Addendum 2
ITN DOH17-026
CMS Managed Care Plan

DATE: March 2, 2018

TO: Prospective Vendors

FROM: Diana K. Trahan, Department of Health
Purchasing

SUBJECT: Addendum 2 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.

1. **Responses to Questions**

   This is a partial response to questions that were received on February 21, 2018. It is anticipated that the remainder of questions from February 21, 2018 and any new questions that are received by March 7, 2018 will be responded to on March 14, 2018.

2. **ATTACHMENT A-1 EVALUATION CRITERIA**

   Option II - Risk Phase In

   - **Non-risk Prepaid Inpatient Health Plan** – For the first two years, the CMS Plan will operate as a cost reimbursement Contract for pharmacy (Year 1 only) and Inpatient (Year 1 and Year 2) claims. The Department will make interim non-risk payments to the ~~Department~~ Respondent on a quarterly basis and more frequently based on the Respondents satisfactory performance of its duties and responsibilities as set forth in the Contract. Those payments will be settled to actual expenditures, based on utilization, at the Medicaid FFS fee schedule rate for Medicaid and the established rate(s) for CHIP services.

3. **Data Books Appendix**

   Excel sheets of the Data Book Appendix will be made available at the following link:
   http://www.floridahealth.gov/programs-and-services/childrens-health/cms-plan/cms-plan-invitation-to-negotiate/itn-response-materials.html

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

Q1) What rate cell structure is the State expecting to assign for the rates for this population going forward? Many states we've seen have split out members by age and waiver type in order to better reflect the associated risks for these members in their projections.

A1) The rate cell structure the Department intends to use is described in Attachment D - Cost Reply instructions.

Q2) What consideration is Mercer going to make for the CMS members in the MMA program in rate development. Based on the analysis Milliman has done for risk adjustment on the MMA program the members opting into the MMA program are significantly more expensive than the members who have not opted into MMA.

A2) The capitation rate development is based on the enrolled FY 2016/2017 population, with the adjustments described in the Section 7 of the CMS Data Book.

No assumption has been made about future member enrollments/disenrollment.

Q3) Are there any benefits that the CMS members are expected to receive that are not included in the claim costs in the databook?

A3) The CMS Data Book describes all covered services.

Q4) The title XIX data book excludes dental costs and has a "new services" PMPM amount for medical foster care while the title XXI data book includes dental costs and excludes medical foster care expenses. Can the State confirm that these are benefit differences between the two populations?

A4) Yes.

Q5) The databook notes that the administrative allowance will also include consideration for historical CMS Plan administrative costs. Historical CMS plan administrative costs do not appear to be included in the databook, could the state provide the breakout of historical admin costs including care management staff?

A5) Once the vendor is fully at risk, the vendor's capitation rate will include allowance for the Department administrative costs, in addition to the Vendor's own administrative cost, such that the entire administrative cost of managing the CMS Plan will be incorporated into the capitation rate.

Q6) Exhibit D-3, CMS Plan Data Book (Section 7, page 19) documents adjustments not included in the data book, which includes an acuity adjustment due to a change in clinical screening process for the CMS Plan. Another acuity adjustment may need to be made for the CMS Plan voluntary movement that occurred after the end of SFY 15/16 as described by Milliman's RY 17/18 Capitation Rate Development report dated September 8, 2017, however no data or

estimated impact is provided. Can further information be provided in order to assess the impact of this voluntary disenrollment from the CMS Plan?

A6) The acuity adjustment described on page 21 of the data book normalizes the FY 2016/2017 base data for all enrollment changes. At this time, further changes are not expected to be necessary

Q7) Criteria #1 – Statewide or Regional Reply
Does Prepaid Inpatient Health Plan (PIHP) include non-inpatient services? What services are included?

A7) Under the risk phase-in option in Year 1, services covered under the non-risk Prepaid Inpatient Health Plan include inpatient services (including nursing facilities) and pharmacy services. Under the risk phase-in option in Year 2, services covered under the non-risk Prepaid Inpatient Health Plan include inpatient services (including nursing facilities). Please refer to Section 4 of the Data Book.

