



# COMMONWEALTH of VIRGINIA

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

June 3, 2016

## ADDENDUM No. 3 TO VENDORS:

Reference Request for Proposal: RFP 2016-01  
Dated: April 29, 2016  
Due: June 30, 2016

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

**Universal Change:** As referenced throughout the RFP, Eastern Standard Time (EST) is changed to read Local Time.

### Page 26, Section 2.14, Vignette Presentation:

CHANGE – Section 2.14 has been changed per the following:

### ***2.14 VIGNETTE PRESENTATION***

DMAS plans to request Offerors to present vignettes in-person. Details on vignette presentations will be shared ~~as an addendum~~ with Offerors after the proposal due date/time and during the evaluation process.

### Page 27, Section 3.0 Technical Requirements:

CHANGE – Section 3.0, third paragraph has been changed per the following:

Unless otherwise required in this RFP, the Offeror may perform all of the processes outlined in this RFP internally or involve subcontractors for any portion, but the Offeror must identify subcontractors by name and by a description of the services/functions they will be performing. The Contractor shall be wholly responsible for the performance of the resulting contract whether or not subcontractors are used.

**Page 51, Section 3.5.5 Provider Recruitment Strategy**

**CHANGE – Section 3.5.5 has been changed per the following:**

The Offeror shall submit a provider network file to the Department in an electronic MS-Excel spreadsheet format. Additional instructions are included in Attachment C and are detailed in the *Provider Network Adequacy Data System (PNADS) Manual, (updated June 3<sup>rd</sup>, 2016)* available on the DMAS MLTSS webpage. Submissions not meeting the network file requirements will be rejected and returned. DMAS will use this data to evaluate the Contractor's provider network in accordance with requirements described in this RFP.

Preliminary networks submitted with the RFP are not required to include the procedure codes for provider designations 06, 08, 09. Procedure codes for provider designations 06, 08, and 09 shall be required with final network submissions during readiness.

Offerors shall not contact the Department's BHSA to request any data, including provider participation information. Medicaid Fee-For-Service Providers utilized by MLTSS populations is available on the DMAS MLTSS website at: [http://www.dmas.virginia.gov/Content\\_pgs/mltss-ihp.aspx](http://www.dmas.virginia.gov/Content_pgs/mltss-ihp.aspx). The Department or its designee shall be the sole determiner of network sufficiency.

**Page 66, Section 4.2.1 Past Experience Examples**

**CHANGE – Section 4.2.1 has been changed per the following:**

**4.2.1 Past Experience Examples**

Offeror shall provide three (3) past experience examples which demonstrate the Offeror's experience with the following: rebalancing, value-driven care, care transitions, Value-Based Payments design and implementation, integration of behavioral health and acute care, and social determinants of health, and needs of Medicaid population. For each past experience example, Offeror's response shall include the following information. DMAS intends to contact the references provided in these past experience examples.

**Page 66, Section 4.2.3 Stakeholder References**

**CHANGE – Section 4.2.3 has been changed per the following:**

**4.2.3 Stakeholder References**

Offeror shall provide 10 total references from this group of stakeholders (DMAS intends to contact the stakeholder references submitted for this section):

6. Member (~~required~~ optional;) If the Offeror submits a member reference, the Offeror's proposal submission for this section must include the member's contact information. The Offeror shall also include a signed copy of the member's consent to be included as a stakeholder reference for the Offeror. The Offeror shall redact any member references in the redacted version of its proposal, per Section 2.4 of the RFP.

**Page 88, Section 6.2.17 Continuity of Care Provisions**

**CHANGE – Section 3.0, third paragraph has been changed per the following:**

**Current Providers:** The Contractor must allow an enrollee to maintain his or her current providers (including out-of-network providers) for 90 days, or, where services are authorized, for the duration of the service authorization or 90 days, whichever comes first.

**Page 97, Section 6.2.26 Exclusions from MLTSS Participation**

**CHANGE – Section 6.2.26 has been renumbered as follows:**

7. Individuals enrolled in a Medicaid-approved hospice program at the time of enrollment. However, if an individual enters a hospice program while enrolled in MLTSS, the member will remain enrolled in MLTSS.
8. Individuals who live on Tangier Island.
9. Individuals under age 21 who are approved for DMAS Psychiatric RTC Level C programs as defined in 12VAC 30-130-860.
10. Individuals with end stage renal disease (ESRD) at the time of enrollment into MLTSS. However, an individual who develops ESRD while enrolled in MLTSS will remain in MLTSS (DMAS will manually exclude these individuals going forward upon receipt of notification).
11. Individuals who are institutionalized in state and private ICF/ID and state mental health nursing facilities.
12. Individuals who reside at Piedmont, Catawba, and Hancock State facilities operated by DBHDS.
13. Individuals who reside in nursing facilities operated by the Veterans Administration.
14. Individuals participating in the CMS Independence at Home (IAH) demonstration. However, IAH individuals may enroll in the MLTSS program if they choose to disenroll from IAH (DMAS will manually exclude these individuals).
15. Certain individuals in out-of-state placements as will be specified in the MLTSS contract.
16. Individuals enrolled in Plan First (DMAS' family planning program for coverage of limited benefits surrounding pregnancy prevention).
17. Individuals who have any insurance purchased through the Health Insurance Premium Payment (HIPP) program.
18. Individuals enrolled in the Governor's Access Plan (GAP), which provides basic medical and targeted behavioral health care to some uninsured Virginians with severe mental illness, or other limited benefit aid categories.

**Page 98, Section 6.3.1 Staffing**

**CHANGE – Section 6.3.1 has been changed per the following:**

**6.3.1 Staffing**

The Contractor shall have staff who are assigned and available to provide immediate individualized assistance to providers including but not limited to community based providers,

nursing facilities, and other providers who are both new to managed care delivery systems and need assistance with the managed care delivery systems.

At a minimum, tThe Contractor's MLTSS care coordinators, shall ~~at a minimum,~~ have a bachelor's degree in a health or human services field with at least one year of experience directly working with individuals who meet the MLTSS target population criteria or be a Registered Nurse (RN), licensed in Virginia with at least one year of experience working as a RN.

A care coordinator's direct supervisor shall be a licensed social worker, licensed Mental Health Professional (as defined in 12VAC35-105-20) or registered nurse with a minimum of two (2) years of relevant health care (preferably long-term care) experience. Care coordinators and their direct supervisors shall have demonstrated ability to communicate with members who have complex medical needs and may have communication barriers.

The Contractor's MLTSS care coordinators for ~~NF residents and EDCD or~~ Technology Assisted Waiver members shall be an RN licensed in Virginia with at least one year of experience working as a RN and with experience working with ~~the elderly,~~ individuals with physical disabilities, or individuals with complex medical needs.

Contractors may also subcontract with Community Based Organizations (CBOs) for the provision of care coordination services. The Contractor shall ensure that care coordination staff subcontracted through the CBO to handle care coordination responsibilities under the MLTSS contract meet the contractual standards for care coordinators or are accredited through NCQA as an LTSS Case Management organization. Additional information on NCQA LTSS Case Management accreditation is available at: [ncqa.org](http://ncqa.org).

#### **Page 126, Section 6.3.4.1**

**REPLACE – Section 6.4.1 with the following:**

#### **6.3.4.1 Comprehensive Health Coverage**

Under Section 1902 (a)(25) of the Social Security Act (42 U.S.C. §1396 a (a)(25)), the State is required to take all reasonable measures to identify legally liable third parties and pursue verified resources. The Contractor shall take responsibility for identifying and pursuing comprehensive health coverage. Any moneys recovered ~~by from~~ third parties shall be retained by the Contractor and identified monthly to the Department. The Contractor shall notify DMAS on a monthly basis of any members identified during that past month who were discovered to have comprehensive health coverage.

#### **Page 127, Section 6.4.2 Secure Email**

**REPLACE – Section 6.4.2 with the following:**

#### **6.4.2 Secure E-mail**

- The Contractor shall provide secure email access (TLS-encryption) between DMAS and the Contractor for correspondence containing sensitive private health information (PHI) or personal identifiable information (PII). The TLS technique is required for communications between DMAS and the contractor containing sensitive information.

- Neither direct connection of VPNs to DMAS will be used for this purpose nor will DMAS use individual email certificates for its staff. DMAS will provide no special application server(s) for this purpose.
- It is recommended that routing of emails between DMAS and the Contractor shall support Secure SMTP over Transport Layer Security (TLS) RFC 3207 (or latest) over the Internet. The vendor will coordinate TLS encryption set up with DMAS technical security staff as needed to establish TLS.
- TLS email encryption shall be maintained through the mail gateway. Bidirectional TLS email encryption must be tested, documented and maintained between DMAS and the Contractor's SMTP server.
- DMAS additionally has implemented functionality that allows for point-to-point TLS email encryption.
- All expenses incurred in establishing a secure connectivity between the Contractor and DMAS, any software licenses required, and any training necessary shall be the responsibility of the Contractor.

~~The Contractor shall provide secure email services between DMAS and the Contractor and any other entity where PHI is communicated. The emails associated with PHI must be sent to DMAS using COV security standards and encrypted methods to ensure the receiver of email has the capability to view the content based on the submission encryption and is able to do so.~~

~~All expenses incurred in establishing a secure connectivity between the Contractor and DMAS, any software licenses required, and any training necessary shall be the responsibility of the Contractor.~~

~~The Contractor shall provide SSL secure email access over the Internet between DMAS and the Contractor and any other entity where PHI is communicated. No direct connection of VPNs to DMAS will be used for this purpose nor will DMAS use individual email certificates for its staff. Such secure email will only require DMAS staff to use a greater than 128 bit SSL enabled web browser to access the Contractor or send email to the Contractor. DMAS will provide no special application server(s) for this purpose. Routing of emails over point to point telecommunications circuits between DMAS and the Contractor supports Secure SMTP over Transport Layer Security (TLS) RFC 3207 over the internet. The solution must include a method for secured industry standard email using strong encryption keys (greater than 128 bit) between DMAS and the Contractor throughout the contract term. Bidirectional TLS email encryption must be tested and documented between DMAS and the Contractor's SMTP server. DMAS additionally has implemented functionality that allows for point-to-point TLS email encryption.~~

**Page 140, Section 6.7.9 Provider Payment:**

**CHANGE – Section 6.7.9 has been changed per the following:**

### 6.7.9 Provider Payment

Notwithstanding the exceptions outlined below, in accordance with section 1932(f) of the Social Security Act (42 U.S.C. § 1396a-2), the Contractor shall pay all in-and out-of-network providers on a timely basis, consistent with the claims payment procedure described in 42 C.F.R. § 447.45 and section 1902 (a)(37), upon receipt of all clean claims for covered services rendered to covered individuals who are enrolled with the Contractor at the time the service was delivered. In the absence of an agreement between the Contractor and the provider, the Contractor shall pay out of network providers, including out of state providers at the prevailing DMAS rate in existence on the date of service. This reimbursement shall be considered payment in full to the provider or facility. Additionally, claims for emergency services shall be paid in accordance with the Deficit Reduction Act (DRA) of 2005 (Pub. L. No. 109-171), Section 6085. Reference the CMS State Medicaid Director Letter SMDL #06-010.

