

# COMMONWEALTH of VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES  
600 East Broad Street, Suite 1300  
Richmond, VA 23219

April 26, 2013

## ADDENDUM No. 1 TO VENDORS:

Reference Request for Proposal: RFP 2013-05

Dated: April 10, 2013

Due: May 15, 2013

Below are updates that may delete, add, modify or clarify certain aspects of the aforementioned RFP. Please incorporate as necessary.

**1) See Attachment 1 for the Department of Medical Assistance Services response to questions/inquiries as submitted by potential Offerors.**

Please Note: Some questions may take additional time in order to generate an adequate response. If you do not see a response to a question you have submitted, please monitor the DMAS and eVA website for future addendums.

A signed acknowledgment of this addendum must be received by this office either prior to the due date and hour required or attached to your proposal response. Signature on this addendum does not substitute for your signature on the original proposal document. The original proposal document must be signed.

Sincerely,

*Christopher M. Banaszak*

DMAS Contract Manager

Name of Firm: \_\_\_\_\_

Signature and Title: \_\_\_\_\_

Date: \_\_\_\_\_

**Attachment 1**  
**RFP 2013-05, Addendum 1**  
**Medicare-Medicaid Financial Alignment Demonstration Questions and Answers**  
**\*All responses are subject to change based on final MOU and CMS 3-way contract terms.\***

Question Number	RFP Reference	Page #	Question	Response
1	Letter to Prospective Offeror	3	The applicant letter indicates that questions are due on April 19. When can applicants expect to receive answers from the state?	April 26, 2013.
2	1.1	9	Can the State provide more information on how passive enrollment will occur? In order to staff to perform the HRAs within the required timeframes, it would be very helpful to understand how many individuals will be passively enrolled and during what timeframes. If passive enrollment is phased-in in a geographic region over a period of months, this will make the HRA process much more manageable.	<p>As currently plans: Phase I will begin January 1, 2014 and will include the Tidewater and Central Virginia regions. Phase II will begin in May 1, 2014 and will include Roanoke, Northern Virginia and Charlottesville/West regions. Each phase will begin with a 90 day opt in only period, meaning that eligible individuals must actively choose to enroll. After the 90 day opt in only period is complete, passive enrollment will begin, where people who do not choose to opt out will be enrolled, but everyone can disenroll or change MCOs at any time during the Demonstration. This plan is subject to Participating Plans meeting CMS and DMAS' requirements, including successfully passing the Readiness Review and Plans' capacity to accept new enrollees. Attachment A to this response outlines the enrollment processes and timeframes.</p> <p>DMAS estimates that approximately 79,000 individuals will be eligible for the FAD, but it is unknown how many will opt in, move to passively enrollment and remain in the Demonstration once enrolled. See Page 11 of the RFP which provides an estimate of the number of potential eligibles by region.</p>
3	1.1	9	The RFP indicates that implementation will be phased-in. What are the implementation dates for each region and/or population type?	See response to Question 2.
4	1.1	9	Where in the application should the plan indicate the service areas that it is applying for?	The Offeror will indicate in sections 6.10.1 (Executive Summary) and 6.10.3 (Tasks and Technical Approach) which service area(s) the

Question Number	RFP Reference	Page #	Question	Response
				Offeror intends to apply.
5	1.2	10	Will the state be implementing a stand-alone Medicaid managed care contract with selected plans to provide Medicaid benefits to members that opt out of the demonstration for Medicare? If so, will there be an option for members to opt out of Medicaid managed care altogether?	No.
6	1.2	10	Please describe the methodology and the selection criteria the enrollment facilitator will utilize to assign members to participating health plans.	The methodology and selection criteria are still under review by CMS. When approved, it will be outlined in the final Memorandum of Understanding (MOU) between CMS & DMAS and in the three-way contract.
7	1.6	11	<p><b>“It is estimated that these numbers will increase by approximately one-third by January 2014.”</b></p> <p>This represents a dramatic increase in the number of eligible individuals since Calendar Year 2011. Can the state please provide any additional information about what caused this increase and whether it was across the board in all geographic areas and types of eligible individuals, e.g., nursing home residents? This will assist in our preparations to participate in this program, if chosen.</p>	This estimate was based on historical trends and the overall expected growth of the Medicaid program, and was not estimated by segments of the population.
8	1.7	11	What is the timeline and process the Department envisions for negotiating rates with selected health plans?	The Medicaid rates are targeted to be established and published in the late Summer 2013. There will be an opportunity for selected health plans to review draft rates before they are finalized. CMS will establish the timeline for the Medicare portion of the rates.
9	1.8	11	When does the Department anticipate announcing awards for this RFP?	The Department anticipates announcing the awards in June 2013.
10	1.8	11	What is the significance of including the Medicare Open Enrollment Period in the timeline?	To signify that Medicare-Medicaid enrollees who are potentially eligible for Virginia’s Demonstration will have the opportunity to participate in Medicare’s Open Enrollment period prior to the Demonstration’s effective date of January 1, 2014. Education and Outreach efforts will be timed to work with the Medicare Open Enrollment process to ensure those individuals will be aware of the Dual Eligible Demonstration opportunity beginning in 2014.

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11	2.3	13-14	Why do the provider and member appeal definitions say “Medicaid only”?	At this time, the MOU has not been finalized with CMS to confirm the extent of how the Medicaid and Medicare appeals processes will be integrated. Details will be outlined in the finalized MOU and three-way contract.
12	2.3	13-14	Please confirm that an appeal filed by a provider on behalf of a member is considered a Member appeal.	Confirmed.
13	2.3	20	If the member elects to opt-out of the demonstration, can they remain in the Managed Care Program? If not, do they lose eligibility for LTSS, or can they return to Medicaid FFS for their LTSS benefit?	No, if a member opts-out of the Demonstration, he/she will return to fee-for-service. As long as an individual remains eligible for LTSS, he/she will receive those benefits in the fee-for-service environment if he/she opts out of the Demonstration.
14	2.3	20	Will the Department require MCO’s to contract with particular PERS providers, or is the selection of the provider at the discretion of the MCO?	It is at the discretion of the MCO.
15	2.3	20	Please confirm Offerors may utilize their own Plan of Care format. If a standardized format is required, it is available for review?	Correct, Offerors may utilize their own Plan of Care format as long as the required elements in the Model of Care are incorporated.
16	2.3	20	Will the health plans be responsible for collecting patient pay amounts, rather than the nursing facility? If yes, how will the health plans know the monthly amounts to bill on a timely basis? What are the consequences of non-payment?	DMAS will provide the required patient pay amount to the Participating Plans via the transition report and the Participating Plans will decrease the primary long-term care (LTC) provider’s reimbursement by the patient pay amount. Under the Demonstration, the Participating Plan will determine which LTC provider is deemed the primary provider. When multiple providers are involved in an individual’s care, the Participating Plan will coordinate the patient pay process with the providers. The capitation payment will be net of the patient pay amount. Participating plans will receive a monthly report that will reflect changes in patient pay amounts.  If the patient pay is not paid to the provider, then the provider will not be able to bill the Participating Plan or DMAS for the patient pay amount.
17	2.3	20	May the health plans contract with any PERS provider that needs DMAS standards, or does DMAS have a preferred provider? Please confirm this is a covered benefit for those receiving another EDCD service.	Plans may contract with any PERS provider that meets DMAS’ standards. PERS is a covered benefit under the EDCD Waiver.

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18	2.3	20-21	How will health plans coordinate with the PAS team? Will the health plan be the entity to actually authorize services?	<p>Local and Hospital Preadmission Screening (PAS) Teams will conduct the initial assessment for eligibility for LTSS (including nursing facility, EDCD Waiver, and PACE). While enrolled in the Demonstration, if an individual needs to be screened for LTSS, Participating Plans will refer the individual to a PAS within their area. If the PAS determines an individual meets criteria for LTSS and the individual chooses nursing facility or EDCD Waiver supports, the Participating Plan will work with the individual to authorize necessary LTSS.</p> <p>At program launch, Participating Plans must honor all existing Plans of Care and service authorizations for new enrollees until the authorization ends or 180 days from enrollment, whichever is sooner.</p>
19	2.3	22	Please confirm transition of care (in this context) is limited to repatriation from institutional residency to home and community based services and excludes discharge planning or transition of care from acute care facilities to home.	Transition services included in Section 2.3 of RFP are a specific Medicaid-funded EDCD Waiver service as outlined in 12 VAC 30-120-2010.
20	2.3	22	Will the \$5,000 transition stipend for members in the current FFS program, continue in the demo program? If so, will the plans or the Department be providing this stipend to the members?	Yes, transition services are an EDCD Waiver benefit will be available under this Demonstration per 12 VAC 30-120-2010.
21	2.3	22	Please confirm that the defined scopes of Transition Coordination and Transition Services are not limited only to Money Follows the Person (and therefore not excluded from Demonstration).	Confirmed. Transition coordination and transition services are EDCD Waiver services and are MFP Demonstration services. They are included services under the Duals Demonstration.
22	Section III	23	<p><b>“The Applicant shall provide a detailed narrative of how it will define and perform each of the required tasks listed in this section and cross-reference the application response to each RFA requirement.”</b></p> <p>Will the State please clarify which are the required tasks?</p>	It is expected Participating Plans will respond to all requirements outlined in Section III (Technical Requirements) of the RFP. Participating Plans are expected to outline how they will to meet the technical requirements and provide information that will allow the Department to evaluate the capacity to perform all of the required functions.
23	Section III	23	The RFA asks to identify and provide information on all subcontractors. This broad definition could include many organizations and single individuals. We suggest	This is standard RFP language.

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			narrowing this requirement to “Material Subcontractors” only.	
24	3.1	23	The first bullet in this paragraph refers to Medicare experience and lists the Offeror or it’s parent organization. The second bullet refers to Medicaid experience; however does not indicate if it applies to the Offeror and it’s parent organization. For these questions what is the definition of Offeror? Does the scope of this question encompass the Offeror responding to the RFP, the Offeror’s parent organization and its subsidiaries?	An Offeror is an entity that is offering a proposal in response to this RFP.  Yes, this question encompasses the Offeror responding to the RFP, the Offeror’s parent organization and its subsidiaries. .
25	3.1	23-24	Please confirm that the second bullet asking about Medicaid sanctions is asking only with respect to the actual Offeror, and not also about the Offeror’s parent and/or affiliated companies (i.e. other subsidiaries of the parent company).	See response to Question 24.
26	3.2	24	Is it the Commonwealth's expectation that the Offeror include both LOI and contracted providers?	In the Excel listing, Offerors should include both providers that have signed letters of intent and those that have signed contracts. In #19, of the Excel listing, Offerors should indicate the status of providers’ contracts (letter of intent or signed contract).
27	3.2	24	Please confirm that the Department will provide a member file that includes the number of members within each zip code of each region. If so, when can this be expected?	DMAS will release these data by FIPS code. To comply with HIPAA FIPS that have less than 20,000 individuals will be combined with larger population FIPS. The file is targeted to be released in the first week in May.
28	3.2.1	24	In submitting hospitals on the Microsoft Excel file for which plans have signed letters of intent, should the plans also submit hospitals with full network participation agreements?	Offeror’s should include both (those with signed letters of intent and those with full network participation agreements).
29	3.2.1	24	Does the Department want the requested provider network Excel file per region or on a statewide basis?	Single file. The network analysis will take into consideration the service area/region that the Offeror is proposing and all adjacent localities.
30	3.2.1	24	The RFP states: "Excel: For the purposes of this proposal, plans shall submit letters of intent as well as any existing members of their provider network which the plan believes will participate in the Demonstration." <b>Please clarify:</b> Is it the Commonwealth's intention that	In the Excel listing, Offerors should include both providers that have signed letters of intent and those that have signed contracts. In #19, of the Excel listing, Offerors should indicate the status of providers’ contracts (letter of intent or signed

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			the Offeror submit an actual Letter of Intent for each provider or is it acceptable to simply specify in the EXCEL submission that there is an LOI on file within Column Heading 19. Status of contract (letter of intent or signed contract)?	contract). Offerors do not need to submit actual copies of the letters of intent.
31	3.2.1	24	When will plans be notified of network adequacy percentages relative to the standard for any covered service for which Medicare requires a more rigorous network adequacy standard than the Medicaid standard. Will that occur before readiness review?	Overlapping services should have been submitted to the HPMS for network adequacy evaluation. CMS will evaluate those networks for adequacy.
32	3.2.1	24	It is our understanding that CMS is developing specific network standards for Dual Eligibles. Are these standards going to be used in Virginia? When will plans be notified about what the standards are?	Offeror should direct this question to CMS.
33	3.2.1	24	Please confirm that Offerors are not required to provide copies of signed letters of intent with their proposal submissions.	Correct, Offerors do not need to provide copies of signed letters of intent.
34	3.2.1	24	Please describe how the preliminary network relative to the Medicare/Medicaid standards in this section will be evaluated.	DMAS will evaluate networks for Medicaid services to ensure they meet the needs of the expected population and provide adequate choice for enrollees.
35	3.2.1	24	In reference to the CMS HPMS System mentioned in this section, and that more information is forthcoming, what is the timing around the release of this information? Is the intent that this information would be required prior to the RFP due date, or is it after the RFP and therefore part of the final network review?	Offerors do not need to submit their Medicaid only provider networks through CMS' HPMS system.
36	3.2.1	24	Must Offerors obtain Letters of Intent for potential providers as part of their proposal?	Offerors do not need to submit copies of the signed letters of intent in their proposals. However, in the Excel listing, Offerors should include providers that have either signed a letter of intent or an actual contract. In #19, of the Excel listing, Offerors should indicate the status of providers' contracts (letter of intent or signed contract).
37	3.2.1	24	The RFP requires a Medicaid provider file be submitted in Excel format. Please confirm that the content of the file is limited to those providers where Medicaid is the primary payer.	That is correct.
38	3.2.1	24	What are the Commonwealth's access standards for Medicaid LTSS?	See Section 3.2.4 and 3.2.5 of the RFP.