Q8) Criteria #1
Clarify Option 2 and risk for Pharmacy (Year 2 only)?

A8) Under the risk phase-in option, pharmacy services are at-risk for Year 2.

Q9) Criteria #1 – Statewide or Regional Reply
Under Option II should the second sentence read: The Department will make interim non-risk payments to the Respondent…?

A9) Yes.

Q10) ATTACHMENT D-3 – Data Book
Risk Adjustment: Will CMS be its own risk pool if more than one plan wins an award or will it be lumped into the entire managed Medicaid population?

A10) Rates will be developed for the CMS Plan population and will not include non-CMS Plan participants.

Q11) ATTACHMENT D-3 – Data Book
Specialty Pharmacy: Will there be any carve outs for new drugs that take into account the high cost drugs used in this population?

A11) At this time, the Department does not anticipate any carve-outs for new drugs, other than the carve-outs described in Section 4 of the Data Book.

Q12) 5.1.4 Cost Reply
How will transplants be covered, solid organ, bone marrow, and stem cell? Are these included with databook rate?

A12) Please refer to Section 4.2 of the data book. Transplant services labeled as "At-risk" are included in the data book.

Q13) 5.1.2 Technical Reply Evaluation
Will ABA be a carve out for CMS T19, but not T21, as it is now?

A13) Yes. Please refer to Section 4 of the Data Book.

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.

Q14) For Criteria #1 Statewide or Regional Reply, is it possible for a respondent to use the 2 priority option replies to bid as statewide MCO for one priority and statewide Risk Phase In for the other priority?

A14) A respondent may submit a Statewide MCO bid as a priority 1 and a Statewide Risk Phase-In bid as a priority 2 (or vice versa).

Q15) For Criteria#1 Statewide or Regional Reply: if a respondent prefers a statewide contract but is willing to take one or more regional clusters how should they utilize the Priority 2 reply? Since it would be unknown which regional clusters are available should a respondent include all 3 regional clusters in the Priority 2 reply?

A15) The respondent should indicate that the priority 1 bid is for a statewide contract and that the priority 2 bid is for a multiple regional cluster bid with the respondent willing to accept a single regional clusters bid as the third priority. If the respondent is willing to accept any of the regional clusters as a single bid, please note that willingness.

Q16) For a respondent replying statewide it appears there is not a point differential for replying as an at-risk MCO vs. as a risk phase in. Are there any additional points or any other consideration provided that will differentiate these two types of replies? We are asking since there is a point difference for MCO vs. risk phase-in if a respondent submits a regional reply.

A16) Preference will be given to state-wide bids regardless of risk type. The respondent should note if it is willing to accept full risk (MCO) immediately or risk phase in. No additional points will be given so long as the respondent bids on a state-wide basis. As noted, there is a point difference for MCO vs. risk phase-in if a respondent submits a regional cluster bid.

Q17) Can the Department clarify if the claim cost for the visits to safety net providers in Appendix I are included or excluded in Appendix A-D? The data book states that the utilization (visits) shown in Appendix I are not included in Appendix A-D. Can the Department clarify if the selected vendor will be at risk for costs incurred from members utilizing the safety net specialty providers listed in Appendix I?

A17) 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.

Q18) Can the Department give additional details to describe the specific Title XXI Prescription Drug Cost Containment Measures which caused the -4.8% adjustment listed on page 20 of the data book?

A18) The following Cost Containment Measures were included in the calculation of the -4.8% adjustment described in the Data Book: 1) Initiation of a per claim administrative fee; 2) Increase in the percentage of the drug rebate retained by the CMS Plan vs. the PBM; 3) Adjustment of brand and generic Average Wholesale Price across fulfillment types (retail, specialty, mail order); 4) Formulary edit for Abbott Test Strips; 5) Transitioning to preferring select specialty pharmacies.

Q19) On page 20 of the data book, an adjustment amount of -4.8% for Title XXI Prescription Drug Cost Containment Measures that took effect during the first half of 2017 is presented. Can you

please clarify if this adjustment amount is an average to apply to all 24 months of data or to apply to the 18 months of data July 2015 through December 2016? Was this adjustment already applied to the base data presented?