The following exceptions shall apply:

2. The Contractor shall ensure community LTSS (including these services when covered under EPSDT) and community behavioral health, ~~and SUD~~, and early intervention providers are paid no less than the current Medicaid FFS rate or a different negotiated rate as mutually agreed upon by the provider and the Contractor.

DMAS reserves the right to require uniform billing practices and claims submissions processes for NFs, LTSS, early intervention and community behavioral health providers. The Contractor shall develop, train providers on, and implement uniform practices in conjunction with DMAS and the other selected MLTSS Contractors.

### Page 151, Section 6.9.9 Standards for the Electronic Health Record Technology Incentive Program:

**CHANGE – Section 6.9.9 has been changed per the following:**

#### 6.9.9 Standards for the Electronic Health Record Technology Incentive Program

The Contractor shall comply with the current Federal laws and Regulations with regards to the Standards for the Electronic Health Record Technology Incentive Program as referenced under 42 C.F.R. Part 495 (the “Standards”). The Contractor shall comply with the current Standards at no additional cost to DMAS. The current Standards are located at the following site:

[http://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42cfr495\\_main\\_02.tpl](http://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42cfr495_main_02.tpl)<http://cfr.regstoday.com/42cfr495.aspx>.

The parties will work diligently and in good faith to amend ~~this Contract 10023~~ any future contract, including but not limited to changes in scope of work or price, to conform to any new or revised legislation, laws, or regulations regarding the Standards to which DMAS or Contractor become subject subsequent to the start of the Period of Performance.

### Page 151, Section 6.9.10 Risk Management and Security:

**CHANGE – Section 6.9.10:**

**6.9.10 Risk Management and Security**

~~At the Contractor's central facility, placement of software controls that establish separate files for lists of authorized user access and identification codes;~~

**Page 155, Section 6.10.16.1 Contractor Owner, Director, Officer(s) and/or Managing Employees:**

**CHANGE – Section 6.10.16.1 located on page 155 is renumbered per the following:**

**6.10.16.1 Contractor Owner, Director, Officer(s) and/or Managing Employees**

**See Attachment 1 for list of questions posed by Offerors and the Department of Medical Assistance Services response.**

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 2016-01, Addendum 3  
Vendor Questions and Answers**

Question Number	Section	Question/Comment	DMAS Response
1.	Section 1.0	Will the 115,000 ABD Medicare-Medicaid enrollees transition to MLTSS as well?	Refer to the table on page 13 of the RFP.
2.	Section 1.0, pg. 12	DMAS provides that 212K members are eligible for LTSS. Could they provide the 212K members by region and eligible population groups for that region?	Yes, please see <a href="http://www.dmas.virginia.gov/Content_pgs/mltss-ihp.aspx">http://www.dmas.virginia.gov/Content_pgs/mltss-ihp.aspx</a> .
3.	Section 1.0, pg. 12	Can DMAS clarify when the 5 year contract start date will be? Is it 5 years from award date of December 9, 2016 (which is the notice of intent to award)? Does it start 7/1/2017?	It is anticipated that the five (5) year contract start date will begin 7/1/2017.
4.	Section 1.0, pg. 12	Does DMAS intend for the contract and rates to convert to a calendar year basis after the initial 6 month period (7/1/2017 - 12/31/2017)?  Does DMAS intend for the contract and rates to convert to a calendar year basis in a future year? If so, can you please clarify when you expect the contracts and rates to be on a calendar year basis?	Yes, please see response to Question # 3.
5.	Section 1.0, pg. 12	Does the first rating period end 12/31/2017 or 6/30/2018? If the first rating period extends to June 2018, and CCC members will start rolling into this program starting Jan 2018, how will DMAS develop the rates for the CCC members given that their experience is not included in the data book?	The first rating period will end 12/31/2017.
6.	Section 1.0, pg. 13	Please provide detailed LTSS populations by Region, where do the 80K ABD members reside?	See response to Question #2.
7.	Section 1.0, pg. 13	Please provide a breakdown of MLTSS program eligible populations by region and age group. When can Offerors expect this breakdown to be released?	See response to Question #2 and the MLTSS databook.
8.	Section 1.0, pg. 13	What is the distribution of the 212,059 members by the Data Book level of detail - region and rate cohort?	The 212,059 value is a point in time count as of March 1, 2016. The Databook is based on membership over the experience period – CY 2013 through CY 2014. The average monthly membership for the same population during the Databook experience period is 207,182. The distribution of the 207,182 is shown on the “Explanatory Notes” and “TOC - Annual MMs & PMPM” tabs in the Databook.
9.	Section 1.0, pg. 13	Please confirm that the member counts on this chart EXCLUDES the 76,000 ABD individuals who will transition from Medallion 3.0 to MLTSS in January 2018 AND the 69,003 CCC program population who will transition to MLTSS	The chart includes both the ABD populations who will transition from Medallion 3.0 to MLTSS and CCC

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Question Number	Section	Question/Comment	DMAS Response
		in January 2018	program populations. Also see response to Question #2.
10.	Section 1.0, pg. 13	What is the distribution of the 76,000 ABD individuals transitioning on January 1, 2018 by region?	See response to Question # 2.
11.	Section 1.0, pg. 13	What is the Commonwealth's goal - specifically for members - for including persons in the ABD eligibility category (non-duals and those who do not receive LTSS) into the MLTSS program?	Including persons in the ABD eligibility category will allow for improved continuity of care and help to mitigate serve gaps. The goal of serving the ABD population under one fully integrated program is to identify needs in advance and reduce or eliminate the need for LTSS services in the future. Current ABDs are essentially duals in waiting. They will likely transition to the MLTSS program at some point, and if this occurs, it could happen at a time where the individual has the most complex level of care needs.
12.	Section 1.0, pg. 16	What is the distribution of the populations shown – 39,493 eligible but not enrolled and 29,510 enrolled - by rate cohort?	This data is in development.
13.	Section 1.0 & 8.0, pg. 17 & 189	Please confirm when and how Money Follows the Person will be used to support facility transitions since the Contractor is required to support transitions, but those who are enrolled in MFP will be dis-enrolled from MLTSS (e.g., health plan's role in member identification, transition support, follow up coordination upon discharge, etc.).	<p>MLTSS is considered the next step in the Commonwealth's Medicaid LTSS rebalancing initiative. The MLTSS capitation rates will be designed to incentivize these rebalancing efforts.</p> <p>Virginia's MFP demonstration program funding will only be available to support individuals who transition from an institution to community living on or before December 31, 2017. As such, one of the critical MFP services (transition services) was created as a permanent part of the HCBS waiver system. Transition services will continue to be available as a core LTSS service offered by the MLTSS health plans even when the MFP Program ceases to exist. The intent of</p>

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Question Number	Section	Question/Comment	DMAS Response
			<p>this is to continue allowing individuals to transition from an institutional level of care into the community.</p> <p>MLTSS enrollees will continue to have the option to move from a NF to the community through either the MFP program or within the MLTSS model. Before an enrollee enters the MFP Program, he/she will remain enrolled in his/her MLTSS health plan. Plans will need to ensure that enrollees in NFs 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 disenrolled from MLTSS. After the enrollee's 12 months of MFP eligibility are up, if he/she continues to meet the eligibility criteria for MLTSS, he/she will be eligible to re-enroll in MLTSS.</p> <p>With this said, it is not necessary for an individual to disenroll from MLTSS to access transition services/care management support to enable the individual to safely transition out of an institution into the community.</p>
14.	Section 2.0 & 3.3.5, pg. 23 & 43	The RFP states that the vignettes shall be a maximum of five pages per vignette, yet the chart on page 23 says that the vignettes are limited to three pages each. Please clarify which standard will be used.	The vignettes shall be limited to three (3) pages each. See RFP Addendum.
15.	Section 2.1, pg. 18	Section 2.1 states that "The proposals may include additional information that the Offeror considers relevant to this RFP." Are there specific requirements that the Offeror must meet – for example, format and location – if including additional information in its proposal?	Offerors still need to meet the requirements outlined in Section 2.10 of the RFP.
16.	Section 2.1, pg. 18	It is common in public sector proposal practice to precede the Offeror's response with the RFP question or requirement to which the Offeror is	See page limits guidance table attached to this Addendum.

**Attachment 1**  
**RFP 2016-01, Addendum 3**  
**Vendor Questions and Answers**

Question Number	Section	Question/Comment	DMAS Response
		<p>responding.</p> <p>Does DMAS have a preference as to whether this RFP question or text is included?</p> <p>If included, will that RFP question or text be excluded from consideration in determining whether the Offeror’s response is within the page limit?</p>	
17.	Section 2.1 & 2.10, pg. 18 & 22	Please clarify whether additional, relevant information included in the proposal (as permitted in section 2.1) would count toward the prescribed page limits on pages 23 and 24.	Yes and see response to Question #15.
18.	Section 2.2	Does the page limit account for space used by listing each question? The RFP questions take up valuable writing space in the response. We recommend adding 5 pages to each section limit that will allow Offerors to make up for the lost writing space.	See response to Question # 16.
19.	Section 2.2, pg. 18	<p><i>"Offerors may use a larger size font for section headings and may use a smaller font size for footers, tables, graphics, exhibits, or similar sections, if necessary."</i></p> <p>Please confirm footers and page numbers do not fall within the 1” page margin requirement?</p>	Confirmed.
20.	Section 2.2, pg. 18	RFP Section 2.2 references 8 1/2” x 11” paper with 1” margins and printed on “one side only.” We interpret this to mean that DMAS is expecting Offerors to print their hard copy responses one side of each page. Due to economic and environmental considerations, will DMAS reconsider this requirement and allow Offerors to print their hard copy responses on two-sided pages?	Yes, this confirms that Offerors may print response on both sides of paper.
21.	Section 2.2, pg. 18	RFP Section 2.2 states: “A tab sheet keyed to the Table of Contents shall separate each major section. The title of each major section shall appear on the tab sheet.” Please clarify what the term “major section” represents. For example, please confirm if DMAS considers major section titles the two digit level RFP sections, such as “3.3 System of Care”; or two and three digit level RFP sections/subsections, such as “3.3 System of Care” and “3.3.1 Covered Services?”	Two digit level, such as 3.2, 3.3, etc.
22.	Section 2.2, pg. 18	<p>RFP Section 2.2 states: “The Offeror shall also submit five electronic copies (thumb drives preferred) of their proposal in MS Word format (Microsoft Word 2010 or compatible format).”</p> <p>1. Attachments and/or other supplemental documentation required by Offeror’s may not always be available electronically via MS Word format. Please confirm if it is permissible to provide electronic copies via PDF format when files are not available in a MS Word format?</p>	<p>1. This confirms that it is permissible to provide electronic copies via PDF format when files are not available in a MS Word format.</p> <p>2. This confirms that it is permissible for Offerors to submit (non-redacted)</p>

