AHCA Medicaid SMMC Contract?

A113) The specific requirements for inclusion in provider contracts will be guided by Addendum 1 Attachment A-2 of this ITN as well as the AHCA Medicaid SMMC Contract.

Q114) Please confirm plans should enter an "X" into the appropriate yellow shaded area(s) to indicate their reply and nothing additional is needed for Criteria #1.

A114) Yes, answering with an "X" in the appropriate yellow shaded area is sufficient.

Q115) Historically, Title V funding was available for non-covered services. Will that funding continue?

A115) Title V funding is not, as a standard practice, currently utilized to fund the CMS Plan. This is not expected to change.

Q116) 3.2 Facts Demonstrating Need
Is the ITN intended to include those members currently receiving services under the PACC program?

A116) Yes.

Q117) Item 4.10.1 Statement of Non-Collusion
The instructions reference "Attachment C" but the Non-Collusion Statement is "Attachment B". Please clarify.

A117) Correct, it should be Attachment B.

Q118) Item 4.5.2.3 Hardcopies of the Reply
When including attachments & exhibits to the responses; should the responses be submitted in a format that follows the corresponding criteria or should there be section for all supporting documentation?
A118) Refer to section 4.5.2.3(b) of revised ITN document included in Addendum 1.

Q119) Item 4.5.2.3 Hardcopies of the Reply
Will the Department accept charts and graphs that are imbedded within the responses?
A119) Yes.

Q120) Reply Evaluation Process and Criteria
Can the Department provide the names, titles, and experience of the individuals who will be scoring the responses?
A120) No.

Q121) 5.5 Protests
It appears the Department wants replies delivered to the Procurement Officer but filings such as notices of protest delivered to the Agency Clerk's Office. Is this correct?
A121) Correct.

Q122) Ranking of Replies
What number of top ranking plans will be invited to negotiation per cluster?
A122) Unknown at this time.

Q133) Ranking of Replies
What number of top ranking plans will be invited to negotiation statewide?
A133) Unknown at this time.

Q134) Contract Negotiations
What is the minimum number of plans that will be invited to negotiate – statewide?
A134) Unknown at this time.

Q135) Contract Negotiations
What is the minimum number of plans that will be invited to negotiate per cluster?
A135) Unknown at this time.

Q136) Respondents Staffing Requirement
How many members are currently enrolled in Care Management/Care Coordination by category type i.e. Complex/Nursing Facility, PDN?
A136) All members are assigned to a care coordinator upon enrollment. Of those, the CMS Plan currently has approximately 975 members part of enhanced care coordination.

Q137) Respondents Staffing Requirement
Can you provide a listing of the Department staff and their credentials to assist in the development of the hiring plan? Can you provide resumes?

A137) No.

Q138) Respondents Staffing Requirement

What is the difference between: a) Full Time FTE b) Full Time FTE devoted to CMS Plan c) Dedicated 100% of their time employed with the Managed Care Vendor to the CMS Plan contract?

A138) a. A single full-time employee or multiple part-time employees of the Respondent who work a full-time equivalent of hours.
b. A single full-time employee or multiple part-time employees of the Respondent who work a full-time equivalent of hours and spends 100% of their time on CMS Plan functions.
c. The same as b.

Q139) Criteria 1 – PRIORITY 1 REPLY and PRIORITY 2 REPLY tables.

Cluster B is identified as (5-8) and (9-11) in both reply tables. Will the tables be updated to reflect Cluster C (9-11)?

A139) Yes, an addendum will be posted to update this information.

Q140) Criteria 3

Does "existing" refer to contracts that are active at the time the ITN was published on January 30, 2018?

A140) Refer to the date in the ITN.

Q141) Criteria 4

How is the scoring calculated for Item 2 where 8 or more functions are performed in Florida but at least 1 function is performed outside Florida?

(409.966(3)(c)3 - For purposes of this subparagraph, operational functions include
1. corporate headquarters
2. claims processing
3. member services
4. provider relations
5. Utilization & prior authorization
6. case management
7. Disease & Quality
8. Finance and
9. Administration.

A141) Scoring related to the Respondents corporate headquarters location is related to Criteria #4, 1(a-b). Scoring related to the Respondents operational function location other than corporate headquarters are included in Criteria #4, 2(a-g). Finance and Administration are considered a single operational function.