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39	3.2.1	24	What is the definition of "other services"?	Refer to the DMAS past expenditure data book that was provided on April 23,2013. In response to the network composition section, Offerors only need to include behavioral health and LTC networks. Offerors should explain how they will provide non-emergency transportation services (e.g., subcontract) and how they will contract with FQHCs in their respective sections of the RFP.
40	3.2.1	24	If providers are listed on HSD tables, should they also appear on the Medicaid excel spreadsheet? What provider types should be included in the excel spreadsheet?	Offerors should include providers for historically Medicaid-covered services in the excel table.  Offerors should also submit the hospitals for which they have signed letters of intent or signed contracts. For hospitals only, include information you had to include in HPMS.
41	3.2.1	24	Do we only include providers for which we have an LOI or a signed contract for legacy Medicaid/Medicare? OR are we also including providers that have signed neither, but we believe they will participate in the Demonstration?	Offerors must include preliminary provider networks for historically Medicaid-covered services. Offerors must include providers that have either signed a letter of intent or an actual contract. If a provider has signed neither, they should not be included in the Offeror's response.
42	3.2.1	24	Please confirm that Primary Care Physicians and Medical Specialists do not need to be submitted as part of this Application since Medicare is the historical primary payer for these services.	Confirmed.
43	3.2.1	24	For those Providers that provide services in more than one city or county, should they be listed in multiple rows with each row corresponding to one city or county or should multiple city/county codes be listed in one cell in one row? A sample of a successful submission would be helpful.	To support an unduplicated submission, the provider should only be listed once. If that provider services members from more than one locality, you can list each city or county on that one line.
44	3.2.1	24	Please clarify whether an LOI has to be on file for Providers to be submitted. Section 3.2.1, paragraph 2 states that "Only providers with which applicants have signed letters of intent may be included," but paragraph 4 states that "plans shall submit letters of intent as well as any existing members of their provider network which the plan believes will participate."	See response to Question 41.

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45	3.2.1	24	Will the state please provide guidance on the difference between Provider Type and Provider Specialty?	Provider Types typically are: Ancillary, Specialist, Hospital, Pharmacy, etc. Provider Specialties typically are: Free-Standing Ambulatory Surgery Center, Cardiologist, Acute Inpatient Care, etc. Provider types may not have a specialty (e.g., Adult Day Health Care).
46	3.2.1	24	Please confirm the Department does not want physical copies of LOIs, but rather wants Offerors to include an LOI indicator on the Network File. Also, please confirm the Network file should include only providers with a signed LOI and providers who are contracted to provide services under this program.	Offerors should include which providers they have LOIs with, not actual copies of the LOIs. The network file should contain providers with signed LOIs and those who are contracted.
47	3.2.1	24-25	Please confirm how the Medicare and Medicaid Networks will be scored. Is the Network Section 3.2 part of the evaluation criteria?	CMS will evaluate the Medicare networks. DMAS will evaluate Offerors' Medicaid services networks for adequacy as described in Sections 3.2.4 & 3.2.5 of the RFP. DMAS will use GeoNetworks to evaluate the network for historically Medicaid-covered services and hospitals based on criteria outlined in the RFP.
48	3.2.1	24-25	If a specific provider will provide both Medicare covered services and Medicaid covered services, should Offerors list the provider in the required Excel file (even though the provider is already included in the HPMS file)?	If a provider provides Medicaid-funded LTSS or behavioral health services in addition to Medicare services, include them in the network. Otherwise, if the provider has been submitted to HPMS, they do not need to be resubmitted in response to the RFP.
49	3.2.1	24-25	Please provide clarification regarding the difference between "Provider Type" and "Provider Specialty" required in the Excel listing.  Are we limited to three Provider Types as noted in items 3-5 (i.e., Provider type1, Provider Type 2, Provider type 3)?	See response to Question 45.  Do not add or delete columns.
50	3.2.1	25	Will DMAS release additional file layout specifications for the provider network Excel spreadsheet for?	No.
51	3.2.1	25	#14. Geographic area served: can one provider be listed with multiple FIPS? For example, Dr. Smith's office is in Hanover County, but he also services the neighboring county of Henrico.	To support an unduplicated submission, the provider should only be listed once. If that provider services members from more than one locality, you can list each city or county on that one line.
52	3.2.1	25	For organizations such as Adult Day Care, Personal Health etc. how should these entries be entered, e.g.,	For any/all facilities or ancillary providers place the full name in the Provider Last Name column.

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			enter them into the Provider First name/Provider Last name columns?	
53	3.2.1	25	Will DMAS provide additional guidance as to the definition of Provider Type vs. Specialty? What would be an acceptable Provider Type and Specialty?	See response to Question 45.
54	3.2.1	25	For multiple geographic locations (#14) how should those be displayed? Should they be entered with multiple FIPS codes in one cell or should each be entered into its own cell?	Multiple FIPS codes should be entered into one cell.
55	3.2.1	25	For Offerors bidding on multiple regions, should a single file be submitted? If so, how should Offeror's arrange the data?	Single file. The network analysis will take into consideration the service area/region that the Offeror is proposing and all adjacent localities.
56	3.2.1	25	Mapping is typically performed using physical locations; however some services such as personal care are provided by individuals who travel to member locations distant from their physical address. How should these services be mapped?	For the mapping software (GeoNetworks) a single location is used (the actual location of the provider). For providers that travel to a member's location, a physical address will still be needed; however, DMAS' analysis will take into account provider networks that cover significant distances from physical addresses. Offerors should note distance differences from what is outlined in the RFP and why.
57	3.2.1	25	#18. Can we insert multiple columns if a provider speaks different languages (i.e., more than one non-English language)?	No. Do not add or delete columns. All files need to be formatted the same. If a provider speaks more than one language, use the one defined space to include all spoken languages (except English as that is assumed).
58	3.2.1	25	#19. Please provide clarification on "status of contract." Do we indicate: letter of agreement or signed contract only? Or do we include "intended provider"?	In the Excel listing, in #19, Offerors should indicate the status of providers' contracts (letter of intent or signed contract).
59	3.2.1	25	Do we have to map ONLY the 19 specialties listed on page 25 under the title " <b>Mapped?</b> "	Yes.
60	3.2.1	25	May we combine services where appropriate? For example, Community Service Boards (CSBs) provide many of the services listed on page 25: crisis intervention, crisis stabilization, psychosocial rehab, etc. If we indicate clearly on a key that all these services are provided by the CSB, can we only map the one CSB for multiple services? Example two: One Home Care agency provides respite and personal care. Can we map the one agency and	The file layout allows for up to three Provider Types and/or three Provider Specialties to be defined. Overall, keep in mind UNDUPLICATED list of providers. It is expected that a provider or organization will be listed once, per location.

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			address in the key that it is for personal care and respite?	
61	3.2.1	25	<p>On the Provider Network Composition (3.2.1) submission - would it be possible to not include the following items:?</p> <p>15. Office Telephone Number 16. Tax ID number 18. Additional language abilities</p> <p>The reason for this request is that we have already provided provider tables for the CMS Application that do not include these fields. We can certainly provide these fields in time for the Readiness Reviews, but inclusion of these fields for the RFA will require re-working already created tables.</p>	<p>In response to the RFP, Offerors must submit all providers and potential providers for historically Medicaid-covered services. Plans must submit an electronic listing using Microsoft Excel and a mapped version of their preliminary network. To successfully complete this task, Offerors must include all the information included in Section 3.2.1, including office telephone number, tax ID number, and additional language abilities.</p> <p>Offerors must also submit the hospitals for which they have signed letters of intent. Since plans had to submit their intended hospital networks through HPMS, in response to the RFP, Offerors may submit the same hospital information that was included in HPMS.</p>
62	3.2.1	25	<p>Section 3.2.1 states, “Mapped: In addition to the Excel submission, plans shall also submit a separate mapped version of their proposed network by region (using network mapping software) for the following services...” Please confirm that Applicants may submit the maps electronically.</p>	<p>Yes, if the mapping software used can be opened and read by the State. DMAS uses GeoNetworks. Otherwise, send the maps converted/imported into another tool, like PowerPoint, for example.</p>
63	3.2.1	25	<p>Please confirm that, at this time, preliminary provider networks for historically Medicaid-covered services will only be provided to the state in the Excel format. They should not be submitted to the CMS HPMS system at this time and will be submitted only if direction is given from CMS.</p>	<p>Confirmed.</p>
64	3.2.2	26	<p>Do we need to provide proof that we have performed the criminal records check as a part of the application? If so, where?</p>	<p>Offerors should provide a detailed narrative of how it will perform this task in response to Section 3.2.2 of the RFP.</p>
65	3.2.2 & 3.7.7	26 & 42	<p>Section 3.2.2 discusses criminal records checks and section 3.7.7 discusses the Department will pay the F/EA administrative fees. Please clarify who pays for Consumer Directed employees’ background checks (the participating plan or the F/EA)? Is there a limit to the number of background checks per enrollee for each need?</p>	<p>The Participating Plan will pay the administrative fee. There is no limit on the number of background checks per enrollee. An assistant must go through a new background check every time the assistant is hired by a new enrollee. This will be finalized during the three-way contract.</p>

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66	3.2.2	26	Section 3.2.2, a requirement in this section states, “For consumer-directed services, the participating plan shall be responsible for conducting criminal records checks.” It’s our understanding that the current process for consumer-directed services has the employer complete the request for criminal record checks and submit them to the fiscal agent contracted by DMAS for processing. The fiscal agent then processes criminal records checks and child protective services checks and notifies CD employer of results. The RFA requires that “The Department will contract with a consumer-directed F/EA and participating plans shall use this F/EA as the F/EA for their enrollees and the Department will pay the F/EA administrative fees directly to the contracted F/EA.” Please clarify 1) whether the F/EA will continue to process the criminal record checks; and 2) the requirement in the RFP that states the participating plan is responsible for conducting criminal record checks in addition to the F/EA check?	Yes, the F/EA will continue to process criminal record checks on behalf of the employer (enrollee) for consumer-directed services. The Participating Plan is responsible for conducting criminal record checks when they are directly hiring staff; otherwise, they are responsible for ensuring this is performed through their credentialing process. This will be finalized during the three-way contract.
67	3.2.2	26	Section 3.2.2, in the Final Proposal DMAS submitted to CMS, DMAS included that “Under the Demonstration, MCOs will have the option of subcontracting or directly providing F/EA services and service facilitation.” The DMAS RFP is clear that MCOs will need to use the fiscal agent contracted by DMAS. However, it does not mention service facilitation. Do MCOs still have the option to subcontract service facilitation or directly provide?	MCOs will have the option of subcontracting or directly providing service facilitation services.
68	3.2.3	27	Please specify whether or not Psychiatrists (MDs) need to be included in our network submission. Psychiatrists were included in our submission in HPMS.	Yes, Psychiatrists can be included in a health plan’s network submission to demonstrate network sufficiency for Medicaid funded behavioral health services.
69	3.2.3	27	Please provide a definitive listing of all provider types required for the Behavioral Health Network.	<ul style="list-style-type: none"> <li>• Psychiatrists</li> <li>• Clinical Psychologists</li> <li>• Licensed Clinical Social Workers</li> <li>• Licensed Professional Counselors</li> <li>• Licensed Marriage &amp; Family Therapists</li> <li>• Psychiatric Clinical Nurse Specialists</li> <li>• Substance Abuse Practitioners</li> </ul>