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Question Number	Section	Question/Comment	DMAS Response
		<p>2. For purposes of a more efficient means of allowing “searchable” electronic media and compatibility, please confirm that it will be permissible for Offerors to submit (non-redacted) electronic copies of its proposal in PDF format (vs. Word format).</p> <p>a. If PDF files are permissible, due to file size limitations, may Offerors submit multiple files (in PDF version) vs. one compiled PDF file?</p>	<p>electronic copies of its proposal in PDF format (vs. Word format).</p> <p>a. This confirms that it is permissible for Offerors to submit multiple files (in PDF version) vs. one compiled PDF file. However, Offerors are responsible for ensuring responses are submitted in total and in an orderly fashion to ensure evaluators have no issues finding response to requirements.</p>
23.	Section 2.2, pg. 18	RFP Section 2.2 states: “In addition, the Offeror shall submit a redacted electronic copy in PDF of its proposal, in which the Offeror has removed proprietary and trade secret information.” Please confirm if Offerors are expected to provide a redacted hard copy of its proposal response.	Offerors only need to provide a redacted electronic copy of their proposal submission in PDF. Submission of a redacted hard copy is not required.
24.	Section 2.2, pg. 18	Please confirm what DMAS’s expectations are for placement of supplemental attachments/documentation within the binding of its proposal responses.	Supplemental attachments must adhere to the page limit requirements outlined in the guidance table attached to this Addendum.
25.	Section 2.2, pg. 18	<p><i>“A tab sheet keyed to the Table of Contents shall separate each major section.”</i></p> <p>Please define what constitutes a “major section” (e.g. “3.0 Technical Requirements” vs. “3.1 Executive Summary”).</p>	See response to Question # 21.
26.	Section 2.2, pg. 18	<p>RFP Section 2.2 states: <i>“Offerors may use a larger size font for section headings and may use a smaller font size for footers, tables, graphics, exhibits, or similar sections, if necessary. The smaller font size must be legible.”</i></p> <p>May Offerors include the relevant RFP text for reference for a corresponding proposal section? If so, can we assume that RFP text is excluded from the page-limit provided in RFP Section 2.10?</p>	See page limits guidance table attached to this Addendum.
27.	Section 2.2, pg. 18	The RFP states that “The proposals shall be typed, bound, page-numbered, single-spaced no smaller than a 12-point font on 8 ½” x 11” paper with 1” margins and printed on one side only.” Printing single-sided will double the size of each Offeror’s proposal, making more and larger binders necessary, ultimately making binders more difficult for evaluators to use. Please consider allowing proposals to be printed on both sides of the paper.	See response to Question # 20.
28.	Section 2.2, pg. 18	The RFP states that proposals shall be page-numbered. Should the response be consecutively page numbered from beginning to end, or numbered by section?	Page numbering sequence (beginning to end or numbered by sections) is at the option of the Offeror but should allow

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Question Number	Section	Question/Comment	DMAS Response
			easy reference to various sections of the proposal response.
29.	Section 2.2, pg. 18	The RFP states “Each hard copy and all documentation submitted shall be contained in single three-ring binder volumes where practical.” Can DMAS please confirm that proposals may be submitted in multiple three-ring binders that constitute a “single volume”?	This confirms that proposals may be submitted in multiple three-ring binders that constitute a “single volume”.
30.	Section 2.2, pg. 18	Section 2.2 references “each major section” several times—please clarify to which level of structure this refers.	See response to Question # 21.
31.	Section 2.2, pg. 18	Section 2.2 states that “The Offeror shall also submit five electronic copies...of their proposal in MS Word format (Microsoft Word 2010 or compatible format).” Some reports and attachments may not be available in Microsoft Office formats. Please confirm that Offerors can submit components of their unredacted electronic submission in PDF format.	See response to Question # 22.
32.	Section 2.2, pg. 18	Is Adobe pdf. considered to be a MS Word Compatible format?	See response to Question # 22.
33.	Section 2.2, pg. 18	The Department states that proposals are to be submitted in Word 2010 or compatible format. <ul style="list-style-type: none"> <li>• Does this format restriction apply only to our narrative?</li> <li>• May we submit some documents, including, but not limited to, signed forms, and financial statements as PDFs?</li> <li>• May we submit our electronic version of the project work plan in MS Project or as a PDF?</li> <li>• Please confirm that financial statements are exempt from the single-sided printing requirement.</li> </ul>	See response to Questions # 22 and 27.
34.	Section 2.4, pg. 19	The requirement states, in part: “Confidential information shall be clearly marked in the proposal and the reasons why the information should be confidential shall be clearly stated.”  Please confirm that we are to provide justification for protection only on Attachment G.	This confirms that the Offeror’s justification for protection only needs to be provided on the DMAS supplied Attachment G.
35.	Section 2.5, pg. 20	#1.a: Please confirm this language refers to only state or local government contracts held within the Commonwealth of Virginia, and that identification of government contracts held with Federal agencies or state or local agencies outside the Commonwealth will not be required to satisfy this requirement in the Transmittal Letter.  Please also confirm that this language does not pertain to provider contracts that would include FQHC’s, RHC’s or Community Agencies.	#1.a: The language in this section is all inclusive and Offerors must identify all contracts or agreements held with the listed entities whether inside or outside the Commonwealth of Virginia. Note for this Section, contracts with Federal agencies are not one of the required entities to be listed.

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Question Number	Section	Question/Comment	DMAS Response
			Provider contracts should be included if they are with a state or local government entity.
36.	Section 2.5, pg. 20	#4: Please confirm that the “authorized representative of the organization who will interact with DMAS on any matters pertaining to this RFP and resultant contract” is not required be the same authorized representative who is to sign the contract and RFP submission.	This confirms that the “authorized representative of the organization who will interact with DMAS on any matters pertaining to this RFP and resultant contract” is not required be the same authorized representative who is to sign the contract and RFP submission.
37.	Section 2.5, pg. 20	<p>In the transmittal letter, Offerors “must be able to present <i>sufficient assurances</i> ... that [contract award] will not create a conflict of interest between the Contractor, the Department and its subcontractors.” (emphasis added)</p> <p>Would the Department please elaborate on the type and nature of the assurances that would need to be included in the transmittal letter?</p>	In this instance, <i>sufficient assurances</i> would be the Offeror’s written confirmation to attest to the fact that, after thorough review of all its business relationships, an award of contract would not create any conflicts of interest.
38.	Section 2.7, pg. 21	Please confirm that questions may only be submitted to the designated principal point of contact before the May 13, 2016 deadline (as referenced on RFP page 25), and that no questions may be submitted after this deadline unless specifically requested by DMAS in an RFP addendum.	Confirmed.
39.	Section 2.8 and elsewhere, pg. 21 and elsewhere	Should references throughout the RFP be stated in terms of Eastern Time, and not Eastern Standard Time? Critical deadlines are stated in terms of standard time – e.g., the deadline for submission of the Proposal is stated as 10:00 AM EST. However, we are currently under Daylight Saving Time, which is one hour later – 10:00 EST = 11:00 EDT.	Reference to Eastern Standard Time (EST) and any other reference to time has been changed to “Local Time”. See RFP Addendum No. 3
40.	Section 2.9, pg. 21/22	Potential Means for Further Evaluation: How would points be assigned for each of evaluation tools, if chosen by DMAS?	See Section 5.2 of the RFP.
41.	Section 2.10, pg. 22	<p>“Offerors must respond to all sections of the RFP”.</p> <p>Please confirm that the attestation we provide as part of Transmittal Letter, in response to Item 2 on page 20 of the RFP, in addition to developing the specific required responses found in Item 2.10 Proposal on 22, are sufficient to satisfy this requirement?</p>	Confirmed.
42.	Section 2.10, pg. 22	Is it DMAS’ intent that Offerors who are *not* responding as a Specialty plan respond only to Sections 3 and 4 of the RFP as specified in the outline table on RFP pages 23-24, while recognizing that their response must conform to the requirements in Section 6.0, Terms and Conditions, and Section 7.0, General	All Offerors have to respond to the RFP per the instructions in Section 2.10. However, Offerors do not need to respond to Sections 1 and 5-7 of the

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		Terms and Conditions? Or must Offerors who do *not* respond as a Specialty plan also respond to each of the elements in Section 6.0 and Section 7.0? Please clarify.	RFP. These Sections provide important MLTSS background information.
43.	Section 2.10, pg. 22	<p>Section 2.10 confirms the Offeror can submit a proposal for one or more regions. Section 3.7 indicates the Offeror shall provide a project work plan for each region that it bids that includes timelines, responsible parties, milestones, and dependencies, etc.</p> <p>To be able to provide both comprehensive narrative responses and detailed work plans, would the Department consider applying the 12-page limit to the narrative responses only (Items 2-5 of Section 3.7) and excluding the workplans from the page limit?</p>	See page limits guidance table attached to this Addendum.
44.	Section 2.10, pg. 22	<p>Please clarify if the text in this section that states "Offerors must respond to all sections of this RFP" means that Offerors must acknowledge every requirement from page 1 through the end of the RFP or if this means that Offerors must respond to all Sections within the RFP that ask for a response or submission of information including:</p> <ul style="list-style-type: none"> <li>~ Section 1.0 Background,</li> <li>~ Section 2.0 Proposal Instructions,</li> <li>~ Section 3.0 Technical Requirements,</li> <li>~ Section 4.0 Past Experience,</li> <li>~ And any required forms and Attachments included in the RFP</li> </ul>	See response to Question # 42.
45.	Sections 2.10 & 5.1, pg. 22 & 69	Page 22 specifies 7 required documents to be submitted with proposals. Page 69, Section 5.1, lists 6 required documents. Attachments C and D are not included on the list on page 69. Please confirm that Attachments C and D are required for submission.	Confirmed.
46.	Section 2.10 & 3.2.6, pg. 23 & 30	Please confirm that the requested resumes and job descriptions will not count towards the 10-page section limit.	See page limits guidance table attached to this Addendum.
47.	Section 2.10, pg. 23	RFP Section 2.10 states: "Offerors must respond to all sections of this RFP." It also states "The Offeror's Technical Proposal response should adhere to the page limits for each section or subsection identified in the chart below." In the referenced chart, RFP Sections 3.0 and 4.0 are listed along with page limits. Please confirm that DMAS is not expecting written narrative responses to RFP Sections 6.0 and 7.0.	See response to Question # 42.
48.	Section 2.10, pg. 23	<p>RFP Section 2.10 provides page limits for each section or sub-section. Please confirm the following:</p> <ol style="list-style-type: none"> <li>1. There is a 10-page limit for Section 3.2, Corporate Overview. Please</li> </ol>	See page limits guidance table attached to this Addendum.