1. claims processing
2. enrollee/member services
3. provider relations
4. utilization and prior authorization
5. case management
6. disease management and quality functions, and
7. finance and administration

Five additional points will be awarded if Respondent meets Items 1(a) and 2(a).

Q142) Criteria 9

Regarding the section of the ITN after “For members ages 18-21”, is it the intent of the Department that for these measures will only be used for this age group? How are these measures identified in Exhibit A-1-a?

A142) Respondents are to report on results of the adult measures because the Age 18-21 cohort is included in the CMS Plan population. Respondents should report on HEDIS measures as outlined in the HEDIS instructions. The data for adult measures will not be limited to solely those members ages 18-21. The State will provide a revised Attachment A-1-a.

Q143) Criteria 9

Regarding HEDIS measure by ages 18-21; the instruction does not match the criteria. The scoring methodology references 16 measure rates however the tool referenced as exhibit A-1-a includes more than 16 measures. Please confirm and confirm how these will be reconciled.

A143) Respondents should report on HEDIS measures as outlined in the HEDIS instructions. The data for adult measures will not be limited to solely those members ages 18-21. CMS noted that their plan has members ages 18-21 to point out that the adult measures listed are relevant to this population. There are 16 measures with Child and Adolescent Access to PCPs being reported in four ages bands and each age band worth .5 points so that the Child and Adolescent Access to PCPs is worth the same total of 2 points as the other measures. The State will provide a revised Attachment A-1-a.

Q144) Criteria 9

Attachment A-1-a, It was noted that the formulas in the document are not working. Will the Department provided a revised attachment?

A144) Yes, the State has provided a revised Attachment A-1-a at http://www.floridahealth.gov/programs-and-services/childrens-health/cms-plan/cms-plan-invitation-to-negotiate/index.html

Q145) Criteria 9

Question references National and Regional Medicaid Means. Will the Department provide t the National and Regional Medicaid “means”?

A145) The updated Attachment A-1-a scoring has been corrected. The State will utilize the National and Regional Medicaid means for scoring but will not provide to Respondents.

Q146) Criteria 9

Question references an exhibit not an attachment – Please confirm this question is in regards to Attachment A-1-a?

A146) Correct. Should be Attachment A-1-a.

Q147) Criteria 14

Please clarify the scoring criteria. Each question is worth 5 points and the total raw points available is 20 points however there are only 3 questions.

A147) Question 3 has two parts, worth 5 points each.

Q148) Criteria 17

Question references an exhibit not an attachment – Please confirm this question is in regards to Attachment A-1-b?

A148) Should be Attachment A-1-a.

Q149) Criteria 17

Exhibit A-1-b, is not provided in Excel format for completion. Will an excel version be provided?

A149) The Exhibits should be named Attachments and are provided in Excel at the following link: http://www.floridahealth.gov/programs-and-services/childrens-health/cms-plan/cms-plan-invitation-to-negotiate/index.html

Q150) Criteria 17

How does Exhibit A-1-b table tie to the allotted points described?

A150) The Respondent should modify the A-1-b chart to provide a complete listing of the items that will be offered by the Respondent under In lieu of and Expanded Benefits. The points as outlined in the Evaluation criteria will be applied to the items listed in the Respondents proposal in addition to any tool proposed to be used by Care Coordinators/Case Managers.

Q151) Criteria 17

Is Exhibit A-1-b, a tool to be completed by the Respondent?

A151) Yes.

Q152) Criteria 24 / Exhibit 6

What is the Provider Network Standards/Ratio for Private Duty Nursing?

A152) Respondent will propose provider network ratios for Private Duty Nursing.

Q153) Criteria 18

The reference is to an “Exhibit A-1-c” however the document reads “Attachment A-1-c”. Will the naming be corrected?

A153) Yes.

Q154) Criteria 22

Attachment A-1-d is not provided in Excel format for completion. Will an excel version be provided?

A154) The Exhibits should be named Attachments and are provided in Excel at the following link: http://www.floridahealth.gov/programs-and-services/childrens-health/cms-plan/cms-plan-invitation-to-negotiate/index.html

Q155) Criteria 22

Reference is made to “Exhibit A-1-d”however the document reads “Attachment A-1-d”. Will the naming be corrected?

A155) Yes.

Q156) Criteria 54

Reference is to an “Exhibit A-1-e”however the document reads “Attachment A-1-e”. Will the naming be corrected?

A156) Yes.