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				<ul style="list-style-type: none"> <li>• Community Mental Health Rehabilitative Service providers</li> <li>• 6 private mental health hospitals <ul style="list-style-type: none"> <li>• Dominion Hospital</li> <li>• Poplar Springs Hospital</li> <li>• Virginia Beach Psych Center</li> <li>• Snowden at Fredericksburg</li> <li>• Riverside Behavioral Health Center</li> <li>• Kempsville Center for Behavioral Health</li> </ul> </li> <li>• 40 Community Services Boards/Behavioral Health Authorities (see <a href="http://vacsb.org">http://vacsb.org</a>).</li> </ul>
70	3.2.3	27	<p>Section 3.2.3, This section states, “Participating plans shall be required to have an adequate network of behavioral health and substance abuse providers to meet the needs of the dual eligible population, including their community mental health rehabilitative service needs (see Appendix C).” Appendix C includes the following services: Substance abuse targeted case management, Substance abuse crisis intervention, Substance abuse day treatment, Substance abuse intensive outpatient treatment and opioid treatment. However, Appendix F states, “The plan shall cover substance assessment and evaluation and outpatient services for substance abuse treatment for individuals enrolled in the Dual Demonstration. Emergency counseling services, intensive outpatient services, day treatment, opioid treatment, and substance abuse case management services are carved-out of this contract and shall be covered by the Department. Transportation and pharmacy services necessary for the treatment of substance abuse, including for carved out services, shall be the responsibility of the plan.” Please clarify whether substance abuse targeted case management, substance abuse crisis intervention, substance abuse day treatment, substance abuse intensive outpatient treatment and opioid treatment are carved into the MCO benefit?</p>	<p>We apologize for the discrepancy in Appendix F. Appendix C is correct in that substance abuse targeted case management, substance abuse crisis intervention, substance abuse day treatment, substance abuse intensive outpatient treatment and opioid treatment are included in the health plan benefit and will be the health plan’s responsibility to administer.</p>
71	3.2.4	27	<p>#1. Can we do Medicaid access standards by region? For example, Roanoke currently has 12,771 eligibles.</p>	<p>Time and distance standards will continue to apply. DMAS will provide to Offerors the number of dual</p>

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			This is anticipated to grow by 33%. Members in a region require a choice of two community-based providers? Can we calculate this by region? Or how do we calculate?	eligibles within in each region at the locality level by May 1, 2013 to assist with this process. DMAS expects plans to create robust provider networks, which will be finalized during the readiness review process. See question #27.
72	3.2.4	27	Would the state consider not requiring the same access standards for Home Health Providers and Skilled Nursing Facilities as the rest of the EDCD-Waiver Service Providers since Members do not have to travel in order to receive these services?	Yes.
73	3.2.4	27	How will the State evaluate the nursing home network if nursing homes choose not to participate in the program?	DMAS will evaluate Offerors' proposed networks using the travel time and distance standards outlined in the RFP.
74	3.2.4 & 3.2.5	27-28	Please confirm time and distance standard do not apply to services delivered in the home, such as Personal Assistance, Respite, and Personal Emergency Response systems	Time and distance standards will not apply to Personal Emergency Response Systems. DMAS will evaluate proposed access standards for Respite and Personal Assistance services in addition to the time and distance standard.
75	3.2.4	27	Please confirm that the Department will provide enrollment by eligibility category (EDCD, ABD, etc.) for each region. If so, when can this be expected?	The Department will provide a count of dual eligibles by region to Offerors by May 1, 2013.
76	3.2.5	28	GeoAccess does not distinguish time between normal traffic conditions vs. commuting hours; it does however distinguish "estimated driving distance" vs. "as the crow-flies distance." Please confirm that "estimated driving distance" is an acceptable travel distance standard.	Yes, estimated driving distances is an acceptable travel distance standard.
77	3.4	28	This section indicates that the credentialing/recredentialing policies and procedures will be outlined in the three way contract. It has been our understanding that these standards will either be in line with NCQA or, if not specified by NCQA, then the requirements outlined in the specific provider manuals as referenced on pages 25-26.  If there are going to be different or additional guidelines/policies/procedures outlined in the three way contract will we have this information in time to include in our contracts with our network and to complete the	This will be finalized in the three-way contract; however, details of credentialing standards for Medicaid services will be determined this summer in order to meet the necessary contracting timeline. Credentialing standards will be based on NCQA and DMAS provider manuals and regulations.

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			contracting and credentialing process?	
78	3.5	28-30	In light of the fact that CMS has not finalized the requirements regarding transmission of eligibility and enrollment files, does the Department have an established policy regarding transmission of eligibility and enrollment files? If so, please provide. If not, is the Department looking for Offerors to suggest an approach?	The process for the transmission of eligibility and enrollment files will be based on CMS requirements and outlined in the three-way contract. The Department is not requesting input on this process at this time.
79	3.5.1	28	If a plan identifies a dual demo enrollee needing LTSS services, how will LTSS eligibility be established with the Department?	The Plan will refer the individual to a local or hospital Preadmission Screening (PAS) Team to conduct the initial assessment for eligibility for LTSS (including nursing facility, EDCD Waiver, and PACE).
80	3.5.2	28-29	Individuals in State Hospitals are excluded from this demonstration per Section 3.5.2, Paragraphs 4 and 5. Will MCOs be notified when dual-eligible individuals are being discharged so that community-based treatment planning can begin prior to discharge?	<p>No, because these individuals will not automatically become enrolled in a Participating Plan upon discharge. When enrollees no longer meet the criteria for exclusion from the Demonstration, they will be passively enrolled in the Demonstration (if they meet all the eligibility criteria). Under the Demonstration, after the opt-in period is completed, newly eligible individuals will be placed in pre-assignment on a monthly basis. Those who are included in pre-assignment will be eligible the 1<sup>st</sup> day of the 2<sup>nd</sup> month after pre-assignment.</p> <p>When an individual is discharged from the State Hospital, the Community Services Board generally will establish the initial discharge plan. If the individual is eventually enrolled in a Participating Plan, the Plan should work with the CSB to coordinate the continuation of services.</p>
81	3.5.2 & 4.2	29 & 46	<p>In Section 3.5.2 Excluded Populations, item #4 explains that individuals who are inpatient at a state mental hospital are ineligible. However, in section 4.2, Recoupment and Reconciliation, it indicates that capitation will not be recouped in cases in which an enrollee is eligible for any portion of the month.</p> <p>1. Does this mean that members inpatient at state hospitals are temporarily disenrolled if they are in the state hospital for any given calendar month? Or does it</p>	<p>1. Enrollment and disenrollment for this situation will be clarified in the three-way-contract.</p> <p>2. Enrollment and disenrollment for this situation will be clarified in the three-way-contract</p> <p>3. See response to Question #80.</p>

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			<p>mean that admission to a state hospital makes a member categorically ineligible for the demonstration?</p> <p>2. Please clarify the dis-enrollment and re-enrollment standards for members who no longer meet an exclusion criterion.</p> <p>3. Similarly, if a member is inpatient at a state hospital at the initiation of the demo, we understand that the member will be initially ineligible. Upon a successful transition to the community, is the member immediately eligible for the demonstration?</p>	
82	3.5.2	29	#13: Please confirm you intend to exclude duals enrolled in Money Follows the Person program. Typically the health plans would assist in repatriation and provide oversight to ensure appropriate services are provided to facilitate a successful transition.	Correct, Money Follows the Person Program participants will be excluded from the Demonstration.
83	3.5.2 & 3.7.1	29 & 40	<p>Since individuals who elect hospice will be disenrolled from the demonstration, is it correct that the Medicare and Medicaid hospice benefits are not covered (paid for) by the health plan but are carved out and arranged by the health plan?</p> <p>"However, plans shall refer these individuals to the EDCD Waiver pre-admission screening team for additional LTSS." Please confirm when DMAS will disenroll the member. Will DMAS retro disenroll the hospice members from the time they began hospice or will the plan need to reimburse for hospice services from the time the member starts services until the time DMAS disenrolls the member from managed care?</p>	Individuals who need hospice services mid-month (i.e., before the individual moves to FFS to receive the Medicare hospice benefit) should be referred for hospice services, however, expectations for coordination and payment of these services during that month will be further defined in the three-way-contract.
84	3.5.2	29	#5: Please confirm members in LTSS services who require Long Term Acute Care (LTAC) services (i.e., respirator weaning, rehabilitative services, etc.) are disenrolled from the demonstration.	Virginia does not cover LTAC services in Virginia; however, specialized care enrollees who live in nursing facilities will be covered.
85	3.5.2	29	#5 reads, "Dual eligible individuals who are institutionalized (State Hospitals; ICF/MR facilities; Residential Treatment Facilities; long stay hospitals).	Residential Treatment Facilities are another term for Psychiatric Residential Treatment Facilities, which serve individuals 21 years of age and under. Section

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			Note that dual eligible individuals residing in NFs will be enrolled in the Demonstration.” Please clarify how residential treatment is being defined. Does this exclusion apply to pregnant women? (Note that in section 3.2.1, residential treatment for pregnant women is listed as a service requirement).	3.2.1 refers to Section 12 VAC 30-50-510 which describes substance abuse residential treatment services for pregnant woman, which is a community-based service for women with substance use disorders.
86	3.6	30	We believe that we are not required to submit a newly-written Model of Care (CMS questions), but would appreciate confirmation of this from the State.	Plans must submit the Model of Care that was submitted to CMS and address all the Virginia-specific elements.
87	3.6	30	We believe that this is not meant to indicate that we must re-submit to CMS the MOC that we submitted in April and that was already scored by NCQA, but would appreciate confirmation from the State.	That is correct. Plans do not need to resubmit a MOC to CMS that incorporates the Virginia-specific elements.
88	3.6	30	Please confirm the previously established NCQA CMS scores will be the base for the Model of Care evaluation with added scoring for the added VA RFP specific elements.	Confirmed.
89	3.6	30	Please confirm Offerors should add to the CMS approved MOC only where the RFP has added new Virginia specific requirements.	See response to Question 86.
90	3.6	31	<p>It is our interpretation that we should submit our Model of Care, as submitted and accepted by CMS, and respond to the state-specific questions, if any, at the end of each of the 11 elements, and then address the additional state elements. Is this correct? Or do we need to submit the state-specific responses as a separate document?</p> <p>Can we assume that the evaluator will read the response that was included in the CMS application before reading the response to the state-specific question? Or do we need to repeat the information from the CMS response? For example, on page 34, #7e, we are asked to discuss how the plan will ensure that initial HRAs are conducted. Can we build on the description in our CMS response in order to respond to this question, or do we need to repeat the information from the CMS response? Another example is on page 35, #h1: most of this is addressed in our response to the CMS MOC. Can we</p>	<p>Plans should submit their MOC, as submitted and accepted by CMS, and build upon its response to incorporate the Virginia-specific elements.</p> <p>The evaluators will read the MOC that is included in the plan’s response to the RFP. The review team will not refer to what was submitted through HPMS for the MOC review. The review team will focus on the Virginia specific elements, however, it will need the additional MOC information in order to conduct a complete review.</p>