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		<p>confirm the following items are excluded from the 10-page limit:</p> <ul style="list-style-type: none"> <li>a. Resumes</li> <li>b. Job descriptions</li> <li>c. Licenses and certifications</li> <li>d. Organizational charts</li> </ul> <p>2. RFP Section 3.3.3 states: “Submit for review any tools or flow charts that illustrate the proposed processes.” Is it DMAS’s intent that the tools and flow charts be included in the page limits for Section 3.3.3 or may the tools be included as attachments?</p> <p>3. RFP Section 3.3.3.7 regarding “Care Coordination Staffing” states: “The Offeror shall submit job descriptions for all staff members involved in care coordination activities.” Please confirm if job descriptions are included in the 10-page limit.</p> <p>4. Please confirm the following regarding Section 3.5.1:</p> <ul style="list-style-type: none"> <li>a. Whether or not the organizational charts, dedicated staffing numbers by position, job descriptions and staff qualifications, locations, subcontract descriptions and oversight and management plan are included in the 8 page limit. <ul style="list-style-type: none"> <li>i. Some Offerors may have parent companies and subsidiary companies in multiple lines of business, and their corporate structure may be complex. Would the state consider increasing the page limit for Section 3.2 or excluding the organizational chart(s) from the page limit?</li> </ul> </li> <li>b. Whether or not the staff training approach is included in the 8 page limit.</li> <li>c. Whether the knowledge transfer approach is included in the 8 page limit.</li> </ul> <p>5. RFP Section 3.5.2 states: “In response to this RFP, the Offer shall also submit for review any tools or flow charts that illustrate the proposed communications processes.” Are the tools and flow charts included in the 4-page limit?</p> <p>6. Will supplemental Attachments/documentation be counted towards the allotted RFP page limits?</p>	
49.	Section 2.10, pg. 23	RFP Section 2.10 provides a listing of the documents (items 1-7) required of this RFP. Please confirm that DMAS is expecting Offerors to place items 1-7 within the binding of their proposal responses, in sequential order or as represented within RFP Section 2.10, page 22.	The Offerors’ proposals shall be in sequential order as represented in Section 2.10 of the RFP.

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50.	Section 2.10 & 3.3.5, pg. 23 & 43	RFP Section 2.10 provides a page limit of 18 pages for Section 3.3.5 Vignettes, and states that each Vignette is limited to 3 pages. RFP Section 3.3.5 states: "Vignettes shall be a maximum of five pages per vignette, single-spaced."  Please confirm the page limit per Vignette.	See response to Question # 14.
51.	Section 2.10 & 3.3.5, pg. 23 & 43	Vignette limits are defined as three (3) pages each on RFP page 23 and five (5) pages each on RFP page 43. Please confirm that five (5) pages per vignette (and thus 30 pages total), as written in the Technical Requirements section, is the correct limit.	See response to Question # 14.
52.	Section 2.10 & 3.3.5, pg. 23 & 43	Page 23 specifies that vignettes are limited to three pages each. Page 43, Section 3.3.5, specifies that vignettes are a maximum of 5 pages each. Please confirm the page limit.	See response to Question # 14.
53.	Section 2.10, pg. 23	Please confirm that resumes and job descriptions do not count toward the 10-page limit for Section 3.2 of proposal responses.	See page limits guidance table attached to this Addendum.
54.	Section 2.10, pg. 23	Can offerors submit attachments or appendices to their proposals with additional pertinent information? If so, do these count toward the section's page limit?	See response to Question # 15.
55.	Section 2.10, pg. 23	Proposal Section 2.10 outlines page limits for proposal sections. Should bidders assume that if no page limit is specified for a given RFP Section, that any response for that section is neither necessary nor desired? For example, while the individual Models of Care (MOC) (Sections 3.3.3.1 through 3.3.3.8) each have separate page limits, their overriding section, 3.3.3, does not. Is our assumption correct that DMAS does not desire a response that directly addresses the requirements found in section 3.3.3? Similarly, RFP Section 3.0 has no page limit indicated but its subsections do. If no responses to these sections are desired, where should Offerors address the requirements included in these sections?	Section 3.3.3 provides a framework on how to respond to each subsection of the Model of Care and each of these subsections has a defined page limit.
56.	Section 2.10, pg. 23	The RFP requires Offerors to submit supporting material in numerous sections throughout the RFP, that aren't necessarily referenced within the page limits table in RFP Section 2.10.  Will the Commonwealth consider excluding supporting documents, attachments, exhibits, etc. from the section page limits, beyond those items specified in the Section 2.10 page limit table?	See page limits guidance table attached to this Addendum.
57.	Section 2.10, pg. 23	May Offerors submit additional material to support our response (exhibits, diagrams, samples, etc.) even in sections of the proposal where the RFP has not explicitly advised to do so? If so, can Offerors assume these supporting materials are excluded from the page limit?	See page limits guidance table attached to this Addendum.

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58.	Section 2.10, pg. 23	<p>RFP Section 2.10 states: <i>“The Offeror’s Technical Proposal response should adhere to the page limits for each section or subsection identified in the chart below. If the Offeror is proposing to operate in multiple regions, the Offeror should adhere to the page limits detailed below.”</i></p> <p>Did the Commonwealth not want to set additional page limits for responses proposing to operate in multiple regions (e.g., <i>“If the Offeror is proposing to operate in multiple regions, the Offeror should still adhere to the page limits detailed below.”</i>)?</p>	Correct, the page limits remain regardless of how many regions the proposal addresses. Also, see page limits guidance table attached to this Addendum.
59.	Section 2.10, pg. 23	The page limit for 3.2 Corporate Overview is listed as 10 pages, not including financial statements. Please confirm that resumes that must be included with section 3.2.6 do <u>not</u> count toward the 10-page limit applicable to section 3.2 overall.	See page limits guidance table attached to this Addendum.
60.	Section 2.10, pg. 23	<p>The RFP states that <i>“The Offeror’s Technical proposal response should adhere to the page limits for each section or subsection identified in the chart below.”</i></p> <p>Can DMAS confirm that the question text is excluded from the total page count?</p>	See page limits guidance table attached to this Addendum.
61.	Section 2.10 & 3.3.5, pg. 23 & 43	The page limit for section 3.3.5 Vignettes on page 23 states <i>“Vignettes are limited to 3 pages each.”</i> In section 3.3.5 Vignettes on page 43, the narrative states <i>“Vignettes shall be a maximum of five pages per vignette, single-spaced.”</i> Can DMAS please clarify the page limit for vignettes?	See response to Question # 14.
62.	Section 2.10, pg. 23	Confirm the page allocation for the vignettes. The table on page 23 references 3 pages each and 3.3.5 (page 43) instructions state a maximum of 5 pages.	See response to Question # 14.
63.	Section 2.10 & 3.7, pg. 23 and 58	We understand that the page limit for section 3.7 is limited to 12 pages including the requested work plan. May Offerors submit a full project plan in Microsoft Project as an attachment to this section?	No. See page limits guidance table attached to this Addendum.
64.	Section 2.10, pg. 23-24	Do the questions as outlined in Section 3.0 Technical Requirements that require responses count in the page allocation as outlined on pages 23 and 24?	See response to Question # 16.
65.	Section 2.10, pg. 24	Please confirm that all region-specific responses must be completed within the listed page numbers.	See response to Question # 58.
66.	Section 2.10, pg. 24	Please confirm that flow charts and other supplemental information (included those required and not required) are not included in the listed page numbers.	See page limits guidance table attached to this Addendum.
67.	Section 2.11, pg. 24	If a contractor makes claims for the delivery of services and does not follow through and is thus terminated. How will the population that was awarded them be distributed if they are one of the two plans selected for a region? Would the existing contractors in other regions be allowed to move into that region or would those members be available to the remaining contractor in that region or would the region be put up for another bidder?	A transition plan would be created and the transition process will be outlined in the MLTSS Contract.

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68.	Section 2.12, pg. 25	When will the Readiness Review criteria or tool be provided? Are the readiness elements phased over time between August-December? What are Readiness due dates for Network Adequacy and other deliverables?	The Readiness Review tool, including milestones and timelines, will be available at the time Offerors are selected for negotiations which is anticipated to occur in August 2016.
69.	Section 2.14, pg. 26	Please confirm which two vignettes Offerors will be required to present in July of 2016.	RFP Section 2.14 has been updated. Information regarding vignettes will be sent to participating Offerors after the proposal due date/time (see Addendum).
70.	Section 2.14, pg. 26	When does DMAS expect to share the addendum providing details and timing on in-person vignette presentations? Please confirm that Offerors will be able to submit separate questions on this addendum when released.	See response to Question # 69. DMAS may respond to questions Offerors may have concerning their scheduled presentation date.
71.	Section 3.0, pg. 27	Regarding the sentence: <i>“Offerors are encouraged to present innovative in how the requirements outlined in this RFP are accomplished.”</i> Please confirm that DMAS intends this sentence to be: <i>“Offerors are encouraged to present innovative methods in how the requirements outlined in this RFP are addressed.”</i>	Confirmed, the sentence should read <i>“Offerors are encouraged to present innovative methods in how the requirements outlined in this RFP are addressed.”</i>
72.	Section 3.0, pg. 27	Please confirm that Offerors are only required to identify subcontractors that are directly responsible for performing core services required under the MLTSS program contract.  Other States have established financial materiality thresholds (e.g. Subcontractor is defined as “material” if receiving payments from the Offeror in amounts equal to or greater than ten (10) million dollars annually during the State fiscal year). Please provide any related thresholds or definitions required for this program.	Identify subcontractors that will perform any requirements outlined in the RFP.
73.	Section 3.0, pg. 27	RFP Section 3.0, paragraph three states: <i>“Offerors are encouraged to present innovative in how the requirements outlined in this RFP are accomplished. The Offeror may propose alternate strategies to accomplish any of the requirements described below and how the alternate strategies will meet the DMAS requirements and objectives as appropriate.”</i> It appears that language may be missing from this requirement. Can DMAS provide the missing language?	See response to Question # 71.
74.	Section 3.0, pg. 27	Please confirm that section headings for which there are not specified page limits are to be interpreted as instructions to Offerors and not as separate technical requirements. For example, the language below the 3.0 heading and above the 3.1 heading on RFP page 27.	Section headings provide a framework on how to respond to each corresponding subsection. Subsections have defined page limits.