Failure to file a protest within the time prescribed in Section 120.57(3), Florida Statutes, or failure to post the bond or other security required by law within the time allowed for filing a bond shall constitute a waiver of proceedings under Chapter 120, Florida Statutes.

Q157) Criteria 55

Reference is made to “Exhibit A-1-f” however the document reads “Attachment A-1-f”. Will the naming be corrected? Also, there is no formula in column I-8 to calculate score based on input into column B-8.

A157) See updated A-1-f attachment at http://www.floridahealth.gov/programs-and-services/childrens-health/cms-plan/cms-plan-invitation-to-negotiate/index.html

Q158) Qualification of Respondent Eligibility

Is there a preference for not-for-profit entities? How many points would the fact that a Respondent is a not for profit entity be worth?

A158) Requirements are reflected in the ITN.

Q159) Qualification of Respondent Eligibility

What is the minimum and maximum number of Plans required per cluster to be awarded?

A159) Only one Respondent will be selected per cluster with preference given to Respondents with statewide and multiple cluster proposals.

Q160) Qualification of Respondent Eligibility

How will the Department deem a Respondent to be a qualified plan?

A160) The Respondent must submit a completed Exhibit 3 with the appropriate information marked and meet the requirements of the ITN.

Q161) PSN Certification

Per 409-974(1) and 409.966,F.S. will the Department apply the PSN preference in the selection process?

A161) Requirements are reflected in the ITN.

Q162) PSN Certification

Assuming, there is a PSN preference, will there be a minimum or maximum number of PSNs required per cluster?

A162) Only one Respondent will be selected per cluster with preference given to Respondents with statewide and multiple cluster proposals.

Q163) Cost Reply Instruction

According to the data book provided, there is a line item for Case Management; Can the Department expand on what services are included in this line item?

A163) See attachment 2 (P.84 and P.96.) for care coordination/case management and disease management requirements.

Q164) Will the Department continue to conduct the eligibility screenings?

A164) Yes.

Q165) Who will be generating/providing the eligibility file to the plan?

A165) AHCA.

Q166) What file format will be used to provide the eligibility file to the plan?

A166) Per AHCA SMMC contract.

Q167) How often will the T-XIX eligibility file be provided to the plan? (Daily, Monthly)
A167) Per AHCA SMMC contract.

Q168) How often will the T-XXI eligibility file be provided to the plan? (Daily, Monthly)
A168) CMS Plan intends to provide the Respondent with an enrollment file each month with data for the following month. CMS Plan intends to provide the Respondent with a supplemental file during each month to capture any changes for the current month.

Q169) Will the Department retain its AAAHC accreditation?
A169) The Respondent is expected to be accredited as an organization per AHCA SMMC contract.

Q170) Attachment A-1
The second bullet, "Crisis Stabilization…" directly contradicts p. 99 of the existing contract: "(n) Crisis stabilization units shall not be used in lieu of inpatient psychiatric care". Please confirm can be offered as an ILS as reflected in the most updated SMMC AHCA Contract.
A170) Crisis stabilization can be offered as an in lieu of service.

Q171) ITN Section 4.5
In order to be more environmentally friendly, will CMS consider allowing respondents to provide electronic only files for any attachments larger than 20 pages? (examples include manuals, financials, etc.)
A171) No, please follow the reply submission requirements.

Q172) ITN Section 5.1.3 and Attachment A-1
In Attachment A-1, Section G. Statutory Requirements starts with Criteria #51. This does not align with Table 4 Scoring within Section 5.1.3 where Section G. starts with Criteria #55 Provider Network Agreements/Contract - Essential Providers. Please revise the scoring criteria table to align with Attachment A-1.
A172) Attachment A-1 has been updated to reflect that Criteria #51-54 are in Section F.

Q173) Attachment A-1
Evaluation Criteria #1 asks that Respondents submit a table that "…identifies any applicable VBP arrangements across lines of business for children with medical complexity…" Will CMS please clarify that the term "lines of business" refers to product lines such as Medicaid, Medicare, Marketplace, commercial, etc?
A173) The term "lines of business" refers to product lines such as Medicaid, Medicare, Marketplace, commercial, etc.

Q174) Attachment A-1
Evaluation Criteria #1 (h) asks that Respondents submit "Service types governed under the arrangement" as part of the table described in Evaluation Criteria #1. Will CMS please clarify that the term "service types" refers to care categories such as primary care, specialty care and hospital-based care?