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			build on this response and just address the relationship to targeted case management in our state-specific response?	
91	3.6	31	<p><b>“Plans shall demonstrate in their responses that they have staff experienced in person-centered practices and how they will provide ongoing staff training on these principles. In addition, Applicants will demonstrate that they have the infrastructure and systems in place to monitor the delivery of person-centered care management.”</b></p> <p>It is our impression that this is introductory language that describes the requirements of our Model of Care and that we addressed these issues in the Model of Care that we submitted to CMS. Please clarify if this is the case, or if this requires a response.</p>	That is correct. This is introductory language that describes the Model of Care requirements and the elements that will be addressed in the Model of Care.
92	3.6	32	In each region, what is the current case mix ratio between members permanently residing in the nursing facility vs. those residing in the community?	Please refer to the table in Section 1.6 of the RFP.
93	3.6	33	Is a response required related to the statement that State staff may plan to attend Model of Care trainings?	Plans must acknowledge their understanding that State staff may attend MOC trainings.
94	3.6	33	#7: MCO’s are required to utilize the Department’s standardized assessment and level of care tools. Please confirm that MCOs will be able to utilize their own care management software/IT systems.	<p>In their responses, Offerors need to describe the health risk assessment tool they intend to use. DMAS is not proscribing a standardized assessment tool. However, for EDCD Waiver participants, Participating Plans need to conduct annual face-to-face assessments (functional) for continued eligibility for the EDCD Waiver and Plan of Care review. The Level of Care (LOC) annual reassessment must include all the elements on the DMAS 99-C LOC Review Instrument for individuals who are in the EDCD Waiver (available at: <a href="https://www.virginiamedicaid.dmas.virginia.gov/wps/portal">https://www.virginiamedicaid.dmas.virginia.gov/wps/portal</a>).</p> <p>Participating plans will be required to submit LOC reassessment data to DMAS in a file format and timeframe that will be specified in the three way</p>

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				contact.
95	3.6	34	#F & G: We are required to perform assessments within 60 or 90 days depending on population and reassessments within 365 days. In the event that the Health Plan is unable to perform the assessment, what are the DMAS expectations? Are there number of attempts requirements, bad telephone number responsibilities, etc?	<p>It is expected participating plans will need to work with service providers to arrange to meet with the enrollee.</p> <p>For individuals receiving LTSS: These individuals are receiving in home or facility based LTSS care and should not be difficult to find.</p> <p>For community well: Attempts to contact the enrollee should be documented and DMAS must be notified if the enrollee is unreachable.</p> <p>Processes will be outlined in the three-way –contract.</p>
96	3.6	34	#8: Once a Plan is awarded a contract, how will they receive the POCs of enrollees currently in the waiver programs? Please describe the expected timing of the transfer.	This will be described in the three-way contract.
97	3.6	34	#H: What are the health plan responsibilities/requirements to perform LOC reassessments on nursing facility (NF) residents in the event that the NF does not allow the Health Plan staff to perform the assessment?	Participating plans are required to ensure LOC reassessments are conducted for all enrollees, even if the provider is not in the network. Medicaid providers, regardless of their network status will be required to work with Participating Plans to ensure LOC reassessments are completed in a timely manner.
98	3.6	35	#8: Is there a standardized format for the POC? If so, can this be provided? Additionally, if there is a standardized format, please confirm Plans are allowed to expand the POC.	This question applies to the Model of Care (MOC). There is no standardized format for the POC but elements for the Model of Care must be included. Refer to Section 3.6 of the RFP for specific elements required.
99	3.6	35	Please confirm enrollees will have the option to move from the NF to the community through either the MFP program or within the Managed Care Transition Model.	Confirmed.
100	3.6	35	Model of Care element 8.h.4 indicates that those individuals in nursing facilities wishing to move into the community “will be referred to the Money Follows the Person Program MFP”; however, the MFP Program enrollees are excluded from the demonstration. Please clarify how members who do enter the MFP program will be handled relative to their Demo MCO before,	Before an enrollee enters the MFP Program, he/she will remain enrolled in his/her Demonstration MCO. Participating Plans will need to ensure that enrollee in nursing facilities who wish to move to the community get referred to the preadmission screening teams as appropriate and/or the MFP Program. If the enrollee enrolls in the MFP Program, he/she will be

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			during, and after their 12 month MFP eligibility.  Please confirm the members retain the choice to stay with the health plan or can choose the MFP program for community repatriation.	disenrolled from the Demonstration. After the enrollee's 12 months of MFP eligibility are up, if he/she continues to meet the eligibility criteria for the Demonstration, he/she will be eligible to re-enroll in the Demonstration.  Confirmed. It is the individual's choice to enroll in the MFP Program or remain enrolled in his/her Demonstration MCO.
101	3.6	35	#F: The Commonwealth will send us prior authorizations for community-based services. We will bump that list up by provider and outreach the providers to ensure that members are receiving services from them, and the number of hours is correct. Since the Commonwealth is telling us that we must continue services for either the authorization end date or 180 days, what do we do when we find that the needs of the enrollee differ from the authorization?	A plan can implement a revised plan of care sooner than 180 days from an enrollee's enrollment if a significant change occurs with the enrollee since the previous authorization or upon documented request by the enrollee, their legal representative, or the EOR for consumer-directed services. This will be further outlined in the three way contract.
102	3.6	35	Element 8.f: Please clarify if the clock starts for the 180 days at "enrollment" or "effective date". From the definition "enrollment" could be prior to the effective date.  How will a plan know what a member's "enrollment" date is as outlined in the definition?	It is the effective date of enrollment (the 1 <sup>st</sup> of a month). Some existing service authorizations may end prior to the 180 day period.
103	3.6	35	Element 8.g: For subsection g., similar to above, do the timeframes really mean from "enrollment" date or "effective date"? These terms seems to be used interchangeably but by definition are distinct. Please clarify.	See response to Question 102.
104	3.6	37	Element 11.g: Is this simply an acknowledgement (as it states in the sentence) or is the State looking for plans to describe how they will meet this?	Offerors need to attest that they will meet the state's expectations outlined in 11.g. Offerors do not need to describe how they will meet these requirements.
105	3.6	37	In the RFP the new element for 12.a. asks the MCO to describe how the plan will ensure that communication of an admission or discharge will be conveyed to the PCP, care manager and home and community-based providers within 24 hours. Is the 24 hour requirement based on	It is based on calendar days.

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106	3.6	38	<p>business days or calendar days?</p> <p>The RFP states the following:            "Describe any innovative arrangements the plan will use to provide care management. Plans are strongly encouraged to partner and/or contract with entities that currently perform care management and offer support services to individuals eligible for the Demonstration. This flexibility includes the use of innovations such as health homes, sub-capitation, shared savings, and performance incentives. Entities can include, but are not limited to Community Services Boards (CSBs), adult day care centers, and nursing facilities."</p> <p><b>Question:</b> This element is titled "Partnering with Community Care Management Providers". Adult day health and nursing facilities are not typically considered "community care management providers". Given CMS' attention about "conflict free care management", will CMS allow managed care plans to delegate care management to service providers? Does the Commonwealth have a list of "community care management providers" that are not Medicaid service providers?</p>	<p>Participating plans are expected to coordinate care management responsibilities with appropriate community care partners. However, participating plans will continue to be responsible for ensuring oversight and monitoring of the enrollee's Plan of Care.</p> <p>Examples of community care partners are listed in the RFP. It is the responsibility of the Offeror to be innovative and flexible in developing and describing the partnering relationships with community providers. For the purposes of this RFP, this may include nursing facilities and adult day health centers for those enrollees who utilize these services.</p>
107	3.6	38	<p>The RFP states:            "Describe any innovative arrangements the plan will use to provide care management. Plans are strongly encouraged to partner and/or contract with entities that currently perform care management and offer support services to individuals eligible for the Demonstration. This flexibility includes the use of innovations such as health homes, sub-capitation, shared savings, and performance incentives. Entities can include, but are not limited to Community Services Boards (CSBs), adult day care centers, and nursing facilities."</p> <p><b>Question:</b> Is it the Commonwealth's intent that we include these types of organizations listed above in our care management plan?</p>	<p>Yes. See response to Question 106.</p>
108	3.6	38	<p>The RFP states the following:            "Describe any innovative arrangements the plan will use</p>	<p>Interpret the term "support services" as services and supports.</p>

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			<p>to provide care management. Plans are strongly encouraged to partner and/or contract with entities that currently perform care management and offer support services to individuals eligible for the Demonstration. This flexibility includes the use of innovations such as health homes, sub-capitation, shared savings, and performance incentives. Entities can include, but are not limited to Community Services Boards (CSBs), adult day care centers, and nursing facilities."</p> <p><b>Question:</b> What is the Commonwealth's definition of "support services"?</p>	
109	3.6	39	The Department and CMS have very extensive and comprehensive POC requirements for Nursing Facility members. Please confirm documentation or POC review/concurrence by the MCO is sufficient for replication of the POC in the NF.	The elements of the MDS can serve as the POC. Please see the definition of POC in the RFP for further guidance.
110	3.6	30	Is it correct to assume that the Model of Care should be submitted as an Attachment to the application?	It should be submitted in the body of the response, in accordance with Section 3.6 (Model of Care).
111	3.6	30	The RFP states plans must include a detailed description of the Model of Care (MOC) and multiple examples that are varied to address the needs of the population defined in Element 1. Should Applicants incorporate these descriptions and multiple examples into the attached MOC or provide a separate narrative description of the MOC, along with additional examples within the narrative to address Section 3.6 requirements?	The examples should be embedded in the Model of Care that is submitted in response to Section 3.6.
112	3.6	35	<p>Element 8(h)(4): The MOC state-specific element asks the plan to describe how the organization will ensure that individuals in nursing facilities (NFs) who wish to move to the community be referred to the Money Follows the Person (MFP) Program. Please clarify which members in NFs should be referred. Is referral limited to NF residents with a length of stay or anticipated length of stay equal to the MFP Program eligibility requirement (6 months or longer)?</p> <p>If a resident declines referral, is the plan required to make the referral?</p>	<p>Please refer to the September 16, 2011 Medicaid Memo that outlines the eligibility rules for the MFP Program. The Medicaid Memo can be accessed at <a href="https://www.virginiamedicaid.dmas.virginia.gov/wps/portal">https://www.virginiamedicaid.dmas.virginia.gov/wps/portal</a>.</p> <p>No.</p>

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			Please confirm that members will have the choice of participating in MFP (if they are eligible) or may remain enrolled in the plan and transition to the community with assistance from the plan (transition planning, authorization of transition supports, etc.).	Confirmed.
113	3.7.1	40	This section mentions hospice as a covered benefit. In 3.5.2.7 it states that hospice utilizers are excluded. Which is the case?	Enrollees who choose to elect the hospice benefit will be disenrolled from the Demonstration. However, enrollees who have a terminal condition who do not elect the hospice benefit could still remain in the Demonstration and choose to receive services and supports from the Participating Plan.
114	3.7.1	40	Coverage or arrangement of hospice services is listed. Please clarify that the plan would be responsible for arranging not covering hospice services.	Correct. The Participating Plan is responsible for arranging hospice services if they enrollee chooses the hospice benefit.  Also see the response to question #83.
115	3.7.2	40	Can you please provide some additional detail on what we are expected to discuss in response to this requirement? Do we need to discuss every Medicaid service and how it will be delivered?	The Offeror's response to this section needs to be sufficient to the Department that the Offeror understands Medicaid-funded services that are available and how they will be provided to enrollees as needed.
116	3.7.2	40	In this section you state: "Each offeror's response to this RFA shall provide a description of the understanding of each service and how services shall be provided." Please provide more detail on the degree to which you wish services described, e.g. level of care criteria specific to service, types of providers utilized, etc.	See response to Question 115.
117	3.7.2	40	Please provide a file with a comprehensive list of Medicaid covered services. If not, is there a specific source where this can be found, and will it be provided? If not, please provide guidance on how to determine which services to include.	Please see Appendices C, F and G of the RFP for additional guidance.
118	3.7.2 & 3.7.8	40 & 42	Should the Behavioral Health services that would also be covered under Medicaid Services in section 3.7.2 be excluded from this response list?	Offerors are expected to include behavioral health services in this section.
119	3.7.3	41	Since CMS does not allow telemedicine in the Medicare fee schedule except in underserved rural areas, please clarify how the Department anticipates this will work	DMAS is working with CMS to address this concern.