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		Alternatively, if Offerors are meant to interpret this language as separate technical requirements, please specify applicable page limits for these sections.	
75.	Section 3.2, pg. 27-31	With regard to the supporting material required in RFP Section 3.2, we understand that financial statements are not included in the 10-page limit for the section. Items such as the business license, service area approval and certificate, D-SNP verification or plan, NCQA accreditation plan, and Prohibited Affiliation information via the Disclosure of Ownership and Control Interest Statement (CMS 1513) may also take up a significant number of pages. Please confirm that these items could be provided as attachments that do not count toward the 10-page limit.	See page limits guidance table attached to this Addendum.
76.	Section 3.2, pg. 28 & 29	Do the copies of licenses, certifications and accreditations count toward page limits? Can these be included in an attachment?	See page limits guidance table attached to this Addendum.
77.	Section 3.2 & 3.2.2, pg. 28	Does the requested licensure documentation count towards the ten (10) page limit of the Bureau of Insurance section?	See page limits guidance table attached to this Addendum.
78.	Section 3.2 & 3.2.6, pg. 29	Are the requested job descriptions and resumes included in the 3.2 Corporate Overview section page count of ten (10) total pages?	See page limits guidance table attached to this Addendum.
79.	Section 3.2.1, pg. 27	Must the organizational chart include all subsidiaries and owned entities for the Offeror and the Offeror's parent organization?  Does this chart count toward the page limit?	Yes.  See page limits guidance table attached to this Addendum.
80.	Section 3.2.1, pg. 27	Would the Department confirm that the organization charts do not count toward the page limit for this section?	See page limits guidance table attached to this Addendum.
81.	Section 3.2.1, pg. 27-28	Please confirm that organizational charts should include only those subsidiaries and businesses owned by the Offeror's parent company that are, in turn, directly owned by the Offeror itself and not all subsidiaries and businesses owned by an Offeror's parent company, even if they are not directly owned by the Offeror itself.	The organizational charts should include all subsidiaries and businesses owned by an Offeror's parent company, even if they are not directly owned by the Offeror itself.
82.	Section 3.2.1, pg. 27-28	Some Offerors have parent companies with numerous subsidiaries in lines of business unrelated to the Medicaid/LTSS business that is the subject of this proposal. To the extent the Commonwealth requires that organizational charts include all subsidiaries and businesses owned by an Offeror's parent company even if they are not directly owned by the Offeror itself, would the Commonwealth be amenable to limiting the subsidiaries and businesses required to be included in the organizational charts to those in the Medicaid/LTSS line of business only.	No.
83.	Section 3.2.1, pg. 27-28	RFP Section 3.2.1 states: “the Offeror shall submit an organizational chart and description of the Offeror’s corporate structure.” Would the Department	See page limits guidance table attached to this Addendum.

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84.	Section 3.2.2, pg. 27-28	<p>RFP Section 3.2.2 states: <i>“If currently operating in Virginia, the Offeror must submit a copy of their valid and current license (not under suspension or revocation) from the Virginia State Corporation Commission’s Bureau of Insurance (BOI), and copies of quarterly and annual filings submitted to the BOI within the past two calendar years. These must be submitted prior to MLTSS contract signing (if selected).”</i></p> <p>As a newly licensed health plan, Molina Healthcare of Virginia has not yet submitted quarterly and annual filings to the Bureau of Insurance. Given that, is there something else we should provide in lieu of that information, such as the parent company’s audited financial statements for the last three years? What alternative does the Commonwealth suggest?</p>	Yes, the Offeror should submit its last three (3) years of audited financial statements. In addition, submit the Offeror’s financial plan for how it will raise the capital required by the BOI to operate as a health plan in Virginia.
85.	Section 3.2.2, pg. 28	For currently licensed Offerors, please confirm copies of licenses and quarterly and annual filings submitted to the BOI are not expected to be included in Offerors’ proposals to DMAS, but should be submitted prior to contract signing.	Copies of licenses and quarterly and annual filing submitted to BOI shall be submitted in response to the RFP.
86.	Section 3.2.2, pg. 28	<p>The first paragraph indicates that Offerors currently operating in Virginia must submit their license and Bureau of Insurance filings. However, the last sentence of this paragraph states "These must be submitted prior to MLTSS contract signing (if selected)."</p> <p>Please clarify whether the license and insurance filings are to be submitted with the proposal or at contract signing.</p>	If currently operating in Virginia, Offerors must submit a copy of their valid and current license (not under suspension or revocation) from the Virginia State Corporation Commission’s Bureau of Insurance (BOI), and copies of quarterly and annual filings submitted to the BOI within the past two calendar years. These will also be required prior to contract signing, if selected as a MLTSS health plan.
87.	Section 3.2.2, pg. 28	RFP Section 3.2.2 states: <i>“If the Offeror does not have a valid and current license from the BOI to operate as a licensed health plan in Virginia, the Offeror must submit a copy of its last three (3) years of audited financial statements.”</i> Given the large page volume of audited financial statements, would the Department consider allowing Offerors to submit in an electronic format only, rather than paper?	Offerors may submit the statements in an electronic format.
88.	Section 3.2.2, pg. 28	RFP Section 3.2.2 states: <i>“If the Offeror does not have a valid and current license from the BOI to operate as a licensed health plan in Virginia, the Offeror must submit a copy of its last three (3) years of audited financial statements.”</i> If printed copies are required, given the large page volume of	Double-sided is acceptable.

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		audited financial statements, will the Department consider allowing Offerors to submit audited financial statements printed double-sided?	
89.	Section 3.2.2, pg. 28	If a plan has a current and valid license from BOI and is not operating in VA, are they required to submit the last three (3) years of audited financial statements and a financial plan for capital requirements? If so, is there a required format for the financial plan or is a narrative on how the plan will raise the required capital sufficient?	Yes.
90.	Section 3.2.3, pg. 28	Please confirm that the certification documents required in response to this section do not count towards the page limit.	See page limits guidance table attached to this Addendum.
91.	Section 3.2.4, pg. 29	RFP Section 3.2.4 requires that Offerors that do not currently operate a D-SNP plan in the localities it proposes to provide services must submit a plan for establishing and operating a D-SNP. May Offerors submit this plan as an attachment, excluded from the 10-page limit that applies to all of Section 3.2?	See page limits guidance table attached to this Addendum.
92.	Section 3.2.4, pg. 29	Offerors are required to submit CMS contracts to verify their Virginia D-SNP. Please confirm D-SNP contracts can be submitted as appendices which will not count toward the 10 page limit for 3.2 Corporate Overview.	See page limits guidance table attached to this Addendum.
93.	Section 3.2.4, pg. 29	Please confirm that the Commonwealth will expedite the process for D-SNP service area expansions since CMS requires 14 months plan experience before allowing expansion.	DMAS does not have any control over CMS' D-SNP service area expansion process, requirements or timelines.
94.	Section 3.2.4, pg. 29	Please confirm the specific contract requirements for D-SNPs beyond the basic MIPPA requirements.	The proposed CY 2017 Dual Eligible Special Needs Plan (D-SNP) contract is available at <a href="http://www.dmas.virginia.gov/Content_pgs/mltss-dsnp.aspx">http://www.dmas.virginia.gov/Content_pgs/mltss-dsnp.aspx</a> .
95.	Section 3.2.4 & 6.1.4, pg. 29 & 72	The language pertaining to the D-SNP requirement varies slightly between the Technical Requirements section (3.2.4) and the Terms & Conditions section (6.1.4). This variation is material due to how the anticipated award date falls relative to the required timelines for Medicare Advantage D-SNP contracting and product filings. Please confirm Offerors are required to both receive a D-SNP contract <i>and</i> begin operating the D-SNP within two (2) years of contract award, and that receiving a D-SNP contract alone by that date will not be sufficient.	Offerors are required to begin operating the D-SNP within two (2) years of contract award. Receiving a D-SNP contract alone by that date will not be sufficient.
96.	Section 3.2.6, pg. 27	Please confirm that an offeror may utilize key CCC staff that will become fully dedicated to the MLTSS program upon termination of the CCC program, to fill the key MLTSS staff positions as defined in section 3.2.6 of the RFP?	Confirmed as long as the Offeror remains fully responsive to both the MLTSS and CCC programs.
97.	Section 3.2.6, pg. 29	Please verify that resumes of key staff members are not included within the total page count.	See page limits guidance table attached to this Addendum.

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98.	Section 3.2.6 & 3.5.1, pg. 29-30 & 47	<p>Section 3.2.6 asks the Offeror to submit office locations and its proposed organizational structure. It also asks the Offeror to submit job descriptions for various specific positions and "other top leadership positions". Section 3.5 also asks the Offeror to submit its proposed organizational charts, job descriptions and staff qualifications, and locations (among other elements).</p> <p>1) Please clarify whether the information is to be submitted in both places.</p> <p>2) If the Offeror creates proposal appendices for these elements, may both sections refer to the same set of such appendices, or must the information be replicated for each Section?</p>	The information can be submitted in one place and referenced in another.
99.	Section 3.2.6, pg. 29-30	RFP Section 3.2.6 requires Offerors to include resumes and job descriptions for key staff and leadership roles. Job descriptions and resumes for the identified key staff and other leadership positions could easily exceed ten pages. Would the Commonwealth consider excluding resumes and job descriptions from the 10-page limit that applies to all of section 3.2?	See page limits guidance table attached to this Addendum.
100.	Section 3.2.6, pg. 30	Would the Department confirm that the resumes and job descriptions do not count toward the page limit for this section?	See page limits guidance table attached to this Addendum.
101.	Section 3.2.6, pg. 30	Please confirm that the Virginia Project Director is considered to be directly employed by the Offeror if he/she is employed by the Offeror's parent organization, is 100% dedicated to the leadership and operations of the plan, and is based/resides in the Commonwealth of Virginia.	Confirmed.
102.	Section 3.2.6 & 3.5.1, pg. 30 & 47	Section 3.5.1 states that "In response to this RFP, the Offeror shall include proposed Virginia MLTSS program organizational charts, dedicated staffing numbers by position (delineated by employer), job descriptions and staff qualifications, locations, subcontract descriptions, and its oversight and management plan" Please confirm that job descriptions and staff qualifications are only required for the positions identified in the first two paragraphs on page 30 of the RFP.	Confirmed. This information is required for: Virginia MLTSS Project Director, MLTSS Project Manager, MLTSS Care Coordination Manager, Virginia licensed Medical Director, and top leadership positions including individuals responsible for network recruitment, credentialing and management, medical oversight, behavioral health oversight, long-term services and supports oversight, pharmacy oversight, quality, financial management, claims payment, utilization management, and IT management.
103.	Section 3.2.6, pg. 30	Is the position referenced in paragraph 1, page 30 as "behavioral health oversight" the same position referenced in paragraph 2, page 30 as "behavioral	Yes.