A19) Adjustment amounts were calculated to apply to the base data time period, noted in Section 7.1.1 to be FY 2016/2017. Consequently, the adjustment amount should be considered applicable to the entire FY 2016/2017 experience (e.g., 6 month effect spread over 12 months).

Q20) On page 10 of the cost reply instructions, under item #5, it states that the cost reply should exclude impacts for "Other program changes excluded from the cost reply instructions or ITN Data Book". Does this apply to items listed in section 7.1.3 of the data book? More specifically, should respondents make adjustments to the base data for the programmatic changes listed in section 7.1.3 of the data book (Title XXI Prescription Drug Cost Containment, MMA Physician Incentive Program, Acuity Adjustment)?

A20) Respondents can apply programmatic change adjustments described in section 7.1.3 of the Data Book in Column I. Respondents should not include adjustments for programmatic changes that are noted as excluded at this time such as changes to the Medicaid Inpatient Hospital and Nursing Facility fee schedule.

Q21) Adjustment amounts for programmatic changes are listed in section 7.1.3 of the data book (Title XXI Prescription Drug Cost Containment, MMA Physician Incentive Program, Acuity Adjustment). Are these adjustments already applied to the base data presented in the data book appendices? We are unsure since the main title to Section 7 is "Adjustments Not Included In This Data Book".

A21) Adjustments described in section 7 are not applied to the base data included in the data book. These adjustments will be applied during the rate development process.

Q22) The second point in section 7.1.5.2. of the data book says final rates "will include administrative allocation for the CMS Plan (including costs for state employees)." Can the Department give additional detail on what this will include or how it will be developed? What specific state employee costs will be included?

A22) Once the vendor is fully at risk, the vendor's capitation rate will include allowance for Department administrative costs, in addition to the Vendor's own administrative cost, such that the entire administrative cost of managing the CMS Plan will be incorporated into the capitation rate.

Q23) Will final rates include any MLR guarantees, or risk share corridors based on a target MLR? Can the department give additional details for any of these items if they will be included in the rates?

A23) The Department does not anticipate offering MLR guarantees or risk sharing corridors at this time.

Q24) Instructions provided on file naming for the cost reply: "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." If a respondent is replying statewide should they list "A-B-C" in the filename? If not, please clarify.

A24) The respondent should replace "X-X-X" with "Statewide" for a statewide bid.

Q25) How will a respondent's cost reply be used to set final capitation rates? Will specific elements/factors from the respondent's cost reply be used in the final rates?

A25) The cost reply will be used as part of a rate negotiation process between the respondent and the Department.

Q26) The quarterly risk scores provided show a decrease in enrollment and an increase in risk score over 2015 and 2016 for both Title XIX and Title XXI populations. Did this acuity increase continue into 2017? Is it expected to continue into 2018 and 2019? How will changes in acuity be reflected in future capitation rates?

A26) As noted on page 21 of the Data Book, the acuity changes continued into early 2017. At this time, the Department believes enrollment has stabilized. Changes in acuity will be considered in the future and an adjustment factor will be calculated if necessary.

Q27) Can the Department provide the most recent prevalence report for the CDPS risk score calculation? It would be helpful to have the disease prevalence of this population.

A27) The Department does not plan to provide this information at this time.

Q28) 3.3 Specific Goals: The Department intends to award one state-wide Contract to a Respondent to assist with the administration of the CMS Plan. The Department will award additional contracts only if there is no acceptable state-wide Respondent for all areas of the state.
If a Respondent in a regional cluster submission outperforms a Respondent in a statewide submission, or otherwise presents efficiencies or other quality advantages to the Department, will the Department retain the discretion to award a regional cluster in lieu of, or in addition to, an acceptable statewide award?

A28) Additional points/preference will be given to state-wide bids regardless of risk type. The Department will award contracts by Regional Cluster only if there is no acceptable state-wide Respondent for all areas of the state. The Department reserves the right to award a contract for multiple regional clusters in that instance, or if necessary, a single contract for each regional cluster.