A174) In Criteria 31 - Value Based Purchasing, "service types" refers the actual services with service under the VBP arrangement. Please be more specific than just "primary care, specialty care and hospital-based care" and include the listing of the actual services under the VBP arrangement using the service names listed at Att A-2 p. 56 at a minimum. Please specific the exact physician specialties under each VBP arrangement as well consistent with the requirements at Att. A-2 (p. 263-264).

Q175) Attachment D - Cost Reply Instructions
Who will manage the PDL under 1) the full risk MCO scenario and 2) the phased-in risk scenario?

A175) Respondent will be responsible to manage the PDL.

Q176) Attachment D-3
In the event CMS/DOH ends up awarding contracts to multiple entities within a regional cluster, how will member assignment take place?

A176) This information is not available at this time.

Q177) Attachment A-1
Please confirm Criteria #2 subsections a. and b. are duplicates and should not be answered twice.

A177) Yes, that is a duplicate.

Q178) Attachment A-1
Evaluation Criteria #5 indicates whether the Respondent has "An existing insurance contract". The Criteria #3 question does not specifically address "existing insurance contract". Please provide additional detail as to what DOH/CMS is wanting the Respondent to provide to fulfill the evaluation criteria.

A178) Criteria #5 relates to whether the Respondent has voluntarily terminated all or part of a contract; has had such a contract partially or fully terminated; has withdrawn from a contracted service area; or has requested a reduction of enrollment levels. Criteria #3 awards points for SMMC, CHIP, and Medicare Advantage Plan experience in Florida as noted under Score.

Q179) Exhibit A-1-d
Please confirm Exhibit A-1-d, labeled as Criteria 21 - Standard CAHPS Measurement Tool, is intended to accompany Criteria 22 instead.

A179) Attachment A-1-d is associated with Criteria 22. The table of contents should refer to Criteria #22.

Q180) Exhibit A-1-d
Please confirm Exhibit A-4-a-4 referenced in the Evaluation Criteria is intended to reference Exibit A-1-d.

A180) Any references to Exhibit A-4-a-4 should be to Attachment A-1-d.

Q181) Exhibit A-1-d
Please confirm the document for Exhibit A-1-d is incorrectly named Attachment.

A181) Attachment A-1-d is correctly named.

Failure to file a protest within the time prescribed in Section 120.57(3), Florida Statutes, or failure to post the bond or other security required by law within the time allowed for filing a bond shall constitute a waiver of proceedings under Chapter 120, Florida Statutes.

Q182) Attachment A-1

Criteria #22 states that "if the Respondent does not have Medicaid and/or CHIP CAHPS results for at least three states, the Respondent will provide commercial CAHPS results for the Respondent's largest Contracts." Will the DOH consider excluding commercial data from this criteria, as the populations do not align with Medicaid and/or CHIP experience?

A182) Medicaid and CHIP data must be utilized if the Respondent has at least three contracts with Medicaid and CHIP. Only if the Respondent does not have at least three contracts with Medicaid and CHIP may use commercial to the extent that the Respondent has included all of the results from Medicaid and CHIP contracts first (i.e., only utilize a single commercial contract results if the Respondent has two Medicaid/CHIP contracts).

Q183) Attachment A-1

Please clarify how CMS is defining "in lieu of services" and whether approved in lieu of services are considered covered benefits.

A183) See the definition of "in lieu of" in Attachment A-2 p. 77 (D.2).

Q184) Attachment A-1

Please clarify how CMS is defining "expanded benefits" and whether expanded benefits are considered covered benefits.

A184) See definition of Other Benefits on page 15 of Attachment A-2 as well as Att. A-2 Item B-1, p. 73.

Q185) Attachment A-1

The ITN states "Respondent will select the following benefits it will offer…(Respondent will check all that apply): "There is no checklist provided for In Lieu of Services or Expanded Benefits; should Respondent create its own, or will CMS/DOH update Criteria #17 and provide a checklist within the template?

A185) The Respondent should utilize Attachment A-1-b to include the In Lieu of Services or Expanded Benefits as the "checklist" and only include services that will be included.

Q186) Attachment A-1

Please confirm that "Note: the following are suggested ILS" should precede the bulleted list of In Lieu of Services, and all bullets under In Lieu of Services are suggested and included.