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			with the integrated 100% Medicare plans filed by bidders.	
120	3.7.3	41	Will the Commonwealth be seeking a Waiver from CMS on Medicare's limitations on the use of telehealth services?	See response to Question 119.
121	3.7.4	41	Please provide a comprehensive list of Medicaid medications and products that should be considered covered within the requirements outlined in section 3.7.4 (i-iv) to ensure inclusion in our formulary submission and response to this RFP section. Also, please provide corresponding NDCs for these in excel format, if possible.	The Department will release this information as soon as it becomes available.
122	3.7.4	41	Will the data book that DMAS intends to release include formulary utilization data? If not, please provide this data (in excel format if possible), or provide an alternate source to find this data.	Yes, the data book includes pharmacy expenditures during the base data period.
123	3.7.4	41	Please provide a list (in excel format if possible) of which companies are approved under Virginia's Medicaid rebate program, along with their 5 digit manufacturers code.	The Department has a Preferred Drug List, which may be accessed at the following link: <a href="http://www.dmas.virginia.gov/Content_atchs/pharm/pdl-20130304.pdf">http://www.dmas.virginia.gov/Content_atchs/pharm/pdl-20130304.pdf</a> .
124	3.7.4	41	Please clarify when DMAS will provide plans with a list of these drugs that are not covered by Medicare Part D.	See response to Question 121.
125	3.7.5	41	Section 3.7.5, item e, states, "DMAS will publish Medicaid rates by nursing home based on current effective rates or the most recent effective rates inflated to the contract period." When will DMAS publish these rates? Will they be available to applicants prior to the RFP response timeline?	The current nursing home rates were sent out to interested Health Plans when the RFP was published. If a Health Plan did not receive this information please send an email to <a href="mailto:dualintegration@dmas.virginia.gov">dualintegration@dmas.virginia.gov</a> and request a copy.
126	3.7.5(e)	41	<b>"Plans will be required to pay not less than the Medicaid rate for Medicaid covered days."</b>  Please clarify what constitutes a "Medicaid-covered day." Are the days that the plan is required to cover in 3.7.5(b) that were previously covered by Medicare to be considered Medicaid days?	Medicare covers a limited number of nursing facility days. "Medicaid-covered days" are defined as those after an individual's Medicare nursing facility coverage ends (e.g., beyond day 100). This will be further defined in the three-way contract.
127	3.7.5	41	Plans are required to contract with all nursing facilities (NFs) eligible to participate in Medicare and Medicaid who are willing to accept the plan's payment rates and	Yes. Participating Plans must notify DMAS prior to termination of a nursing facility for quality of care concerns.

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			contract requirements. During the course of the Demonstration, will plans be permitted to terminate a NF from the network for poor quality of care?	
128	3.7.7	42	Please provide the current Service Level Agreements between the Department and their F/EA (i.e., turnaround time from referral to services being performed through member's employee, support broker services, etc.).	Service level agreements are included in the response (Attachment B). The service level agreements between the F/EA and DMAS will be the responsibility of the Department.
129	3.7.7	42	If a plan has done research on or has lessons learned from other plans/organizations on consumer directed services can the plan respond?	Offeror's can discuss research and lessons learned, but the proposal must include how the Offeror will apply this to the expectations outlined within the Model of Care and RFP.
130	3.7.7	42	Please clarify if the F/EA or the Plan is responsible for CD workers' training of F/EA processes & employment requirements.	The F/EA will continue to be responsible for providing training on F/EA processes and employment requirements. Training is offered to services facilitators. In addition, tutorials on timesheet processes are available for attendants and enrollee employers online.  Enrollees are required to train their own attendants and service facilitators train the enrollees in their employer roles. These responsibilities will be further outlined in the three way contract.
131	3.7.7	42	What services will the F/EA provide? Will they pay consumer-directed claims?	Participating Plans will be responsible for covering the costs of consumer-directed personal and respite care. Details will be outlined in the three way contract.
132	3.7.7	42	This section indicates that participating health plans will be responsible for covering the cost of personal and respite care services. When will DMAS provide more specificity on the roles of the agent and the participating health plan? For instance, who and how will the participating plans be billed for these services?	See response to Question 131.
133	3.7.7	42	The language reads that DMAS will contract directly with the F/EA and pay the administrative fees directly. Page 27 in section 3.2.2 Long Term Service and Support Provider Requirements, states "for consumer directed services, the participating plan shall be responsible for criminal record checks". So, are the plans responsible	See response to Question 65.

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			<p>for criminal record checks on consumer-directed services or does the F/EA continue to provide this service?</p> <p>The clarification is needed as our interpretation from the F/EA are that they assure criminal background checks are completed on applications they receive for consumer directed services. This is part of the administrative services they provide. We want to assure that our understanding of this is correct.</p>	
134	3.7.8 & Appendix C	42 & 58-59	<p>In Appendix C there are references to Virginia Administrative Code (VAC) descriptions for each covered behavioral health service. Are managed care organizations required to use the criteria in the VAC upon which to base utilization review determinations, or may MCOs utilize either nationally recognized or evidence based, proprietary level of care criteria to make these UR determinations?</p> <p>In addition, are MCOs required to utilize the definitions of units of service and service hours, and number of units allowed in a year?</p>	<p>Behavioral health services have to be available and covered by the participating plan. However, Offerors may propose to establish their own medical necessity criteria for behavioral health services. While flexibility exists for participating plans, the Department has the right to review and approve all elements of care as defined in the three way contract.</p> <p>Participating plans shall be in compliance with the Mental Health Parity Act.</p>
135	3.7.8 & Appendix C	42 & 58-59	Are MCOs required to pay for court-ordered treatment, including the first 4 days of a patient on a temporary detention order (TDO) regardless of medical necessity standards?	<p>Yes.</p> <p>The costs for the TDOs are factored into the base rate.</p>
136	3.7.8	42	Does the request to describe our understanding of each service apply to Medicaid covered Behavioral Health services?	Correct.
137	3.7.10	42	We believe that we will be unable to determine whether we will be able to provide flexible benefits until we have performed a thorough analysis of the rates, and that the rates will not be available before we are required to submit the plan benefit package. When will DMAS and CMS need to be informed about this?	The Department acknowledges the challenge with responding to this Section. Offerors should include their proposed flexible benefits in their responses to the RFP. Rates will become available for participating plans to review and adjust their proposed flexible benefits. DMAS will consult with CMS for further guidance on this area. This will be solidified in the three-way contract.
138	3.7.10	42	Must all flexible benefits be offered to every category of eligibility?	No.

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139	3.7.11	43	Please provide the names and lead person contact information for any Community Service Board already providing behavioral health home services or programs that incorporate the requirements for such homes, listed in this section.	The lead contact for Community Services Boards/Behavioral Health Authority (CSB/BHA) shall be the Executive Director of each CSB/BHA. A list of Community Services Boards may be found at <a href="http://vacsb.org">http://vacsb.org</a> .
140	3.8	43	Does the Department anticipate there will be a requirement of Physician Order for all LTSS services?	No.
141	3.9	44	<b>“Plans must honor all existing POCs and Medicaid prior authorizations until the authorization ends or 180 days from enrollment, whichever is sooner.”</b>  How should the plan address the situation where it completes an assessment and care plan and determines that the member’s POC is no longer appropriate?	A plan can implement a revised plan of care sooner than 180 days from an enrollee’s enrollment only if the enrollee agrees. The plan must document the enrollee’s decision to do so.
142	3.9	44	<b>“Plans must honor all existing POCs and Medicaid prior authorizations until the authorization ends or 180 days from enrollment, whichever is sooner.”</b>  If the member is coming from another plan will the State provide information on the previous plan in order for us to contact and obtain the POC?	Yes. This process will be described in the three-way contract.
143	3.9	44	How will we know what has been previously authorized?	DMAS will send this information to Participating Plans via transition reports. Please see the answer for Question #142 if the enrollee was in another Demonstration plan.
144	3.9	44	Transition of Prior Authorizations and POCs is important to maintain continuity of services and of providers. The following questions pertain to these transitions: <ul style="list-style-type: none"> <li>• Does this requirement apply to the initial enrollment from the fee-for-service environment or to the initial and all subsequent plan-to-plan enrollments?</li> <li>• How does DMS plan to provide Prior Authorizations and POCs from the current Medicare and Medicaid environments? Electronically?</li> <li>• Prior authorizations and POCs may detail a specific number of service units over time. This would require an “accumulator” of service units to accompany the PAs and POCs. Is this a</li> </ul>	These specifics will be addressed in the three-way contract.  For individuals transitioning from FFS: DMAS will provide PA information, claims data, and level of care elements to the new plan in the enrollment report that will be sent prior to the enrollment effective date. Specifically, plans will receive 2 years of claims and the prior 12 months of service authorizations.  For individuals transitioning from other plans: DMAS will work with Participating Plans this summer to determine the transfer process and time frames between plans.

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			<p>requirement?</p> <ul style="list-style-type: none"> <li>If a member is coming from another plan will the previous plan be required to respond to the new plan within a certain amount of time? Not receiving this information timely from another plan will impact our ability to meet the required timeframes.</li> </ul>	
145	3.9	44	Will we receive information on the current Part D plan sponsor for these members along with contact information to initiate authorization transfers, and if so, how far in advance of the eligibility effective date will this information be provided?	DMAS will consult with CMS on this question and provide guidance when it becomes available. This process will be outlined in the three-way-contract.
146	3.10	44	Section 3.10 describes a requirement to collect patient pay amounts for members receiving NF and EDCD services. Please clarify whether the state will provide plans with these pay amounts or will plans be expected to calculate.	See response to Question 16.
147	3.10	44	How does the State currently determine the Provider that the Patient Pay Amount is deducted from? Detailed information on how to administer the patient pay amount is necessary to building our claims system for this program	See response to Question 16.
148	3.10, 3.11, 3.12	44	Will the Commonwealth accept recommendations in the Offeror's response relative to Patient Pay Amount, Marketing and Grievance & Appeals sections? If so, what is the Commonwealth's plan for evaluating that input and communicating their decisions to the Offerors?	The Department is open to suggestions for streamlining process. DMAS will work with Participating Plans this summer to finalize processes for inclusion in the three-way-contract. In some areas, however, due to state and federal rules, there may not be much flexibility.
149	3.11	44	Since the three-way contract is not yet available, does the Department have an established policy regarding Marketing and Promotional Materials and Activities? If so, please provide. If not, is the Department looking for Offerors to suggest an approach?	See response to Question 148. The Department does not yet have an established policy for marketing, but will have to adhere to CMS guidance on this issue.

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150	3.11	44	Is the plan required to provide a response here?	Offerors should attest that they will adhere to marketing and promotional requirements that will be specified in the three-way contract. Also see the response to question 148.
151	3.13	44	Is the offeror required to submit EQRO results for two states if they have such results from 2 or more states, or can the offeror select to submit the report for only one state?	If the Offeror has EQRO reports from two or more states, the Offeror shall submit two EQRO reports.
152	3.13	44	Please confirm that Puerto Rico is not considered a “state” for purposes of this response.	If the Offeror operates a Medicaid or Medicare managed care program in Puerto Rico, these programs shall be recognized just as any program in a state would be for the purpose of this RFP.
153	3.13	44	For section 3.13, does the term “Offeror” include the entity that is submitting a proposal plus the entity’s parent and/or affiliated companies (i.e. other subsidiaries of the parent company)?	See the response to Question 24.
154	3.13	44	How will plans that have NCQA accreditation be scored?	NCQA accreditation will be taken into consideration as part of the Application Evaluation Criteria (Section 7.2 of the RFP) under Quality (Medicare and/or Medicaid).
155	3.13	44	HEDIS measures are designed by NCQA for quality review/evaluation and to understand member demography or simple utilization but not quality implications such as member month, enrollment by state, frequency of procedure. Also, there are measures for which benchmarks have not been well established but are used for data gathering so NCQA can research to establish benchmark or finalize measures for the future – such as PCR (all cause readmission) under age 65, RRU measures. Every year, NCQA makes extensive efforts to maintain and update a list of HEDIS measures used in NCQA accreditation with help of experts in the field. These measures are comprehensive for quality evaluation and have been reviewed by experts around the country. Would the State consider the use of these measures from IDSS for evaluation purposes?	The required quality measures will be outlined in the MOU and the three-way contract.
156	3.13	44	Dual members are very different than regular TANF/CHIP members in HEDIS results and audit firms have found it hard to trend performance for these	See response to Question 155.