Q29) Criteria 1 - Option II - Risk Phase In
• Non-risk Prepaid Inpatient Health Plan
1) The Department will be making payments to the Respondent, not to itself. Please confirm.
2) During the period the respondent is not at risk, please confirm that the respondent cannot pay higher than Medicaid rates. Please outline the process of paying higher than Medicaid rate if needed to meet access to care.
3) Please confirm that the Respondent will be responsible to provide all services including Pharmacy on year one even though not at risk and must reconcile/settle to cost with the Department.

A29) 1) Yes, the payments will be made to the Respondent. 2) For the services not at-risk, the contractor must pay the Medicaid fee schedule. Non-risk services are inpatient services

and pharmacy services in the first year and just inpatient services in the second year. All services are at risk in the 3rd year of the contract. For outpatient services which are not at risk at any point, for pharmacy services in the second year and beyond, and for all services in the third year, the respondent may pay higher than Medicaid rates. 3) Yes, the respondent is responsible for delivering all covered ITN services as outlined in A-2 Section XI. Method of Payment, even those for which it is not at-risk.

Q30) Criteria 1
If the Respondent applies for full risk in all or all regional clusters, can additional points be awarded?

A30) The Department does not intend to award additional points for full-risk versus non-risk statewide bids at this time. However, as noted in the Evaluation Criteria for #1, additional points are awarded to regional bids on an at-risk basis over regional bids on a non-risk basis.

Q31) Criteria 1
Can the respondent submit a statewide reply with one regional cluster with a risk delivery system and in a second regional cluster with a non-risk phased in and in a third regional cluster with a non-risk delivery system (ASO)?

A31) The Department will not consider a bid with a permanent non-risk delivery system, such as an ASO.

Q32) Criteria 1
Would the Department consider response that offers a Non-Risk ASO option for one or more cluster(s) – if so, what point value will be assigned to such a response?

A32) The Department will not consider a bid with a permanent non-risk delivery system, such as an ASO.

Q33) Criteria 1
Does a Respondent get extra points for each cluster in which it proposes to assume full risk as opposed to proposing as risk phase alternative?

A33) Additional points/preference will be given to state-wide bids regardless of risk type. The Department will award contracts by Regional Cluster only if there is no acceptable state-wide Respondent for all areas of the state. The Department reserves the right to award a contract for multiple regional clusters in that instance, or if necessary, a single contract for each regional cluster. As noted in the Evaluation Criteria for #1, additional points are awarded to regional bids on an at-risk basis over regional bids on a non-risk basis.

Q34) Cost Reply Instruction
Are hemophilia drugs carved-out for CMS XIX eligible recipients?

A34) Hemophilia drugs are not the responsibility of the vendor for Title XIX-eligible recipients.

Q35) Cost Reply Instruction
Are hemophilia drugs carved-out for CMS XXI eligible recipients?

A35) The vendor is responsible for hemophilia drugs for Title XXI-eligible recipients. If the respondent chooses the phase-in risk option, the hemophilia drugs will be non-risk in

Year 1 and at-risk in subsequent years. If the respondent chooses the full-risk option, hemophilia drugs will be at-risk in Year 1 and subsequent years.

Q36) Cost Reply Instruction
Can the Department provide a pharmacy claims paid file including Rx name?
A36) The Department does not plan to provide this information at this time.

Q37) Cost Reply Instruction
Can the Department provide a pharmacy claims detail file?
A37) The Department does not plan to provide this information at this time.

Q38) Cost Reply Instruction
For the base period, what are the cost of the top 10 major drug types?
A38) The Department does not plan to provide this information at this time.

Q39) Cost Reply Instruction
Can the Department provide more than a year worth of drug cost to establish a trend?
A39) The Data Book contains two years of drug cost information. The Department does not plan to provide any additional pharmacy data at this time.

Q40) Are PDN services covered for CMS XIX eligible recipients?
A40) PDN is a required covered service.