A186) The CMS preferred ILS are listed first. The ILS under the "Note: the following are suggested ILS" are ILS suggested by AHCA and also may be included under the Attachment A-1-b.

Q187) Attachment A-1

Are In Lieu of Services and Expanded Benefits considered to be separate categories within the tool or is DOH/CMS considering In Lieu of Services and Expanded Benefits to both be services that could be provided as part of a member's care plan? In other words, is DOH/CMS indicating that the Respondent can enhance certain In Lieu of Services with Expanded Benefits?

A187) In Lieu of Services and Expanded Benefits are separate categories within the tool and both may be provided as part of a member's care plan.

Q188) Attachment A-1

Will the "tool" be expected to calculate whether a member should receive In Lieu of Services OR Expanded Benefits? Or should the tool separately calculate those categories?

A188) The tool will be expected to calculate whether a child should receive In Lieu of Services and/or Expanded Benefits as part of a member's care plan. A child may be eligible for one or both of the two categories.

Q189) Attachment A-1

For the transitions of care evaluation criteria #1, the question refers to addressing all three transition circumstances (A-C). Please confirm that A-C refers to the following:
a. Experience and strategies pertaining to deploying transitional care coordinators and using evidence-based practices with support from other clinical resources and community- based organizations.
b. Experience and strategies pertaining to individuals who reside in an institutional setting, or have otherwise resided in a facility for less than one year.

A189) There are three separate circumstances: A) Individuals transitioning from institutional to community settings after a short-term stay (e.g., acute hospital stay) as outlined in 1b; B) Individuals transitioning from institutional to community settings after a long term stay (e.g., nursing facility or other long term facility stay) as outlined in 1c; C) Transition from child to adult service systems as outlined in 2.

Q190) Attachment A-1

For criteria #8, is the question requesting one or two transition plan examples?

A190) There are three separate transition plan examples: A) Individuals transitioning from institutional to community settings after a short-term stay (e.g., acute hospital stay) as outlined in 1b; B) Individuals transitioning from institutional to community settings after a long term stay (e.g., nursing facility or other long term facility stay) as outlined in 1c; C) Transition from child to adult service systems as outlined in 2.

Q191) On page 9, the link provided to the Standard Contract terms and conditions (http://www.floridahealth.gov/about-the-department-of-health/about-us/administrative-%20functions/purchasing/_documents/DOH-Standard-Contract.pdf) opens an error "Page Not Found". Can the Department please provide an updated hyperlink.

A191) Updated link is: http://www.floridahealth.gov/_media/procurements/_documents/doh-standard-contract.pdf

Q192) Attachment A-1

The ITN requests a description of the Respondent's plan to hire qualified current CMS state employees for Care Coordinator/Case Manager positions. How many staff does CMS/DOH currently employ and what are their current qualifications?

A192) CMS has approximately 250 care coordinators and they are RNs, social workers and several LPNs.

Q193) Attachment A-1

In the Evaluation Criteria, #57 states: "respondent also will include a description of the EVV reports and costs". Is the DOH requesting that bidders provide a description of the cost to Providers for the use of the MCO-provided EVV solution? If this is not what DOH is requesting, please clarify the phrase: "... include a description of the EVV reports and costs".

A193) The Respondent also will include a description of the EVV system reports available to DOH CMS, providers and beneficiaries as well as any costs to DOH CMS, providers and beneficiaries.

Q194) Attachment A-1-a
The Attachment A-1-a General Performance Measurement tool does not self-calculate. Will the Department be providing updated tools with calculations imbedded or will this be scored upon submission?

A194) Yes, Attachment A-1-a will be providing updated tools.

Q195) Attachment A-1-e, A-1-f
Please confirm that Respondents are expected to include existing provider contract counts for contracts held between Respondents and those providers currently contracted to serve enrollees in the Statewide Medicaid Managed Care (SMMC) Program administered by the Agency for Health Care Administration (AHCA) to meet the requirements in Criteria #54, Criteria #55, "ATTACHMENT A-1-e", and "ATTACHMENT A-1-f" of the ITN.

A195) Respondents are expected to include existing provider contract counts for contracts that will serve CMS Plan Medicaid and CHIP enrollees.

Q196) Attachment A-1 Criteria #22, Attachment A-1-d
Attachment A-1-d includes the HEDIS measure *Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life* (W34). Did DOH intend to include this HEDIS measure as it is not a CAHPS measure?