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			populations by regular Medicaid benchmarks. Also, measures with a small eligible member population tend to have significant year over year statistical variation by “chance” rather by true quality improvement or decrease. Would the State consider that the evaluation method only include data from IDSS with ABD/SSI members as part of the reporting population and measures that have at least 100 eligible members to allow a reliable and pertinent data set to evaluate the MCO experience on the Dual population?	
157	3.14	45	For section 3.14, does the term “Offeror” include the entity that is submitting a proposal plus the entity’s parent and/or affiliated companies (i.e. other subsidiaries of the parent company)?	See response to Question 26.
158	3.15	45	Please confirm that the stated five page limit for the vignette responses is per vignette.	That is correct.
159	3.15	45	Section 3.15 states that “Vignettes should be a maximum of five pages, single spaced.” Does this mean that this section has a maximum of 25 pages (five pages for each of the five vignettes)?	Correct, each vignette is limited to five pages, single spaced.
160	3.15 & Appendix D	45& 61	The RFP states that vignettes should be a maximum of five pages, single spaced. What is the page limit per vignette?	Each vignette is limited to five pages, single spaced.
161	3.15	45	This question indicates that Vignettes are limited to five single spaced pages. Does that mean that all five Vignettes are limited to a total of five pages, or that each Vignette is limited to 5 pages.	Each vignette is limited to five pages, single spaced.
162	Section IV	46	What is the withhold amount?	This will be outlined in the MOU and three-way contract.
163	Section IV	46	Can the entire amount be recouped by plans that meet the specified quality metrics?	This will be outlined in the MOU and three-way contract.
164	Section IV	46	What are the quality metrics plans must meet to obtain reimbursement of the withhold amount.	This will be outlined in the MOU and three-way contract.
165	IV and V	46-47	Are Offerors required to provide responses for Sections IV and V in their proposal submissions? If so, should these responses be included in Chapter 3: Tasks and Technical Approach, or somewhere else?	Offerors should attest that they will meet the requirements as outlined in these sections. If the Offeror is not able to meet all of these requirements as of May 15, 2013, an explanation must be provided.
166	Sections IV and V	46-47	Please confirm these sections do not require a written response.	See response to Question 165.

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167	4.1	46	We are investigating whether we can find a carrier who will provide reinsurance for this program. If we are unable to find a carrier, will the State disqualify us from participation?	See response to Question 165. Plans will be required to meet all Bureau of Insurance requirements during the readiness review process.
168	4.2	46	Regarding retroactive disenrollment or transfer from plan-to-plan: Is the “look-back” limited to “a given month”, i.e., one month?	This process will be outlined in the three-way-contract.
169	4.3	47	What is the preferred or required process and timing for notifying DMAS of the type of financial arrangements negotiated with FQHCs or RHCs for any historically Medicaid-covered services?	Offerors should explain in their response to the RFP their expected financial relationship with FQHCs and RHCs. These processes will be finalized in the three-way-contract.
170	6.2	48	In order for proposals to be printed in a more environmentally-conscious and economic manner, may proposals be printed double-sided?	Yes.
171	6.2	48	Section 6.2 states, “Each copy and all documentation shall be contained in single three-ring binder volumes where practical.” Please clarify this statement. May one copy of an Offeror’s proposal response include more than one binder? Is there any limit on the size of a binder?	Yes, an Offeror’s proposal response may include more than one binder. There is no limit on the size of a binder.
172	6.2	48	Please clarify if the Department is restricting Offerors to one three ring binder or permitting multiple 3-ring binders (clearly labeled for each chapter of the response), if needed.	See response to Question 171.
173	6.2	48	Section 6.2 states that “the plan shall also submit five electronic copies (thumb drives preferred) of its proposal in MS Word format (Microsoft Word 2007 or compatible format).” Certain items, such as signed forms, cannot be in MS Word Format. Will the Commonwealth accept all electronic copies to be submitted in PDF format?	Yes, documents such as signed forms that cannot be submitted in Word can be submitted in PDF format. However, the proposal itself shall be in MS Word Format.
174	6.2	48	Section 6.2 states that “in addition, the plan shall submit a redacted electronic copy in PDF format of its proposal, in which the plan has removed proprietary and trade secret information.” Will the Commonwealth clarify if the redacted version of the proposal should be added to each of the five required electronic copies/thumb drives, or if a separate electronic copy/thumb drive for the redacted proposal is required?	Only one redacted copy is required, and does not have to be placed on all thumb drives.

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175	6.2	48	<p>Section 6.2 of the RFP states: "The plan shall also submit five electronic copies (thumb drives preferred) of its proposal in MS Word format (Microsoft Word 2007 or compatible format)."</p> <p><b>Please Clarify:</b> Due to potentially large file size, is it acceptable for the Offeror to submit the Word version of the proposal as a separate file for each main section (e.g. one file for 6.10.1, one file for 6.10.2, etc.) or do all sections need to be included in one combined Word file?</p>	Separate files for each main section are acceptable.
176	6.2	48	<p>Section 6.2 of the RFP states: "The plan shall also submit five electronic copies (thumb drives preferred) of its proposal in MS Word format (Microsoft Word 2007 or compatible format). In addition, the plan shall submit a redacted electronic copy in PDF format of its proposal, in which the plan has removed proprietary and trade secret information.</p> <p><b>Please clarify:</b> If the Offeror does not intend to mark any proposal content as proprietary, should the Offeror simply omit submitting this 6th thumb drive containing the redacted PDF, or should the Offeror still include a separate, combined PDF version of the proposal on that thumb drive and indicate on the Proprietary/Confidential Information Identification Form that there is nothing to disclose?</p>	The Offeror should include a separate, combined PDF version of the proposal on the thumb drive and indicate on the Proprietary/Confidential Information Identification Form that there is nothing to disclose.
177	6.2	48	<p>Section 6.2 of the RFP states: "Each copy and all documentation shall be contained in single three-ring binder volumes where practical."</p> <p><b>Please clarify:</b> Does this mean that each copy along with all documentation must fit within ONE 3" binder or is it acceptable for each copy of the proposal to consist of multiple 3" binders?</p>	Each copy can consist of multiple 3" binders.
178	6.2	48	<p>Section 6.2 of the RFP states: "The plan shall also submit five electronic copies (thumb drives preferred) of its proposal in MS Word format (Microsoft Word 2007 or compatible format)."</p> <p><b>Please Clarify:</b> Being that section 6.10.4 Chapter Four: Required Forms consists mainly of documents in PDF format and the majority of</p>	Yes.

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			proposal Appendices will also be PDF documents, is it acceptable for the Offeror to submit response to 6.10.1-6.10.3 in a Word document and then include section 6.10.4 plus all proposal Appendices in a separate combined PDF file on the thumb drives?	
179	6.4	48	Is there any limit on the length of the application? The Model of Care we submitted to CMS was over 200 pages in length. This will be part of this application.	There is no page limit on the length of the application. However, responses to each vignette shall be a maximum of five pages, single spaced.
180	6.4	48	Can plans submit EQRO, financials, annual reports and network documents in electronic versions instead of hard copy?	Seven hard copies and electronic copies will be required.
181	6.4	49	Section 6.4 of the RFP states: "The proprietary or trade secret materials submitted shall be identified by some distinct method, such as highlighting or underlining, and shall indicate only the specific words, figures, or paragraphs that constitute trade secret or proprietary information."  <b>Please clarify:</b> It is our understanding based on these instructions that we will mark proprietary information as described above (highlighted but still visible) within the five electronic copies submitted on thumb drives as well as the printed copies, however the redacted PDF on the sixth thumb drive will have proprietary information completely removed/blacked out. Is this understanding correct?	Only the redacted electronic copy in PDF should have the proprietary and trade secret information identified or removed.
182	6.5	49	Item #2 within section 6.5 Transmittal letter is followed by subsections 1-3. <b>Please Clarify:</b> Were subsections 1-3 meant to be formatted as bullets or were they meant to be included on the same level as Item # 2, in which case they would be re-labeled to read as Items 3-5?	They were meant to be on the same level as Item #2, so they should be re-labeled Items 3-5.
183	6.5	49	Please confirm that it is acceptable for a different person, who has the authority, to sign the awarded contract, and addenda if issued, in a case where the person who signed the proposal submission documents is no longer employed, or no longer has authority to sign the awarded contract.	Confirmed.
184	6.5	49, # 1,	Please explain what is meant by the following, "The	The Offeror must provide a list of contracts that the

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		First Bullet	plan must identify any contract or contracts it has with any state or local government entity that is a Medicaid provider or plan and the general circumstances of the contract” (emphasis added).	Offeror has with state or local government entities and provide a brief overview of the nature of the relationship.
185	6.6	49	Section 6.6 states that “the Offeror shall sign the cover page of this RFP...” Is the “cover page” the same as the “RFP Cover Sheet” on p. 5 that is a 6.10.4 Required Form? If not, does the Commonwealth consider the “cover page” to be p. 1 (first page of the DMAS Contract Manager letter) or p. 4 or p. 6?	Please sign page 5, the “RFP Cover Sheet” as well as other pages in the appendix that require signatures.
186	6.9	50	Will the Department conduct ride-alongs with care coordinators as a part of readiness reviews?	This will be addressed with selected plans prior to the readiness reviews.
187	6.10.2.2B	51	For subsection B of 6.10.2.2, does the term “Offeror” include the entity that is submitting a proposal plus the entity’s parent and/or affiliated companies (i.e. other subsidiaries of the parent company)?	Yes.
188	6.10.2.2.B	51	Will a health plan that does not have experience as a Medicare Advantage plan, Medicare Special Needs Plan, or in the delivery of managed long-term services and supports be at a significant disadvantage in the scoring of its application?	Offerors will be evaluated on their experience with Medicare, Medicaid, and integrated programs and the quality of care that they have provided in those programs.
189	6.10.2.1.H	51	Please describe what is meant by “organizational affiliations”. Is this referring to internal or external affiliations?	Both.
190	6.10.2 (2.H)	52	Section 6.10.2, Item 2.H states: Three references of non-Offeror owned customers or previous clients that will serve to substantiate the Offeror’s qualifications and capabilities to perform the services required by the RFP. The Offeror shall complete the Reference Form in Appendix L for each reference, which includes the contract name, address, telephone number, contact person, and periods of work performance for each reference. <b>Please clarify:</b> It would appear that the Reference Form is actually listed as Appendix K. Should the requirement above reference Appendix K instead of Appendix L?	Correct, it should have been referenced as Appendix K.
191	6.10.2	51	Can an Offeror submit more than one bid in a Region?	Offerors must propose to cover all localities included in a region. The only exception to this is in Tidewater where two localities are optional. Only one bid per

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				Offeror will be reviewed. If further clarification is needed on this, please email <a href="mailto:dualintegration@dmas.virginia.gov">dualintegration@dmas.virginia.gov</a> .
192	6.10.2	51	What if an Offeror is the subsidiary of a parent company, and such parent company provides significant and substantial administrative services to another non-related Offeror bidding in the same Regions. Would both bids be accepted and potentially considered for award? Or, would only one Offer qualify given the parent company's relationship with both the subsidiary Offeror, and the non-subsidiary/unrelated third party to which it provides administrative services?	If a plan is only providing third-party administrator services for an Offeror in a given region and adequate firewalls exist, both the Offeror and the plan may submit proposals for consideration in that region. Offerors must fully disclose and explain contractual or legal relations that they have with other potential Offerors for the Department to assess the impact. If further clarification is needed on this, please email <a href="mailto:dualintegration@dmas.virginia.gov">dualintegration@dmas.virginia.gov</a> .
193	6.10.2	51	Are there any prohibitions or restrictions around 2 companies bidding as a joint venture or partnership?	No.
194	6.10.2.2.F	51-52	What types of contract terminations are responsive? Contracts with state and/or federal agencies for government business? Provider contracts? Commercial client contracts? This question could be very broadly interpreted – clarification is necessary.	Information on contract terminations with state and/or federal agencies for government business and material commercial client contracts would be responsive.
195	6.10.2.2.G	52	What is the time frame for this question? Can we use the same 5 year time frame set forth in 6.10.2.2.F?	Yes.
196	6.10.2.2.H	52	For subsection H of 6.10.2.2, please confirm that the Appendix L that is referred to is actually Appendix K.	See response to Question 190.
197	6.10.2.2.H	52	For subsection H of 6.10.2.2, does the term "Offeror" include the entity that is submitting a proposal plus the entity's parent and/or affiliated companies (i.e. other subsidiaries of the parent company)?	Yes.
198	6.10.2.2.H	52	The RFP requires "Three references of non-Offeror owned customers or previous clients..." and directs the Offeror to complete the Reference Form in "Appendix L;" however, the Reference Form referred to on page 52 is actually in Appendix K. Please confirm that the reference on page 52 is a typographical error and that DMAS intended to refer readers to Appendix K.	See response to Question 190.
199	6.10.2.2.H	52	The RFP requires "Three references of non-Offeror owned customers or previous clients..." Please confirm DMAS will contact Offeror references using the information provided on the Reference Forms.	Confirmed.
200	6.10.2.2.H	52	We are a Virginia-based organization providing services	The references should be non-applicant owned