Q41) ITN Section 5.1.4 Cost Reply
It is stated that the cost reply will be evaluated relative to pricing performed by state of Florida actuaries. Will the rates ultimately provided for this program be those contained in the submission, those developed by the state's actuary or some combination of the two?
A41) The capitation rates paid for this program will be negotiated between the respondent and the Department.

Q42) Attachment A-1
The state describes their requirement that "physician compensation rates are equal to or exceed Medicare rates…". Given the bulk of these members are currently covered under a FFS agreement, please provide average compensation rates being paid in the experience period relative to both the Medicaid and Medicare Fee Schedules.
A42) The Department does not plan to provide this information at this time.

Q43) Attachment A-1
Are the In-Lieu of and Enhanced Benefits described in Exhibit A-1-b currently provided to members? If yes: 1) Which ones specifically; 2) Are the claims included in the databook provided by the state?
A43) The current contract structure for the CMS Plan does not permit the provision of In-Lieu of or Enhanced Benefits.

Q44) Attachment D-3
Currently there are a certain number of CMSN members receiving services through the MMA

and Child Welfare programs. Will these members be moved back into the CMS program that is the subject of this ITN? Additionally, has the databook experience been adjusted to reflect inclusion or exclusion of these members?

A44) No assumption is made that children enrolled in other plans will be moved back into the CMS program. The databook experience reflects only those children who were enrolled during the base data time period. As described in databook section 7, an adjustment was made during the capitation rate development to normalize the base data for enrollment changes during FY 2016/2017.

Q45) Attachment D-3
Are the completion factors described on page 16 applied to the utilization component of claims or just the PMPM?

A45) The completion factors were applied to both the utilization component and the PMPM.

Q46) Attachment D-3, Pages 20-21
Please provide support for the adjustments outlined on these two pages including calculation specifics and further description of the changes driving the adjustments.

A46) The Department does not plan to provide this information at this time.

Q47) Attachment D-3, Page 44
Please provide support for the adjustments outlined on this page including calculation specifics and further description of the changes driving the adjustments.

A47) The Department does not plan to provide this information at this time.

Q48) Attachment D-3, Page 48
In the event CMS/DOH ends up awarding contracts to multiple entities, is it expected that the CMS Product will be risk adjusted?

A48) In the event that a single, statewide contract is not awarded, the Department will consider whether any adjustments to capitation rates are necessary.

Q49) Attachment D-3, Page 48
Do these factors include the members who moved from CMS to other health plans described in the Acuity Adjustment section on page 21 of the databook?

A49) The quarterly CDPS scores are provided for the actual enrolled population.

Q50) Attachment D-3, Page 50
Do these factors include the members who moved from CMS to other health plans described in the Acuity Adjustment section on page 21 of the databook?

A50) The acuity adjustment measures all population changes during the final base data year (FY 2016/2017).

Q51) Attachment D-3
Please provide monthly membership figures by Title XIX vs. Title XXI, by region or regional cluster as appropriate, and by whether members stayed in the CMS Managed Care Plan vs. transitioned to the MMA program.

A51) Enrollment informaiton is avilable on the Department's website. The Department does not have disenrollment trends responsive to the quesitons about transition from the CMS MMA Specialty Plan to other MMA plans.

Q52) Exhibit 5
There are certain Managed Care Savings initiatives that cannot be estimated without further information being made available by the state (unecessary ER visits, avoidable IP readmissions, inefficiencies in Rx, etc). These are typically estimated by the state's actuary and detailed calculations shared in rate development discussions and documents. Are there any savings expectations that have been analyzed and estimated by the state's actuary and, if so, can the details be shared with all bidders?

A52) Additional information is available within the publicly-available document found at: https://ahca.myflorida.com/medicaid/Finance/data_analytics/BI/docs/Quarterly_SMMC_Report_Spring_2017.pdf

Q53) Attachment D - Cost Reply Instructions
The CMS managed care plan anticipates using its current actuarially sound methodology for developing capitation rates to evaluate the reasonability of cost replies. Please provide the rate range considered reasonable.

A53) The Department does not plan to provide this information at this time.