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		health lead”?	
104.	Section 3.2.6, pg. 30	Is the position referenced in paragraph 1, page 30 as “long term services and supports oversight” the same position referenced in paragraph 2, page 30 as “long term services and supports lead”?	Yes.
105.	Section 3.2.6, pg. 30	Section 3.2.6 Pg. 30 of the RFP states “... the Virginia MLTSS Project Director must be directly employed by the Offeror.” Please confirm whether a Project Director who lives in Virginia, is 100% dedicated to Virginia MLTSS operations, and has local decision-making authority, but is employed through an affiliate of the Offeror, would meet this requirement.	Confirmed.
106.	Section 3.2.6, pg. 30	If the MCO's personnel are employed by the MCO's affiliated plan manager, pursuant to an arm's length subcontract that meets the requirements of this RFP and applicable law, may the Project Director be employed by the affiliated plan manager?	Confirmed.
107.	Section 3.2.7, pg. 30-31	Must the Offeror include with its Proposal the ownership & control forms of its subcontractors?	No. However, DMAS reserves the right to request this information at any time during the RFP evaluation and we will require it during negotiations.
108.	Section 3.3.2, pg. 31	How many individuals on the ID, DS and DD Waiver waiting lists are enrolled in another waiver (e.g., EDCD Waiver) until a waiver slot becomes available? How long, on average, is a person on a waiting list?	In May 2016, 8,373 individuals were on the ID Waiver waiting list. Of these, 3037 (or 36%) were enrolled in the EDCD Waiver. 2,328 individuals were on the DD Waiver waiting list. Of these, 817 (or 35%) were enrolled in the EDCD Waiver. The average time on the waiting list is four (4) years for the ID Waiver and eight (8) years for the DD Waiver. These timeframes are subject to actions by the General Assembly in allocating slots.
109.	Section 3.3.2, pg. 31	“In response to this RFP, the Offeror shall describe: how it proposes to manage individuals with ID or DD; how it will coordinate acute, behavioral health, pharmacy, and non-LTSS waiver transportation services with waiver services; and how it will identify and access appropriate community-based resources for these individuals.”  Should “identify and access” in the last part say instead “identify the need for and access”?	Yes, it should read “identify the need for and access.”

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Question Number	Section	Question/Comment	DMAS Response
110.	Section 3.3.2, pg. 31	Please clarify if we are to provide LTSS services for this population? Intellectual disabilities (ID), Day support for persons with intellectual disabilities (DS) and individual development disabilities support (DD) waivers.	MLTSS Contractors will not provide ID, DS, and DD Waiver services for individuals on the ID, DS, and DD Waivers. These individuals will continue to receive their ID, DS, and DD Waiver services, including transportation to their Waiver services, through Medicaid fee-for-service.
111.	Section 3.3.2, pg. 31	<p>We have the following questions regarding this RFP language:</p> <ul style="list-style-type: none"> <li>• ID, DS, and DD Waiver members do NOT get LTSS Services. They are only with us for Acute, PH, and BH services.</li> <li>• The State is indicating that they put these members in waivers that do get LTSS Services until a slot in the ID, DS, or DD waiver becomes available.</li> <li>• Do they then lose the LTSS Services when they flip to a waiver that doesn't get LTSS services?</li> <li>• Does that become a denial resulting in the member's right to appeal?</li> <li>• How do we know that a member is on the waiting list and how can we as an MCO prepare for this change?</li> </ul>	<ul style="list-style-type: none"> <li>• MLTSS Contractors shall provide acute, behavioral health, pharmacy, and non-waiver transportation services for individuals on the ID, DS, and DD Waivers. ID, DS, and DD Waiver individuals do receive Waiver services, but under MLTSS, they will continue to receive these Waiver services, including transportation to their Waiver services, through Medicaid fee-for-service.</li> <li>• Correct.</li> <li>• Each waiver has its own accompanying services. Several of the waivers have the same services. See Attachment G for a list of services covered under each waiver. MLTSS Contractors will be required to develop and implement plans for transiting individuals who move from one waiver to another.</li> <li>• No.</li> <li>• The waiting list is managed by DBHDS. These specifics will be worked out during the readiness review process and will be outlined in the MLTSS Contract.</li> </ul>

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Question Number	Section	Question/Comment	DMAS Response
112.	Section 3.3.3, pg. 32	What are the eligibility criteria for Targeted Case Management (TCM)? How many people are receiving TCM by type (mental health, substance use disorder, treatment foster care, etc.) and TCM provider?	<p>The criteria for all targeted case management services is explained in each of the DMAS provider manuals; available at:  <a href="https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual">https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual</a></p> <p>DMAS will share additional data for these services. When this data is available, DMAS will post it on the MLTSS webpage at:  <a href="http://www.dmas.virginia.gov/Content_pages/mltss-ihp.aspx">http://www.dmas.virginia.gov/Content_pages/mltss-ihp.aspx</a></p>
113.	Section 3.3.3, including 3.3.1 through 3.3.3.8, pg. 32-42	RFP Section 3.3.3 and several of its subsections state “ <i>Submit for review any tools or flow charts that illustrate the proposed processes</i> ”. May Offerors submit these processes and tools as attachments, excluded from the maximum page limits for their respective sections?	See page limits guidance table attached to this Addendum.
114.	Section 3.3.3, pg. 33	Please confirm that the offeror should respond to the four questions under 3.3.3 Model of Care in addition to the questions in sections 3.3.3.1-3.3.3.8. If a response is required, please provide the page allocation.	See response to Question #55.
115.	Section 3.3.3, pg. 33	<p>In response to the RFP, the Offeror shall:</p> <ul style="list-style-type: none"> <li>• Describe its approach to the MOC elements, including a detailed description and examples of how it will address each MOC element. Examples should be varied to address the needs of the “Plan Specific Target Population” included in MOC Element 1</li> <li>• Explain how its proposed MOC varies to meet regional needs</li> <li>• Demonstrate that it has the staff, infrastructure, and systems in place to monitor the delivery of person-centered care coordination</li> <li>• Submit for review any tools or flow charts that illustrate the proposed processes</li> </ul> <p>The page limit table on Page 23 of the RFP does not currently list a limitation for Section 3.3.3 Model of Care, but does provide limits for subsections contained within Section 3.3.3. However, on Page 33 of the RFP under Section 3.3.3, Offerors are asked to provide the information requested in 4 bullet points in response to Section 3.3.3.</p>	See response to Question #55.

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Question Number	Section	Question/Comment	DMAS Response
		Would the Commonwealth be willing to allocate a 3 page limit to address these 4 bullet points?	
116.	Section 3.3.3, pg. 33	<p>“In response to the RFP, the Offeror shall:</p> <ul style="list-style-type: none"> <li>• Describe its approach to the MOC elements, including a detailed description and examples of how it will address each MOC element. Examples should be varied to address the needs of the “Plan Specific Target Population” included in MOC Element 1.”</li> </ul> <p>DMAS did not include any pages (per the table on page 23) to respond to this bullet. Does DMAS intend that an Offeror describes its approach and provide examples within or separate from the responses to 3.3.3.1-8? We recommend that DMAS provide at least 1 page per subpopulation to meaningfully describe our approach and provide examples.</p>	See response to Question #55.
117.	Section 3.3.3, pg. 33	<p>“In response to the RFP, the Offeror shall:</p> <ul style="list-style-type: none"> <li>• Explain how its proposed MOC varies to meet regional needs”</li> </ul> <p>DMAS did not include any pages (per the table on page 23) to respond to this bullet. This asks about the MOC overall rather than specific elements. Does DMAS intend that Offerors describe meeting regional needs within or separate from the responses to 3.3.3.1-8? If this should be a separate response, we recommend DMAS provide at least 1 page per proposed region.</p>	See response to Question #55.
118.	Section 3.3.3, pg. 33	<p>“In response to the RFP, the Offeror shall:</p> <ul style="list-style-type: none"> <li>• Demonstrate that it has the staff, infrastructure, and systems in place to monitor the delivery of person-centered care coordination”</li> </ul> <p>DMAS did not include any pages (per the table on page 23) to respond to this bullet. Since this bullet is not applicable to each element, does DMAS intend that Offerors respond separately from the responses to 3.3.3.1-8? We recommend that DMAS provide at least 2 pages to respond to this item.</p>	See response to Question #55.
119.	Section 3.3.3, pg. 33	<p>“In response to the RFP, the Offeror shall:</p> <ul style="list-style-type: none"> <li>• Submit for review any tools or flow charts that illustrate the proposed processes”</li> </ul> <p>Please confirm that tools and flow charts do not count toward page limits.</p>	See page limits guidance table attached to this Addendum.
120.	Section 3.3.3, pg. 33	Similar to Section 3.5.10 Call Center, for which flow charts do not count toward the page count (RFP page 23), can the Department confirm that the tools and flow charts do not count toward the page limit for Section 3.3.3?	See page limits guidance table attached to this Addendum.

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121.	Section 3.3.3.1, pg. 33	<p>“In response to the RFP, the Offeror shall: 1. Describe its MOC approach for each of the subpopulations included in this MOC element. Include both children and adults, and dual eligible members 2. Explain how it will identify each subpopulation 3. Explain how its approach will vary to meet regional needs”.</p> <p>This requirement asks for our approach (including for adults, children, and duals), identification process, and regional variances for 14 subpopulations. Depending on the answer regarding the 3.3.3 bullets for which no pages were allowed, this question may also require providing examples for 14 subpopulations. The page limit is 11 pages. Would the Department consider allowing at least 3 additional pages for this response (for a total of 1 page per subpopulation)?</p>	See response to Question #55.
122.	Section 3.3.3.1, pg. 33-34	<p>#4 Under Description of the MLTSS Target Population : Several sections, such as this one, ask the Offeror to "Submit for review any tools or flow charts that illustrate the proposed processes."</p> <p>Please confirm that, wherever requested, such tools or flowcharts are exempt from the page limits stated on pages 23-24 of the RFP in Section 2.10.</p>	See page limits guidance table attached to this Addendum.
123.	Section 3.3.3.2, number 3, pg. 34	The RFP states “Describe how best practices and information learned during DMAS delivered training will be incorporated into staff training.” Please provide examples, or a link to documentation of current DMAS best practices and/or information learned from DMAS delivered trainings.	DMAS intends to provide MLTSS training sessions to the Contractor. In response to the RFP, DMAS wants the Offeror to describe how they will incorporate DMAS training into their own staff trainings.
124.	Section 3.3.3.3, Item 5, pg. 35	<p>“Describe the Offeror’s approach to monitoring the quality of services provided by its network providers and the quality of continuity of care/choice of providers, including during the implementation/transition to MLTSS”.</p> <p>What does the Department mean by the phrases “quality of continuity of care” and “quality of choice of providers”?</p>	<p><b>Quality of continuity of care-</b> DMAS intends for this to mean how Offerors will evaluate and continuously improve their continuity of care processes.</p> <p><b>Quality of choice of providers-</b>DMAS intends for this to mean how Offerors ensure members have a choice of high quality providers and type of provider, where applicable (e.g., community vs. institutional).</p>
125.	Section 3.3.3.4, pg. 36	MOC Element #4: RFP Section 3.3.3.4 states: “Clearly define when the stratification is conducted (e.g., how far in advance of effective date and on an ongoing basis).” Can DMAS confirm how far in advance of the effective date	Refer to Section 6.3.21 of the RFP.