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			only within the state of Virginia. We would like clarification on the question below as we do not have other state as clients to reference.	customers or previous clients. If such references are not applicable, the Offeror should provide references that are as comparable as possible and be able to substantiate the Offeror's qualifications and capabilities to perform the services required in the RFP.
201	6.10.3	52	Please confirm that a response is required for all of section 3, but not sections 4 and 5.	See response to Question 165.
202	6.10.3	52	Does the Department want a written response for every element of Section III, Technical Requirements? If not, please provide a list of the specific tasks for which the Department requires a written response.	Yes. If the RFP indicates that a specific section will be addressed in the three-way contract (e.g., Section 3.8 Medical Necessity), the Offeror should acknowledge that fact.
203	6.10.3	52	“The plan shall submit all required information and documentation, and fully describe how it intends to meet all of the tasks required in the RFA.”  Can the State please provide a list of the tasks?	The tasks are outlined in Section III (Technical Requirements) of the RFP.
204	6.10.2, subsection 3C	52	Please confirm a submitted application (awaiting approval) for the service area approval certification is sufficient for offerors to meet this requirement.	Confirmed; however, this process must be completed during readiness review.
205	7.2	54	How will the provider network factor into the scoring for the application? There does not appear to be any element of the scoring criteria that is related to network. Is it only necessary to meet the minimum network criteria? The evaluation criteria all seem to apply to a plan's general program. Will the health plans that score the highest on the criteria be awarded contracts in all service areas? If not, how will contracts be awarded in a specific geographic area?	Offerors must meet the minimum network criteria.  Plans that score the highest will be given priority in the specific geographic areas in which they submitted a bid.
206	7.2	54	“Experience with Population” accounts for 15% of the score. If a health plan does not participate in Medicare, will it be at a disadvantage?	Offerors will be evaluated on their experience with Medicare, Medicaid, and integrated programs.  The scoring tool will not penalize Offeror's that only have experience in Medicaid or Medicare; however, plans that have experience with both programs will be in the position to score additional points for this section.
207	7.2	54	The RFA provides general evaluation criteria in <b>Section 7.2 Application Evaluation Criteria</b> . Is there a scoring	Scoring tools have been developed for each Application Evaluation Criteria.

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			scale DMAS will use when reviewing applications, such as 0 represents a non-responsive response and 5 represents a superior response? If so, what is the scoring scale? If there is no scoring scale, how will DMAS determine a plan should be awarded 25% of the possible total score for a specific criterion?	
208	Appendix A	55	With respect to the footnotes – if all other things are equal, will the preference for award go to those Offerors who participate in the designated localities?	Optional means interested plans are encouraged, but not required to participate in these localities. If no plan or only one selected plan applies to participate in these localities, the localities will not be included in the demonstration. Non-participation in the optional localities will not result in a lower score.
209	Appendix F		Can the State provide estimates of the increase in drug expenditures that plans can expect from the elimination of co-pays and where the revenue to cover these expenses will be found?	Participating Plans will not charge Medicare Parts C or D premiums, nor assess any cost sharing for Medicare Parts A and B services. For drugs and pharmacy products (including those covered by both Medicare Part D and DMAS), Plans will be permitted to charge co-pays to individuals currently eligible to make such payments. Co-pays charged by Participating Plans for Part D drugs must not exceed the applicable amounts for brand and generic drugs established yearly by CMS under the Part D Low Income Subsidy, although plans may elect to reduce this cost sharing for all Enrollees, as a way of testing whether reducing Enrollee cost sharing for pharmacy products improves health outcomes and reduces overall health care expenditures through improved medication adherence under the Demonstration. Participating Plans will not assess any cost sharing for DMAS services, beyond the pharmacy cost sharing.
210	General		<p>Our understanding is that information on a number of requirements, including those listed below, will not be available until September, 2013. Some of these are important to the development of our program to serve dual eligibles and will impact on our ability to be ready. Will the State consider issuing information on the following before September, 2013 to enable us to build our systems?</p> <ul style="list-style-type: none"> <li>○ Enrollment and Disenrollment processes</li> </ul>	DMAS will share information with Participating Plans as it becomes available and as decisions are finalized. The Department understands the need to provide timely information to the Participating Plans and looks forward to working with Participating Plans to finalize these processes.

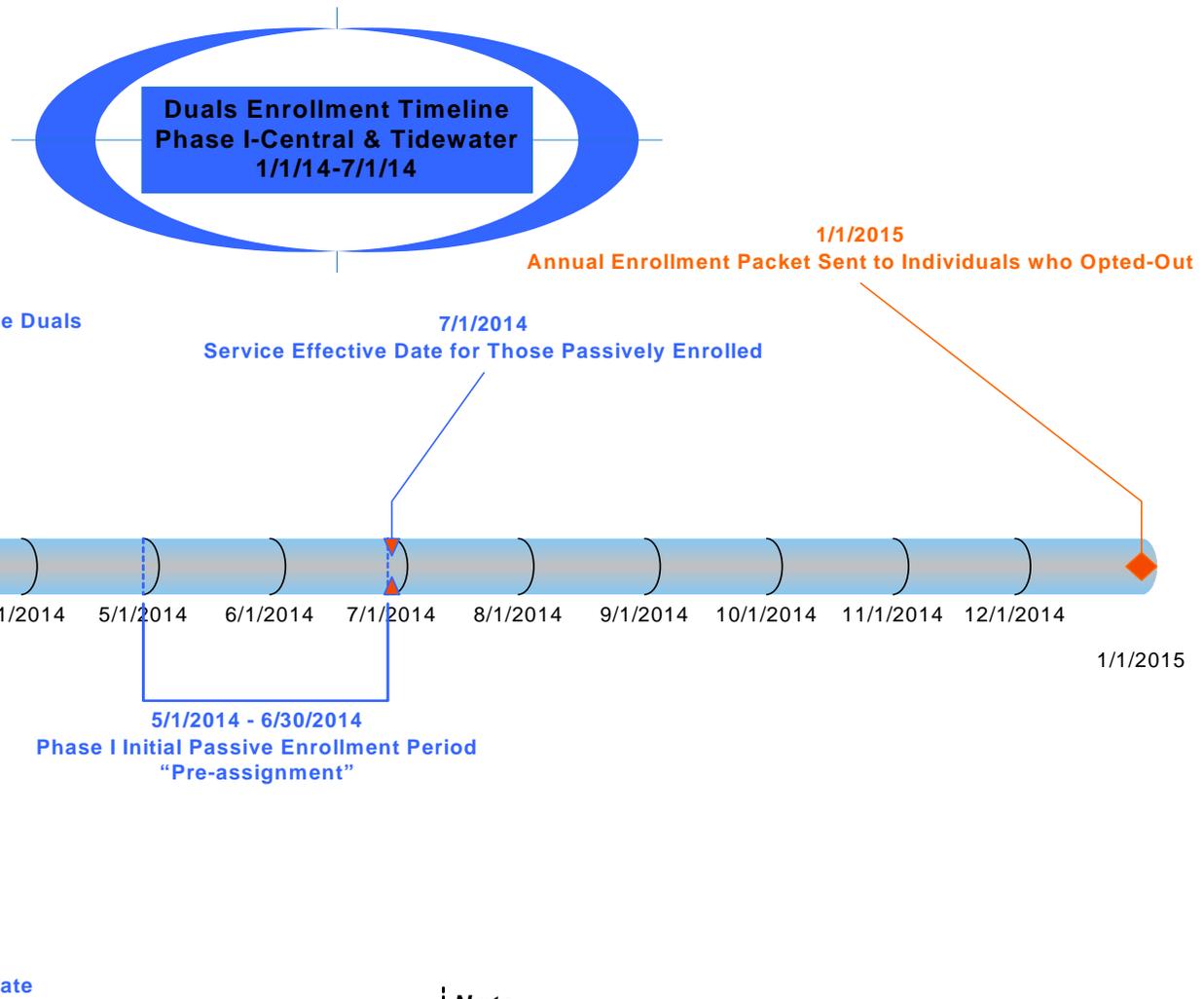
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			<ul style="list-style-type: none"> <li>○ Grievance and Appeals</li> <li>○ Medical Necessity (especially Medicare versus Medicaid)</li> <li>○ Marketing and Promotional materials</li> <li>○ Process for collecting patient pay</li> <li>○ Expectations regarding Consumer-Directed Fiscal/Employer Agent (F/EA) Services</li> </ul>	
211	General		When will the State provide information regarding the requirements to provide encounter data?	See response to Question 210.
212	General	3-4	Will the Commonwealth extend the Proposal Due Date so that prospective offerors will have more time to incorporate any changes needed due to the Commonwealth's responses to questions and inquiries?	No.
213	General		How far back is DMAS planning to retro?	The intent of this question is not clear, so DMAS cannot respond.
214	General		Will voluntary enrollment end once passive enrollment begins 5/1?	No. Individuals may voluntarily enroll at anytime.
215	General		Will the enrollee complete an application during the voluntary enrollment & who then processes the application?	The enrollee will complete an application. DMAS plans to use an enrollment broker (i.e., enrollment facilitator) to facilitate the enrollment process. This will be addressed in the three-way contract.
216	General		Will the health plan take the application directly?	No. See response to Question 215.
217	General		Just to confirm, the effective date will always be the first of the month after eligibility is confirmed?	<p><u>For Opt-In Enrollment:</u> After the first Opt-In effective date, those who opt-in prior to 5 days before the end of the month will be eligible for services the 1<sup>st</sup> day of the following month.</p> <p><u>For Passive Enrollment:</u> After the initial pre-assignment period, any newly eligible individual will be placed in pre-assignment on a monthly basis. Those who are included in pre-assignment will be eligible the 1<sup>st</sup> day of the 2<sup>nd</sup> month after pre-assignment. Pre-assignment is a 60 day process.</p> <p>DMAS continues to work with CMS to finalize these processes and will address enrollment as soon as possible and in the three-way contract.</p>
218	General		The RFP says a minimum of 2 plans but it does not speak to a cap of 3 plans as has been reported	Correct, a minimum of two plans will be selected in each region.

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			previously?	
219	General		The RFP refers to the goals to reduce disparities. What are they?	Reducing health disparities includes increasing access to service coordination and increasing the ability to identify and address racial and ethnic disparities and ensuring access to information for individuals with limited English proficiency.
220	General		What are the credentialing / recertification requirements in the 3-way contract?	See response to Question 77.
221	General		Can DMAS clarify the enrollment impact of the LIS Part D enrollment on the proposed population? It is our understanding that if enrolled into a Part D plan, they are locked in for the remainder of the year.	Beneficiaries subject to Medicare reassignment effective January 1, 2014, either from their current (2013) Medicare Prescription Drug Plan (PDP) or terminating Medicare Advantage Drug Plan (MA-PD) to another PDP, will not be eligible for passive enrollment during CY 2014. However, those individuals eligible to be reassigned to a new PDP effective January 1, 2015 and meeting all eligibility criteria for the Demonstration will be eligible for passive enrollment into a Participating Plan effective January 1, 2015.
222	General		Does DMAS have any experience in "alternative nursing facility placement" (3.7.5.d)? How frequently do they intervene?	DMAS typically does not intervene unless the facility specifically requests assistance with discharge planning and placement. Currently, this happens infrequently.
223	General		What more detail can DMAS provide about the 3-way contract with the F/EA contract?	None at this time. However, DMAS will have a contract with a F/EA for administrative services. Participating Plans must have a separate contract with the same F/EA. Details about the F/EA services will be addressed in the three-way contract between CMS, DMAS, and Participating Plans for the Demonstration.
224	General		Will DMAS permit plans to offer technology solutions such as telehealth / telemedicine and eVisits to members?	Yes. The Department is working with CMS to explore flexibility with telemedicine.
225	General		It will important to know the medical necessity process if we are to respond to the RFP and the BOI.	Below is language included in the MOU that is currently in the final review process with CMS and DMAS. However, this may be subject to change.  <i>1. Medical Necessity Determinations - Medically necessary services will be defined as services: a. (per Medicare) that are reasonable and</i>