Q54) Attachment D-3
Are pharmacy costs reported in the data book gross or net of rebates?

A54) Reported pharmacy costs are net of rebates.

Q55) Attachment D-3
Please provide all data book exhibits in Excel format.

A55) Excel sheets of the Data Book Appendix will be made available at the following link: http://www.floridahealth.gov/programs-and-services/childrens-health/cms-plan/cms-plan-invitation-to-negotiate/itn-response-materials.html

Q56) Attachment D - Cost Reply Instructions
Given the significant amount of data plans must review and respondents' limited experience with this program since it is transitioning from FFS, would DOH/CMS please consider offering a second round of question and answer period?

A56) See amended Timeline, Section 2.4 of the ITN.

Q57) Attachment D - Cost Reply Instructions
Is it DOH/CMS' intent to pay final rates for Title XIX members according to the 11 regions or by the regional clusters?

A57) Final rates will be paid according to the 11 regions. Bidders must adhere to the regional clusters when determining where to bid.

Q58) Attachment D-3
Section 4.2 - Are bidders expected to develop kick payment rates for transplant services in their cost replies? How should these services be reflected in the cost reply template?

A58) Bidders should not develop kick payments; these will be established by AHCA and are not subject to negotiation.

Q59) Attachment D-3
Section 4.2 - Are bidders allowed to propose additional services to receive a kick payment? If so, how should this be reflected in the cost reply template?

A59) No, the capitation rate structure, including covered services, is not subject to negotiation.

Q60) Attachment D-3
Section 4.3 - Have these services been removed from the data book summaries?

A60) Yes, these excluded services have been removed.

Q61) Attachment D - Cost Reply Instructions
Given the high cost and volatile nature of this population, is CMS/DOH considering any risk mitigation mechanisms (especially in the first few years) to help protect all parties in the event of mis-estimation of costs (positive or negative)? This is often included in the rate development process in other states when moving certain populations into Managed Care for the first time.

A61) The Department has offered bidders two options for bidding: a full-risk option and a risk phase-in option. The risk phase-in option is designed to allow the bidder to take on risk of this population gradually. At this time, the Department is not considering any additional risk mitigation strategies.

Q62) Attachment D-3
Given the uniqueness of the CMS Program, which other state Medicaid programs did Mercer consider "similar" when setting trend and managed care savings assumptions for the CY2019 CMS rates?

A62) The Department does not plan to provide this information at this time.

Q63) Attachment D-3
Please provide cost models (similar to how they were provided by region) by disease and/or diagnosis condition. The intention is to understand cost levels by disease condition in order to better assess managed care savings opportunities.

A63) The Department does not plan to provide this information at this time.

Q64) Attachment D-3
Given the uniqueness of the program (e.g. hard to find good comparisons) and historical member migration between CMS and MMA (which may have influenced observed PMPM trends), please provide the annual PMPM trend range (either by region or statewide) in the CY2019 rate development. The trends need not be at the category of service level; overall PMPM trend ranges would be appreciated.

A64) The Department does not plan to provide this information at this time.

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.

Q65) Attachment D-3
Given the uniqueness of the program (e.g. hard to find good comparisons), please provide the range of managed care savings assumptions built into the CY2019 rate development.

A65) The Department does not plan to provide this information at this time.

Q66) Attachment D-3
We note that the base period data was both incurred and paid through June 2017. We acknowledge that Pharmacy claims complete very quickly, but would still expect the completion factor to be greater than 1.000. Please explain why there is no completion factor added to pharmacy claims.

A66) Due to electronic claims processing, there is no historical late payment pattern.

Q67) Attachment D-3
Please provide the Generic Dispensing Rates (both as a percent of scripts and as a percent of paid amounts).

A67) The Department does not plan to provide this information at this time.

Q68) Attachment D-3
Please provide the discount to Average Wholesale Price (AWP) for each Pharmacy vendor, or combined AWP discount for the program.

A68) The Department does not plan to provide this information at this time.

Q69) Attachment D-3
Please confirm that the dispensing fees for pharmacy claims are in the databook and how much these fees are.