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		they will provide member claims history that we can run through our predictive tool?	
126.	Section 3.3.3.4, pg. 36	MOC Element #4: RFP Section 3.3.3.4 requests "how the Offeror will use information from the Minimum Data Set (MDS) section Q and the HRA to identify members who may be appropriate for transition to community settings." Can the responder include strategies other than MDS in this section related to the assessment of transition appropriateness?	At a minimum, Offerors shall use the HRA and MDS. However, Offerors can use additional strategies and should describe them.
127.	Section 3.3.3.4, pg. 36	We understand that the Annual LOC Reassessments must be conducted by the Offeror. Who will perform the Initial LOC Assessment?	Local and Hospital Preadmission Screening Teams will conduct the initial assessment for eligibility for LTSS (including nursing facility, EDCD Waiver, Tech Waiver, and PACE). Preadmission screening services will continue to be covered through Medicaid fee-for-service within DMAS established criteria and guidelines.
128.	Section 3.3.3.4, pg. 36	The RFP states "Describe and submit all of the HRA tools the Offeror will use to identify the specialized needs of its members." Can DMAS confirm that the HRA tools we need to submit can be included as an attachment, or must they be included within the text of the response?	See page limits guidance table attached to this Addendum.
129.	Section 3.3.3.4-3.3.3.8, pg. 41-42	Will there be an extension of the assessment due date period initially as there was with the CCC contract? Example from CCC - For the first year we had 60 days to complete for EDCD waivers rather than 30 days.	No.
130.	Section 3.3.6 (3.3.3.6), pg. 38	Similar to Section 3.5.10 Call Center, for which flow charts do not count toward the page count (RFP page 23), can the Department confirm that the tools and flow charts do not count toward the page limit for Section 3.3.6?	See page limits guidance table attached to this Addendum.
131.	Section 3.3.3.7, pg. 38	Please clarify which call center services are required to operate 24x7 (i.e. Care Coordinator service line, Nurse line? BH crisis line?). Please also clarify whether or not these are required to be separate lines.	<p>The care coordinator service line, nurse line, and BH crisis line all need to operate 24x7. The Pharmacy Technical Support Line may also need to operate 24x7 as applicable (see Section 6.3.16 of the RFP).</p> <p>Offerors shall evaluate whether separate lines will enable them to fulfill all the requirements outlined in Section 6.3.16 of the RFP, including the robust reporting requirements.</p>

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132.	Section 3.3.3.7, pg. 38-40	MOC Element #7: RFP Section 3.3.3.7 requires the Offeror to submit job descriptions for all staff members involved in care coordination activities. May these job descriptions be excluded from the 10-Page limit for this section?	See page limits guidance table attached to this Addendum.
133.	Section 3.3.3.7, pg. 38	Would the Department provide a list of organizations that are currently providing Service Facilitation, Support Coordination and/or Care Management services, and include how many people each organization provides these services to under each relevant waiver?	See the response to question # 112.
134.	Section 3.3.3.7, pg. 38	Are the requested job descriptions for all staff members involved in care coordination activities included in the 3.3.3.7 Care Coordination section page count of ten (10) total pages?	See page limits guidance table attached to this Addendum.
135.	Section 3.3.3.7, pg. 40	Similar to Section 3.5.10 Call Center, for which flow charts do not count toward the page count (RFP page 23), can the Department confirm that the tools and flow charts do not count toward the page limit for Section 3.3.3.7?	See page limits guidance table attached to this Addendum.
136.	Section 3.3.3.8, pg. 40	Care Transition Programs: There are 16 cases listed; the response is limited to six pages overall.  Would DMAS consider increasing the page limit for this response to eight pages to allow sufficient detail for each response?	No.
137.	Section 3.3.3.8, pg. 41	MOC Element #8: In the Model of Care Assessment and Individualized Care Plan (ICP) Expectations: 1. Does the HRA for Tech Assists (and others) begin when the member is assigned or the day we receive the assignment? 2. What is the expected gap in days?	1. The clock starts at the effective date of enrollment and days are measured in calendar days. 2. The gap between assignment and enrollment will vary depending on when they become eligible for MLTSS and member choice of health plan. This will be elaborated on in the MLTSS Contract.
138.	Section 3.3.3.8, pg. 41	MOC Element #8: In the "Model of Care Assessment and Individualized Care Plan (ICP) Expectations" grid on page 41, it indicates that the CONTRACTOR has 30 days from enrollment for initial ICP development for new members at program launch who are participating in the Technology Assisted Subpopulation; however, further in the grid, it states that the CONTRACTOR must honor existing "ICPs and SAs until the authorization ends or 90 days from enrollment." Additionally, it is stated on page 89, "The Contractor shall honor SAs issued by the Department or its Contractors as provided through DMAS transition reports and DMAS' contracted entities for the duration of the SA or for 90 days from enrollment, whichever comes first." Is the responsibility for	Within 30 days of enrollment.

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		the CONTRACTOR to develop the ICP within 30 days or 90 days for the Technology Assisted Subpopulation?	
139.	Model of Care Assessment and Individualized Care Plan (ICP) Expectations, pg. 41	Footnote 7 states that “Local and Hospital Preadmission Screening Teams conduct the initial assessment for eligibility for LTSS (including nursing facility, EDCD Waiver, Tech Waiver, and PACE).” Upon program transition, will these teams continue to perform any functions related to assessments?	See response to Question # 127.
140.	Section 3.3.3.8, pg. 42	MOC Element #8: What characterizes and distinguishes the vulnerable population from vulnerable excluding tech, EDCD and nursing facility?	See the definition of vulnerable subpopulations outlined in the Model of Care Element #1 in Section 3.3.3.1 of the RFP. Also, note that nursing facility vulnerable subpopulation information breaks in the middle of the cell (begins on page 41 and ends on page 42).
141.	Section 3.3.5, pg. 43	“Vignettes shall be a maximum of five pages per vignette, single-spaced.”  This conflicts with the page limits table on page 23, which allows 3 pages per vignette. Please confirm that the 5-page limit per vignette is correct.	See response to Question # 14.
142.	Section 3.3.5 & 2.10, pg. 43 & 23	The page limit table in RFP Section 2.10 states Vignettes are limited to three pages each while RFP Section 3.3.5 states that vignettes “ <i>shall be a maximum of five pages per vignette</i> ”. Please clarify the maximum page limit for the vignettes.	See response to Question # 14
143.	Section 3.3.5, pg. 43 & 23	Each vignette in Attachment F represents a complex individual with deep context and needs; thus, a thorough response will likely take more space. Therefore, we would recommend that the page limit for each vignette be five pages.  Please clarify the maximum number of pages for each Vignette.  Please also confirm the maximum number of pages for the response to Section 3.3.5.	See response to Question # 14.
144.	Section 3.3.6, pg. 44	Is there an expectation that Behavioral Health Homes will continue in the program and increase in scope and how will this be reflected in the pricing components and assumptions?	Yes, that is the expectation. Contracts and rates will be renewed annually and as needed, subject to CMS approval pursuant to 42 C.F.R § 438.6. Amendments will be issued on an as needed basis.

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145.	Section 3.3.6, pg. 44	Does DMAS envision an ACA Sec. 2703-like health homes program in 3.3.6 and 3.8.2? Or is there a different health home structure the Commonwealth seeks to replicate?	No. DMAS is looking for Offerors to propose innovative health home solutions and these do not have to be specific to any specific model.
146.	Section 3.3.7, pg. 45	Regarding the phrase "... consistent with Virginia's requirements in the MIPAA contract," please share with Offerors an existing or draft MIPAA contract that D-SNPs would execute with DMAS.	See response to Question #94.
147.	Section 3.3.7, pg. 45	Coordinating with Medicare question #3: Can the state please provide a copy of the current MIPAA contract between the State of Virginia and Medicare Advantage D-SNP health plans.	See response to Question #94.
148.	Section 3.3.8, pg. 46	RFP Section 3.3.8 states: "The contractor shall be responsible for covering the cost of personal care and respite care services provided through the Consumer-Directed service model." Is it DMAS's expectation that the contractor will be responsible for establishing the rate at which CDS will be reimbursed?	See Section 6.7.9 # 2 of the RFP.
149.	Section 3.3.8, pg. 46	Does the Department intend for our approach to Consumer-Directed services to include topics such as the recruitment and employment of service facilitators, the delivery of training to service facilitators, their ongoing supervision, and quality monitoring of their services? Does the Department have a particular vision for how these functions should be organized and who should provide them in the new MLTSS Program?	Offerors should share their vision for how these functions should be organized and how these would be provided through the Offeror in the MLTSS program.
150.	Section 3.3.8 & 3.3.10, pg. 46	The RFP references Consumer-Directed personal care services as a required benefit (Section 3.3.8) and an enhanced benefit (Section 3.3.10). Please clarify how Consumer-Directed personal care services are both a required and an enhanced benefit.	Consumer-directed personal care services are a required service. However, an Offeror, could potentially also offer personal care services as an enhanced benefit for individuals who do not meet a waiver level of criteria.
151.	Section 3.3.10, pg. 46	RFP Section 3.3.10 requires Offerors to include a list of the enhanced benefits they may offer. May this list be included as an attachment, excluded from the 2-page limit for the section?	See page limits guidance table attached to this Addendum.
152.	Section 3.3.10, pg. 46	Please clarify what criteria the State will apply to decide what scoring weight to assign to a proposer. Will the State consider the estimated PMPM value and take-up rate for each enhanced benefit?	The intent of these questions is not clear.
153.	Section 3.3.10, pg. 46	<p>“(enhanced benefits do not have to be offered to individuals in every category of eligibility)”</p> <p>Please confirm that Offerors may offer certain enhanced benefits to only individuals meeting Nursing Facility Level of Care (“LTSS Eligible”).</p>	Confirmed.