A196) That measure will be removed from the CAHPs attachment - it is already included in the Performance Measure attachment.

Q197) Attachment A-1-d includes Adult CAHPS results. Since the CMS Managed Care Plan is a high risk children program, will the adult CAHPS results request remain?

A197) Yes, the adult measures apply to the CMS Plan population ages 18-21. The adult CAHPs results are requested for CMS to analyze the plan's experience with that population.

Q198) Attachment A-1 Criteria #9
Attachment A-1 Criteria #9 requests scores for members ages 18-21. The HEDIS measures for this specific age group are not reported and need to be recalculated. Is it acceptable to re-calculate the HEDIS scores for this specific age group based on the final audited patient level files already approved ?

A198) Please utilize the HEDIS results for the Contract results calculating the HEDIS measure as required by HEDIS. Please do not modify the results for the ages under the CMS Plan.

Q199) Attachment A-1 Criteria #9 lists 16 measures, eight general and eight for member ages 18-21and the Evaluation Criteria describes the scoring methodology based on 16 measure rates for three states and two calendar years. However, the General Performance Measurement tool (Attachment A-1-a) lists more than 26 measures without counting the sub-measures for the CAPs and Diabetes (CDC). Please confirm the number of measures to be addressed and scored.

A199) There are 16 measures to be scored (the Child and Adolescent access to PCPs will count as a single measure with each of the four age bands being worth .5 points). The

tool has been updated and is available here: http://www.floridahealth.gov/programs-and-services/childrens-health/cms-plan/cms-plan-invitation-to-negotiate/index.html

Q200) Attachment A-1 Criteria #9 request plans to submit the scores for the Children and Adolescents access to PCP (CAP) for each of the four age groups. Attachment A-1-a General Performance Measurement tool lists only one CAP row and does not allow insertion of additional rows to enter the four different age groups. Will the Department be providing an updated toll with the additional rows?

A200) The tool has been updated and is available here: http://www.floridahealth.gov/programs-and-services/childrens-health/cms-plan/cms-plan-invitation-to-negotiate/index.html

Q201) If bidders report the four age groups for the CAP HEDIS measure as requested in Criteria #9, the calculation of the final score must include three more items going from 16 measures for three states for two years to 19 measures for three states for two years. Please clarify how bidders should report these age groups.

A201) There are 16 measures to be scored (the Child and Adolescent access to PCPs will count as a single measure with each of the four age bands being worth .5 points). The tool has been updated.

Q202) Attachment A-1 Criteria #6

In Attachment A-1 Criteria #6, the Care Coordination / Case Management requirements outlined in the care coordination/case management description states that all NF, PDN children require case management and in subsection b, it states, "A description of the algorithm used to identify and stratify eligible enrollees by severity and risk level with at least two percent of the children with high utilization of services in addition to all children receiving nursing facility and private duty nursing services receiving case management."

However in the other subsections a-k of Criteria #6 and in Attachment A-2 Core Provisions (Section IV, E. Care Coordination/Case Management) the expectation seems that all children are placed at a minimum in three categories (High risk [at a minimum NF] , Medium Risk [at a minimum PDN], and low risk [everyone else]) with very specific care management touchpoints and expectations.

Please verify that all children enrolled in the CMS program will require the minimum care management activities outlined in the Attachment A-2 with a minimum staffing ratio of 1:90 (1:15 for NF and 1:40 for PDN) as outlined in Attachment A-1 Criteria #6 unless they opt out of care management and move to disease management? If verified, how many children opt out of care management?

A202) All children are placed at a minimum in three categories High risk [at a minimum NF] , Medium Risk [at a minimum PDN], and low risk [everyone else]) unless the family opts the child into disease management. At a minimum, an additional 2% of members must be at least in the medium and high-risk care coordination/case management. All children enrolled in the CMS program will require the minimum care coordination/case management activities outlined in the Attachment A-2 with a minimum staffing ratio of 1:90 (1:15 for NF and 1:40 for PDN) as outlined in Attachment A-1 Criteria #6s unless they

opt out of care management and move to disease management. It is estimated that 5% of families will opt their children out into disease management.

Q203) Attachment A-1 Criteria #17
Attachment A-1 Criteria #17 requests a tool that allows the Care Coordinator/Case Manager to apply for specialized services or other ILS/Expanded Benefits. Please clarify if this tool is a database, an assessment tool, or some other intervention.