A69) Yes, dispensing fees are included in the Data Book. Fees data are not available at this time.

Q70) Attachment D-3
The cost and utilization levels in the databook vary quite a bit by region. Please provide the disease and/or diagnosis prevalence reports by region so that health plans can better assess opportunities for management.

A70) The Department does not plan to provide this information at this time.

Q71) Attachment D-3
Please provide details on any managed care efforts currently in place by the current program administrators (e.g. Ped-I-Care and South Florida Community Care Network).

A71) The Department does not plan to provide this information at this time.

Q72) Attachment D-1
The cost proposal requires bidders to enter an acuity adjustment by title and region. In its databook, CMS/DOH shows a migration acuity adjustment factor of 3.0% for Title XIX and 2.7% for Title XXI. Please provide the same factors by region.

A72) The acuity adjustment was only done at the statewide level due to concerns about the statistical credibility of a smaller exposure base. Bidders should use the provided

statewide values, their own data, or some combination of the two to enter acuity adjustments by region.

Q73) Attachment D-1
How did the CMS/DOH calculate the acuity adjustment factors of 3.0% and 2.7% for Titles XIX & XXI respectively?

A73) As shown in Appendix G of the databook, the CDPS + Rx risk adjustment model was used to evaluate change in average population acuity. Mercer applied regression analysis to develop an adjustment that, when applied to FY 2016/2017 experience, reflected the average acuity in effect at the end of the experience period.

Q74) Attachment D-1
Please confirm that the comment "For purposes of negotiating capitation rates, inpatient hospital, outpatient hospital and NF fees will remain at the fee schedule levels reflected in the base data" is isolated to program changes only and that if the bidder expects to contract at rates different from 100% of the Medicaid Fee Schedule, then that should be incorporated in the cost proposal.

A74) Yes, the comment is limited to program changes for those services. If the bidder expects to contract at rates different from 100% of the Medicaid Fee Schedule for other services, those rates should be incorporated into the cost proposal.

Q75) Attachment D-1
1) In its databook, CMS/DOH mentions a program change related to "prescription drug cost containment". The value is -4.8%. Please confirm that half of the base data (e.g. January - June 2017) already contains the discounted costs. Also, please confirm that the actual reduction was roughly double 4.8%, or 9.6%. The intention of this question is to understand the overall discount amount and how much of it should be reflected in the cost proposal since the implementation date was halfway into the base period.

A75) The prescription drug cost containment adjustment contains several provisions that were implemented over the course of the first half of 2017. As such, the impact is partially reflected in the base data and the -4.8% adjustment would have an annualized value of 10% (not all cost containment provisions started on 1/1/2017).

Q76) Attachment D-1
Are costs for historical services provided for case management, care coordination, and disease management contained in their entirety in the databook and are historical service levels consistent with the CY2019 requirements as documented in the ITN?

A76) No, historical costs are not consistent with the requirements as documented in the ITN. Bidders should evaluate their cost structure for these functions as described in the ITN and include the appropriate cost level in their bid.

Q77) Attachment D-1
The cost proposal requires bidder to enter program changes at the title, region, and category of service level however the databook only contains program changes (e.g. Pharmacy and

Physician Incentive Program) at statewide levels. Please provide these values at the regional level.

A77) Unless otherwise stated in the Data Book, program changes were calculated at the statewide level. Bidders may leverage the statewide values or prepare their own estimates while preparing region-specific proposals.

Q78) Attachment D-1
If AHCA awards a Children's Chronic Condition Specialty Population Contract under its recent SMMC ITN and a subset of Medicaid eligible CMS children are subsequently enrolled in that specialty plan, does the CMS/DOH intend to incorporate risk adjustment (or any other sort of risk mitigation program) between the CMS and MMA programs depending on how the membership and acuity distribute between the programs?

A78) A programmatic change with a material impact on the risk of the enrolled population would warrant consideration for a capitation adjustment.

Q79) Attachment D - Cost Reply Instructions
With regards to replacing "respondent" with bidding organization's name in the cost proposal Excel filename, can the respondent use an acronym for its name rather than the full name for purpose of naming the Excel file?