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				<p><i>necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. 1395y.</i></p> <p><i>b. (per DMAS) an item or service provided for the diagnosis or treatment of a patient's condition consistent with community standards of medical practice and in accordance with Medicaid policy (12 VAC 30-130-600).</i></p> <p><i>Furthermore, as defined in 42 C.F.R. § 440.230, services must be sufficient in amount, duration and scope to reasonably achieve their purpose. Participating Plans will be required to provide services in a way that preserves all protections to the Enrollee and provides the Enrollee with coverage to at least the same extent provided by Medicare and DMAS.</i></p> <p><i>Where there is overlap between Medicare and Medicaid benefits, coverage and rules will be delineated in the three-way contract; the benefits will maintain coverage to at least the extent provided by Medicare and DMAS as outlined in both state and Federal rules. Participating Plans will be required to abide by the more generous of the applicable Medicare, DMAS, or the combined Medicare-Medicaid standard.</i></p>
226	6.10.2	51	<p>How will DMAS handle the following scenarios:</p> <p>a) Offeror A submits a bid for one or more Regions. After submitting the bid, but before the award date, Offeror A is acquired by another company. Such other company is a prime subcontractor to provide administrative services to Offeror B who has bid in some, or all, of the same regions as Offeror A.</p> <p>b) Offeror A submits a bid for one or more</p>	<p>a) See response to Question 192.</p> <p>b) See response to Question 192.</p>

Question Number	RFP Reference	Page #	Question	Response
			Regions. After submitting the bid and after the award announcement, but before the contract execution date, Offeror A is acquired by another company. Such other company is a prime subcontractor to provide administrative services to Offeror B who has bid in some, or all, of the same regions as Offeror A.	
227	General		Can DMAS clarify the meaning of flexible benefits?	Flexible benefits are ones that Participating Plans would offer under the Demonstration that are above and beyond the required Medicare/Medicaid covered benefits.
228	General		<p>Are there limits to the number of staff that can present the vignettes?</p> <p>Will we be able to use slides or will we only be able to verbally present the information?</p> <p>Who will be present from DMAS?</p>	<p>No.</p> <p>Slides can be used (please refer to the e-mail that DMAS sent to interested plans on 4/23/13 regarding the vignette presentations).</p> <p>Members of the RFP evaluation team, staff working on and/or interested in the Demonstration, and management level staff.</p>
229	General		How soon before the presentation will we learn which 2 vignettes will we be presenting?	Offerors will be required to present on vignettes # 2 (Henry, 46 year old male) & 3 (Laura, 68 year old female). Please refer to the e-mail that DMAS sent to interested plans on 4/23/13 regarding the vignette presentations.
230	General		In subsequent stakeholder meeting since RFP release, DMAS commented that the Vignettes would be presented on June 5 <sup>th</sup> and 6 <sup>th</sup> . Please confirm vignette presentations will occur June 10 and 11.	Vignette presentations will take place on June 10 and 11. Please refer to the e-mail that DMAS sent to interested plans on 4/23/13 regarding the vignette presentations.
231	General		In subsequent stakeholder meeting since RFP release, DMAS commented regarding the number of plans in each region might be limited to two. Please confirm that two or more plans per region will be awarded contracts.	A minimum of two plans will be selected in each region.

# Attachment A: Enrollment Diagrams



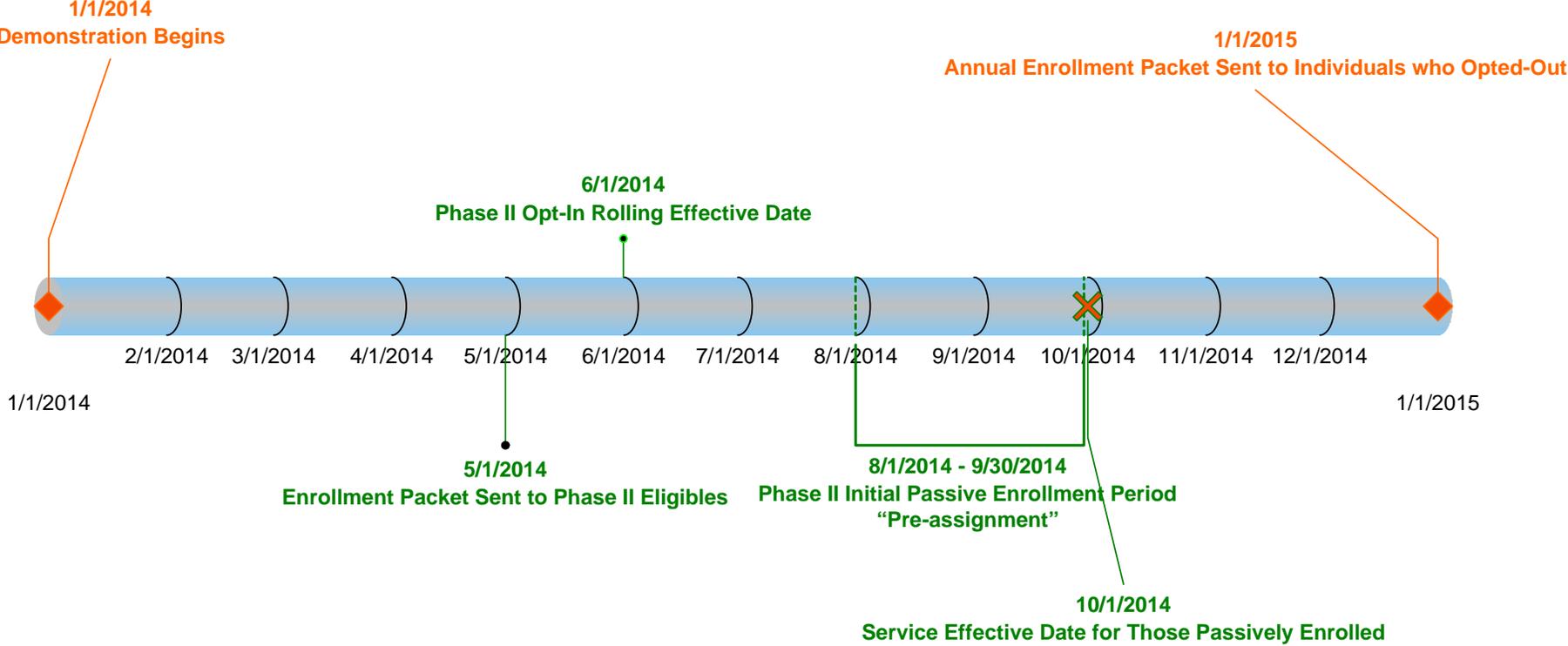
**Note**

*Passive Enrollment:* After the initial pre-assignment period, any newly eligible individual will be placed in pre-assignment on a monthly basis. Those who are included in pre-assignment will be eligible the 1<sup>st</sup> day of the 2<sup>nd</sup> month after pre-assignment.

*Opt-In Enrollment:* After the first Opt-In effective date, those who opt-in prior to 5 days before the end of the month will be eligible for services the 1<sup>st</sup> day of the following month.

**PENDING CMS APPROVAL.**

**Duals Enrollment Timeline**  
**Phase II-Roanoke, NOVA, Western/Charlottesville**  
**5/1/14-10/1/14**



**Note**

*Passive Enrollment:* After the initial pre-assignment period, any newly eligible individual will be placed in pre-assignment on a monthly basis. Those who are Included in pre-assignment will be eligible the 1<sup>st</sup> day of the 2<sup>nd</sup> month after pre-assignment.

*Opt-In Enrollment:* After the first Opt-In effective date, those who opt-in prior to 5 days before the end of the month will be eligible for services the 1<sup>st</sup> day of the following month.

PENDING CMS APPROVAL.

**Attachment B: Vendor Fiscal/Employer Agent (F/EA) for Consumer-Directed Services  
Responsibilities**

The responsibilities of the F/EA currently include: 1) pre-employment services including enrolling Medicaid Individuals (employers) and their Personal Care Assistants (employees) in F/EA services and conducting criminal, child abuse and neglect, and other State and federally required background checks; 2) processing employee timesheets; 3) deducting, filing, and paying State and federal income and employment taxes and other withholdings on behalf of the employer and his/her employees; 4) paying Personal Care Assistants; 5) providing customer service through a Call Center; and 6) providing training, including on-line tutorials, on F/EA enrollment and payroll processing procedures for employers and Service Facilitators responsible for supporting the Medicaid Individual in managing his or her Personal Care Assistants.

The Department will develop and finalize the roles of Participating Plans and the FE/A during the Summer 2013 and prior to signing the three-way contract.

Note that consumer-directed personal care and respite care services will be included in the capitation payments.

**F/EA Performance Standards and Penalties - Service Level Agreement**

**Service Area: Enrollment**

<b>CD Service Area</b>	<b>Performance Standard</b>	<b>Measure</b>
Requests for F/EA Services	Complete and correct service requests shall be successfully entered into the Contractor's database within 3 business days of receipt.	90% of all complete and correct service requests measured on a weekly basis.
Medicaid Individual Enrollment Packet Processing	Complete and correct employer enrollment packets shall be successfully processed and entered into the Contractor database within 5 business days of receipt.	90% of complete and correct employer packets measured on a weekly basis.
Employee Enrollment Packet Processing	Complete and correct employee enrollment packets shall be successfully processed, including submission of all background checks, and entered into the Contractor's database within 5 business days of receipt.	90% of complete and correct employment packets measured on a weekly basis.

**Service Area: Timesheet, Payroll Processing, and Payroll-Tax Reconciliation**

<b>CD Service Area</b>	<b>Performance Standard</b>	<b>Measure</b>
Pended Timesheets	Pended timesheets that are within the purview of the Contractor to correct shall be less than one month	90% of pended timesheets shall be less than one month old, measured on a monthly basis.

	old.	
Timesheet Payment	Correct timesheets, received by the timesheet deadline, shall be accurately processed and disbursed by the payroll cycle pay date.	99% of timely and correct timesheets are accurately disbursed, measured on a two week payroll cycle basis.
Weekly voucher submission to the Department	Weekly payroll vouchers shall be electronically submitted to the Department within the required timelines.	The Contractor shall meet the Department's payroll voucher submission timelines 100% of the time, measured on a weekly basis.
Payroll and tax reconciliations and refunds	Quarterly and end of year payroll, tax, and related reconciliation reports shall be complete and submitted with all refunds to the Department within RFP specified timelines.	100% of payroll and tax reconciliation reports shall be complete and submitted, with all refunds, within RFP required timelines, measured on a quarterly and annual basis.

**F/EA Performance Standards (Other):**

**Service Area: Payroll taxes and other withholdings**

<b>CD Service Area</b>	<b>Performance Standard</b>
Federal taxes	100% of Federal IRS Forms 940 and 941 shall be accurately filed and paid within IRS timelines.
State taxes	100% of Virginia Department of Taxation (DOT) Form VA-5 Shall be accurately filed and paid within thin DOT timelines.
Unemployment Insurance	100% of Virginia Employment Commission Forms FC-20 and FC-21 Shall be accurately filed and paid within Virginia Employment Commission timelines.
Garnishments	100% of all garnishments, levies, and liens on Employee's payroll checks Shall be set up and accurately deducted within the timelines established by the <i>Code of Virginia</i> and Virginia Department of Labor and Industry.
State & federal taxes	100% of state and federal annual information returns shall be in compliance with IRS, Social Security Administration, and Virginia tax filing requirements.

**Service Area: Call Center**

<b>CD Service Area</b>	<b>Performance Standard</b>
Telecommunications System	99% of the time, the Call Center telecommunication systems Shall be fully accessible and functional during RFP prescribed business hours measured on a Monthly basis.
Call Answer	95% of inbound calls Shall be answered within 3 rings or 15 seconds. (If an automated voice response system which places the call in queue is used at the time of the initial call, an option must exist allowing the caller to speak directly with an operator.)
Voice Mail	100% of voice mails and phone inquiries requiring a return call Shall be returned within one business day of receipt measured on an average weekly basis.
Abandoned Calls	The rate of abandoned calls Shall not exceed 5% of incoming calls measured on an average weekly basis.
Queue Time	Queue wait time Shall not exceed 3 minutes for 90% of incoming calls measured on an average weekly basis.

**Service Area: Complaints and Grievances; F/EA Service Satisfaction**

<b>CD Service Area</b>	<b>Performance Standard</b>
Complaints & Grievances	Monthly Complaints and Grievances Shall not exceed 1% of the number of Monthly Active Individuals.
Satisfaction Survey	90% satisfaction rate for each domain measured in the survey.