A203) This tool is described in Attachment A-2, Section VI.B.2.i on p. 73 and Section VI.D.2.e.a on p. 77 and Section VI, G.1.d. The tool should allow Care Coordinators/Case Managers to determine if a child should receive Expanded Benefits and/or In Lieu of Benefits and outline the authorization process for the Care Coordinator/Case Manager and/or family. The tool should also ensure that medically necessary services under EPSDT are not subject to cost effectiveness tests or any requirements for Expanded Benefits.

Q204) Attachement A-2 Core Provisions, Section VIII, Provider Services, A. Network Adequacy Standards, 8. Essential Providers
d. (re: faculty plans) Questions: 1) Are these payments only to faculty plans that have contracted as a provider (so these payments are in excess of the fee schedule that will be negotiated?) or to all FL med school faculty practice plans? 2) How will CMS calculate the base amount for these pmpm payments?

A204) Per section 409.975(1)(b), Florida Statutes, faculty plans of Florida medical schools are statewide resources and essential providers for all managed care plans in all regions. The CMS Plan vendor must include these essential providers in its network. If the CMS Plan directs PMPM payments to faculty plans, a specific schedule and further details will be provided to the Respondent at that time and capitation rates will be adjusted appropriately.

Q205) Attachement A-2 Core Provisions, Section VIII, Provider Services, A. Network Adequacy Standards, 8. Essential Providers
f. re: (payment of non-par provider hospitals at highest MMA rate) How will this method encourage these hospitals to contract and become participating providers, if they could realistically get a higher rate as a non-par who has negotiated a good deal with a different MMA?

A205) This is a requirement contained in the AHCA contract with the CMS Plan and contracting Respondents under this ITN must comply.

Q206) Addendum 2, Question 29 of the First set of Questions/Answers.
If a respondent opts for the phased-in risk and Pharmacy Services are payable at Medicaid FFS rates, is the state agreeable to an equivalent fee structure? If the exact fee for service structure is required, will the state provide a State Maximum Allowable Cost (SMAC) list and AAC pricing file (if FL state doesn't report to FDB or Medispan on the state AAC) that includes key product identifiers, such as NDC and GPI? The list on the AHCA website only includes product name and strength.
(http://ahca.myflorida.com/medicaid/Prescribed_Drug/smac.shtml)

A206) See Attachment A-2, Section VI.A.2.a.11.r p. 67 for a complete description of the Florida drug pricing. For AAC, Florida uses NADAC for generic drugs and WAC if there is no NADAC for the AAC. Those two files are publicly available. The CMS Plan will work with

the winning bidder and AHCA to obtain a detailed SMAC list or to develop an alternative fee schedule that is acceptable.

Q207) Addendum 2, Question 17 of the First set of Questions/Answers.
The answer to Question 17 says that the claim costs (and visits) for safety net providers are NOT included in the data book appendices. The vendor will be at risk for costs incurred from members utilizing the safety net specialty providers. Are Respondents expected to include these costs in their Cost Reply? If so, can the Department please provide an estimate of these costs?

A207) Respondents should price out their unique expected costs based on the historical utilization with the safety net providers.

Q208) Addendum 2, Question 54 of the First set of Questions/Answers.
Question 54 states that the costs are net of pharmaceutical rebates, however Attachment A-2 Core Provisions page 68 states that Title XIX and Title XXI treat pharmaceutical rebates differently. For Title XIX "all rebate payments for drugs on the AHCA's Medicaid PDL will be made to AHCA." Since this is the case, we believe that the capitation rates paid to Respondents should be gross of pharmaceutical rebates for Title XIX since AHCA will receive the rebate payments. Therefore, can the Department please provide details on historical pharmaceutical rebate amounts so that respondents can apply an adjustment in their Cost Reply?

A208) Prescription drug claims for Title XIX as summarized in the databook are gross of AHCA's rebates.

Q209) Attachment D-3 Data Book, Home Health Utilization and Unit Costs
Can the Department separate the private duty nursing utilization and unit costs (CPT codes: S9122, S9123 and S9124) from the other services in the home health service category of the data book? This is important for Respondents to know in order to properly fill out unit cost adjustments in the Cost Reply.

A209) No.