A79) Yes, the respondent can use an acronym for its name.

Q80) Attachment D - Cost Reply Instructions
If the respondent is bidding statewide, please confirm that in the filename "X-X-X" should be replaced with "A-B-C".

A80) The respondent should replace "X-X-X" with "Statewide" for a statewide bid.

Q81) Attachment D
Is DOH/CMS planning to limit provider rates which can be paid by the contractor to the Medicaid fee schedule?

A81) No, provider rates will not be limited to the Medicaid fee schedule for services for which the contractor is at-risk.

Q82) Attachment D
Experience has shown that costs for CMS-eligible children vary dramatically, from $28,000 per month for children requiring Private Duty Nursing, to $9,000 per month for children in nursing facility, to children whose cost of care is similar to the cost of non-CMS children. How do you intend to compensate the CMSN contractor for a distribution of seriously ill children between the CMSN plan and MMA plans?

A82) The capitation rate is based on historical costs of CMS Plan members, including adjustments described in the databook. The capitation rate is projected to be sufficient to cover aggregate costs for all CMS Plan members. Cost and utilization changes will continue to be monitored, including changes from the historical distribution of children between the CMS Plan and MMA plans.

Q83) Attachment D

Are there any other direct or indirect administrative costs for the CMSN that are funded in the Department of Health for CMSN purposes?

A83) The Department's budget does include appropriations for administering the CMS Plan.

Q84) Attachment A-1

Does the CMS Physician Incentive Program follow the same criteria as the AHCA MMA Physician Incentive Program by which only specific provider types may be eligible for enhanced reimbursement (the Medicare equivalent) should they meet qualifying criteria?

A84) No, the CMS Physician Incentive Program specifies mandatory provider types, but the Respondent may propose qualifying criteria.

Q85) Attachment D-1

Was any adjustment to utilization considered related to the Physician Incentive Program as higher reimbursement may increase access to care?

A85) Although higher reimbursement may increase access to care in the longer-term, for the initial rate period CMS and its actuary are not projecting an increase in utilization.

Q86) Attachment A-1

Evaluation Criteria 1. (j) and (k) request that Respondents submit total and total projected medical spending governed under VBP arrangements for relevant lines of business for the most recent fiscal year (2017). Since MCOs may still be in a 2017 run-out period, during which final medical spend governed under VBP arrangements is being calculated, would CMS allow Respondents to instead submit total medical spend governed under VBP arrangements for the most recent closed fiscal year (2016)?

A86) Yes.

Q87) Attachment D-3

'Please confirm or correct the statement that all services (for both Title XIX and XXI) contained within the databook have a Medicaid Fee Schedule amount (as found on the following website: http://ahca.myflorida.com/medicaid/review/fee_schedules.shtml) and that all services were paid for at 100% of the Medicaid Fee Schedule in the base period. If there are exceptions to either of these statements (e.g. all services have an associated fee schedule amount and were paid at 100%) please describe the exceptions so that we can incorporate in our cost proposal.

A87) The databook summarizes the claims. The Medicaid fee schedule was the maximum allowable fee schedule during the historical data period.

Q88) Attachment A-1

Criteria #9 HEDIS measures requests age band 18-21 for certain HEDIS measures. HEDIS technical specifications do not segment this age band. Please confirm that our audited HEDIS can be submitted for this ITN.

A88) Yes, audited HEDIS may be submitted.

Q89) Attachment A-1

Given that the evaluation criteria indicates experience in achieving quality standards for "similar

medically complex children's populations", if a Respondent operates a Child Welfare specialty plan and submitted HEDIS for the Child Welfare population, would DOH/CMS consider the audited rates for Child Welfare population rather than the broader Medicaid population as an acceptable submission?

A89) Yes.

Q90) Please clarify whether the contract formalizing participation in this CMS managed care program will be modified so as to align with the then current SMMC contract.

A90) The Department will use its standard contract, with the scope of work reflecting the requirements of the ITN and as negotiated.

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.