Q210) Attachment D (Data Book Section 7.1.3 & Cost Reply Instructions)
In Section 7.1.3 of the data book and in the instructions for completing the cost reply, it indicates the respondents should not adjust for IP, OP, FQHC & NF fee schedule changes. Should respondents include fee schedule/program changes for professional services in the cost reply?

A210) CMS does not intend to update the capitation rates for any changes in Medicaid fee schedules for professional services. Consequently, the responder should reflect its anticipated costs for these services.

Q211) Attachment D (Data Book Section 7.1.3 & Cost Reply Instructions)
Can Mercer please confirm no adjustment has been made in the data book for the Physician Incentive Program? The data book exhibits shows an increase in Physician Unit Costs from $158.13 to $208.48 for SFY 16 to 17 for Title XIX (Appendix A) and from $110.73 to $139.69 for Title XXI (Appendix C). This is a large increase in unit cost and we would like to confirm this is due solely to severity, and does not include any impact from the Physician Incentive Program.

A211) The databook does not reflect the impact of the Physician Incentive Program payment rates.

Q212) Attachment D (Cost Reply Instructions page 4)

From page 4 of cost reply instructions: "B. Respondents should replace the “X-X-X” portion of the file name with the applicable regional clusters. In the file name, include “A” for North, “B” for Central – SW and “C” for South – SE."
There is no "X-X-X" in the file name of the cost reply templates that were provided. Please confirm that Respondents can place this information after the organization's name in the file name.

A212) Yes, include the regional cluster information after the organization's name in the cost reply template file name. The respondent should include "Statewide" in the file name for a statewide bid.

Q213) Attachment A-2, page 68
Please confirm the quote below does not apply to Respondents that opt for the full risk MCO Option 1.
"Respondent will reimburse covered pharmaceuticals at the AHCA fee schedule pricing the first year of the Contract on a non-risk basis. Pharmaceuticals will be capitated thereafter."

A213) The quote does not apply to Respondents that opt for the full risk MCO Option 1.

Q214) Attachment A-2, page 133
Can Mercer or the Department please confirm if the costs mentioned in the quote below are included in the data book?
"d. Respondent will make monthly payments to faculty plans of Florida medical school faculty physician groups in an amount specified by the CMS Plan. The payment amount will be the per member, per month amount multiplied by Respondent’s monthly enrollment."

A214) The costs of monthly payments to faculty plans are not included in the databook and, per pages 9 - 10 of the cost reply instructions, should not be included in the Respondent's cost proposal.

Q215) Attachment D-3 (Data Book)
Are PBM fees included in the data book?

A215) Title XIX pharmacy data does include PBM fees. Title XXI pharmacy data does not include PBM fees.

Q216) Attachment D-3 (Data Book)
Section 2.2. states that "Siblings of children who are eligible for the CMS Plan are not eligible unless they also meet the clinical and financial eligibility requirements."
When were siblings no longer eligible for the CMS Plan? How was the base data adjusted to account for this eligibility change?

A216) Siblings were no longer eligible for the CMS plan as of August 2014. Since this predates the beginning of the data book claims data period, no base data adjustment is necessary.

Q217) Attachment A-1 Evaluation Criteria #1
For Respondents who opt for Option 2: Risk Phase-in how will IP and Rx costs be factored into their capitation rates once they are at-risk for those services? For example, if they contract above the Medicaid fee schedule for IP in later years will this be reflected in their capitation rates?

A217) See capitation rate development and adjustment in Attachment A-2, Section XI.F.2 p. 253 and I.1 and 2 p. 254-256.

Q218) Pg. 177 of 196
The CMS Managed Care Plan requires a 100% FT Compliance Officer for this contract. For Health plans that also have a FL AHCA contract with a 100% FT Compliance Officer, can this individual serve for both?

A218) No.

THIS ADDENDUM NOW BECOMES A PART OF THE ORIGINAL ITN.

THE ADDENDUM ACKNOWLEDGEMENT FORM SHALL BE SIGNED BY AN AUTHORIZED COMPANY REPRESENTATIVE, DATED AND RETURNED WITH THE ITN RESPONSE AS INSTRUCTED IN SECTION 2.5, ADDENDA.

_____
Printed Name

_____ _____
Signature of Authorized Representative Date

Failure to file a protest within the time prescribed in Section 120.57(3), Florida Statutes, or failure to post the bond or other security required by law within the time allowed for filing a bond shall constitute a waiver of proceedings under Chapter 120, Florida Statutes.