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154.	Section 3.4, pg. 47	RFP Section 3.4 includes “ <i>Other contractors that are part of the MLTSS Program</i> ” as one of several types of key partners and stakeholders of particular interest to DMAS. Please clarify the definition of “Other contractors that are part of the MLTSS Program.” Does this refer to relationships with other MLTSS MCOs throughout the Commonwealth or with the Contractor’s relationship with its subcontractors?	Depending on the nature of the relationship, this could include contractors/subcontractors such as the enrollment broker, the F/EA, the BHSA, etc., and any other contractors/subcontractors who will play a key role in the implementation and operations of MLTSS.
155.	Section 3.5.1, pg. 47	In RFP Section 3.5.1, the staffing plan required (key staff and all other staff members) alone could exceed the 8-page limit for this section, given the detail requested in the requirement. Please advise if we can provide the staffing plan as an attachment that does not count toward the page limit.	See page limits guidance table attached to this Addendum.
156.	Section 3.5.1, pg. 47	RFP Section 3.5.1 states: “ <i>the Offeror shall include proposed Virginia MLTSS program organizational charts, dedicated staffing numbers by position (delineated by employer), job descriptions and staff qualifications, locations, subcontract descriptions, and its oversight and management plan.</i> ” Please clarify the intent of the requirement for inclusion of “ <i>proposed Virginia MLTSS organizational charts</i> ”. Would a single overall organizational chart suffice if we are not utilizing subcontracted staffing?	The intent of the MLTSS organizational chart is to illustrate the corporate structure of the Offeror, including how roles and positions are organized, how information flows, and how authority is distributed. A single overall organizational chart would suffice.
157.	Section 3.5.1, pg. 47	Do the job descriptions and staff qualifications requested in RFP Section 3.5.1 apply to all staff members (in addition to the descriptions and resumes requested for key staff in 3.2.6)? If so, can they be provided as attachments that do not count toward the page limit?	Yes. And, see page limits guidance table attached to this Addendum.
158.	Section 3.5.1, pg. 47	Would the Department confirm that the organization charts do not count toward the page limit for this section?	See page limits guidance table attached to this Addendum.
159.	Section 3.5.2, pg. 48	RFP Section 3.5.2 states “ <i>In response to this RFP, the Offeror shall also submit for review any tools or flow charts that illustrate the proposed communications processes</i> ”. Please confirm our assumption that the tools and/or flow charts submitted are not included in the 4-page limit?	See page limits guidance table attached to this Addendum.
160.	Section 3.5.2, pg. 48	Would the Department confirm that the tools and flow charts do not count toward the page limit for this section?	See page limits guidance table attached to this Addendum.
161.	Section 3.5.3, pg. 48-49	Should Offerors with Medicaid and/or Medicare plans that are accredited by NCQA in Virginia and/or other states provide only items 1 through 3?	Offerors with Medicaid and/or Medicare plans that are accredited by NCQA in Virginia and/or other states should provide responses to all five items, if applicable. Please provide responses to items 1 to 3 in a chart format. Submit the IDSS and the most recent Adult and

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			Child CHAPS reports as attachments.
162.	Section 3.5.3, pg. 49	Is the most recent accreditation certificate provided by NCQA an acceptable alternative to the "most recent accreditation/reaccreditation confirmation letter" requested in the RFP?	Yes, the most recent NCQA accreditation certificate is acceptable.
163.	Section 3.5.3, pg. 49	RFP Section 3.5.3 requests "4. A copy of the auditor-locked interactive data submission system (IDSS) from the most recent HEDIS audit. 5. A copy of the most recent Adult and child CAHPS report, if available." Please clarify the number of states whose IDSS and CAHPS reports should be provided: Virginia only, all states listed in chart of accredited health plans, or other.	Please supply a copy of the auditor-locked interactive data submission system (IDSS) from the most recent HEDIS audit and the most recent adult and children CAHPS reports, if applicable from at least one state. In addition, if the Offeror is accredited in Virginia, then Virginia's results also have to be submitted.
164.	Section 3.5.3 & 2.10, pg. 48-50	The page limit table in RFP Section 2.10 indicates that several attachments mentioned in RFP Section 3.5.3 are not included in page count, including the Auditor-Locked Interactive Data Submission Data (IDSS), most recent Adult and Child CAHPS report, and EQRO reports, QI description, plan, and annual evaluation results from two (2) states. Can Offerors assume any other attachments requested in section 3.5.3, such as the copy of the most recent accreditation confirmation letter, MLTSS Reports, and MLTSS QI Reports, are also excluded from the page limits?	See page limits guidance table attached to this Addendum.
165.	Section 3.5.3, pg. 48-50	RFP Section 3.5.3 states: " <i>Offerors with Medicaid and/or Medicare plans that are accredited by NCQA in Virginia and/or other states shall provide... 2. Current accreditation level (must include a copy of the most recent accreditation/re-accreditation confirmation letter). If the current accreditation level is different from the confirmation letter, an explanation must be included.</i> " Should Offerors include all accreditations among all of their plans, if applicable? For example, should Offerors add Medicaid and Marketplace and Multicultural Healthcare accreditation for their plans?	For section 3.5.3 items 1 to 3, Offerors should list required information in chart format for all of the Offerors' health plans that are currently accredited by NCQA for Medicare and Medicaid lines of business. Also see response to Question # 163.
166.	Section 3.5.3, pg. 48-50	RFP Section 3.5.3 states: " <i>Offerors with Medicaid and/or Medicare plans that are accredited by NCQA in Virginia and/or other states shall provide... 4. A copy of the auditor-locked interactive data submission system (IDSS) from the most recent HEDIS audit.</i> " Offerors may have multiple plans with completed IDSS tools. Is there a certain number of plans for which Offerors submit IDSS tools or should they submit all Medicaid plans?	See response to Question # 163.
167.	Section 3.5.3, pg. 48-50	RFP Section 3.5.3 states: " <i>Offerors with Medicaid and/or Medicare plans that are accredited by NCQA in Virginia and/or other states shall provide... 5. A</i>	See response to Question # 163. DMAS is requesting the CAHPS results

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		<i>copy of the most recent Adult and child CAHPS report, if available</i> Some Offerors may have multiple plans with completed CAHPS surveys. Is there a certain number of plans for which Offerors submit CAHPS survey results? Is the Commonwealth requesting the NCQA crosstab table that was submitted by the survey vendor to NCQA?	submitted from the CAHPS vendor. It should include the crosstab table with all survey results. It should also include other detail survey results.
168.	Section 3.5.3, pg. 49	Section 3.5.3 asks for “A copy of the auditor-locked interactive data submission system (IDSS) from the most recent HEDIS audit.” Is this requesting only the Audit Review Table/cover sheet of the IDS, which summarizes health plan results?	This requirement is for the most recent final reports from NCQA’s Interactive Data Submission System (IDSS) containing final non-survey HEDIS results that have gone through all tiers of validation, plan and auditor lock and health plan attestation.
169.	Section 3.5.3, pg. 49	Each full IDSS report exceeds 100 pages in length. If DMAS wants the full IDSS report, please consider allowing Offerors to submit the IDSS reports in the electronic copies only.	Offerors need to submit the final audited review table within the IDSS final report from at least one state where the Offeror operates Medicaid and/or Medicare line of business. In addition, if the Offeror is accredited in Virginia, then Virginia’s results also have to be submitted.
170.	Section 3.5.3, pg. 49	Quality Question 2“...must include a copy of the most recent accreditation/re-accreditation confirmation letter.” Does the accreditation/re-accreditation letter count toward the page limits? Can it be included in an attachment?	See page limits guidance table attached to this Addendum.
171.	Section 3.5.5, pg. 50	Can the State provide member zip codes to be sure we have provider network adequacy covered?	This information will be provided to Offerors selected for negotiations. Offerors may be able to use the information available at <a href="http://www.dmas.virginia.gov/Content_pgs/mltss-ihp.aspx">http://www.dmas.virginia.gov/Content_pgs/mltss-ihp.aspx</a> .
172.	Section 3.5.5, pg. 50	RFP Section 3.5.5 states: “ <i>The Offeror shall submit a provider network file to the Department in an electronic MS-Excel spreadsheet format.</i> ” Please confirm our assumption that hard copies of the provider network attachments described in RFP Section 3.5.5 are not required and should only be submitted as electronic files.	Confirmed.
173.	Section 3.5.5, pg. 51	For the VA RFP, the network must be adequate to provide access "that is consistent with routine patterns of utilization." 1. Where do we get those patterns from at this point? 2. Will DMAS make claims data and information available to us tied back to provider TIN and NPI and if so when it would be made available?	See the “Medicaid Fee-For-Service Providers Utilized by MLTSS Target Population” file at <a href="http://www.dmas.virginia.gov/Content_pgs/mltss-ihp.aspx">http://www.dmas.virginia.gov/Content_pgs/mltss-ihp.aspx</a> .

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174.	Section 3.5.5, pg. 51	Will Offeror's proposals be evaluated more favorably for submitting providers with signed contracts rather than LOIs? If so, by what margin?	No.
175.	Section 3.5.5, pg. 51	RFP Section 3.5.5 states: "In addition, the Offeror shall ensure that its provider network provides access that is consistent with routine patterns of utilization." Please confirm the following: 1. Will historical data and/or reports related to patterns of performance be made available to the contractor? 2. Will DMAS make claims data and information available to us tied back to provider TIN and NPI? a. If so, when it would be made available?	See response to Question # 173.
176.	Section 3.5.5-Attachment C, pg. 3 of the PNADS	For the Designation of Vision (22), does that refer to the provider (ophthalmologist/optometrist), the actual vision center, or both?	Both.
177.	Section 3.5.5-Attachment C, pg. 5-23 of the PNADS	Do all data elements need to be padded with spaces if the length of the data element does not meet the max field character requirement? Only the PROV_LAST_NM references adding spaces to the data element.	Spaces are not required.
178.	Section 3.5.5-Attachment C, pg. 6-7 of the PNADS	The PNADS document references sending the Network data in MS-Excel in the Overview, but also mentions ASCII delimited files throughout the layout sections. Is Excel the preference or can csv files be submitted?	MS-Excel is required. PNADS document has been updated.
179.	Section 3.5.5-Attachment C, pg. 6 of the PNADS	The Provider Last Name (PROV_LAST_NM) on page 6 states a length of 50, but the example lists only padding with spaces to 25 characters would DMAS please clarify?	See response to Question # 177.
180.	Section 3.5.5-Attachment C, pg. 11 of the PNADS	Page 11 states that the Provider Designation (PROV_DESIG) field format should be numeric. However, some of the applicable codes leading zeroes, which has to be a TEXT/Character field in Excel to store the leading zero. Would DMAS please clarify how to format this appropriately?	Use custom format option with required field length. For example, if the field length is 10 digits, select custom option and type 0000000000. When the number is entered, leading zeros will be present.
181.	Section 3.5.6, pg. 51	RFP Section 3.5.6, item 3, asks Offeror to describe its approach for technical assistance, especially to community behavioral health and LTSS providers and out of network providers during the continuity of care period. How does DMAS define "technical assistance?"	Technical assistance could include activities such as: <ul style="list-style-type: none"> <li>• Needs assessments</li> <li>• Trainings (e.g., billing, credentialing, service authorizations, etc.)</li> <li>• Direct one-on-one support/assistance</li> <li>• Facilitating sharing of best practices</li> <li>• Developing and distributing resources</li> </ul>

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182.	Section 3.5.7, pg. 52	The RFP states “The Offeror shall also describe how it identifies dual eligible members’ PCPs, including the use of Medicare and DMAS data and incorporates the PCP information into their individuals’ medical records to improve care coordination.” Can DMAS identify the content included in the Medicare and DMAS data files, and the frequency in which Contractors will receive this data?	Contractors will need to use the Medicare data that they will have access to through their D-SNPs. The DMAS data will be provided via the MTR in the frequency outlined in Section 6.3.21. DMAS will post the draft full and draft interim MTR layout documents on the DMAS website at <a href="http://www.dmas.virginia.gov/Content_pg/mltss-ihp.aspx">http://www.dmas.virginia.gov/Content_pg/mltss-ihp.aspx</a>
183.	Section 3.5.7, pg. 52	Regarding, “the identification of dual eligible members’ PCPs, including the use of Medicare and DMAS data and incorporates the PCP information into their individuals’ medical records to improve care coordination.” Will PCP information be sent with the other data on new membership? Will the data set take into account that PCP assignment will be consistent for current membership?	See response to Question # 182. DMAS will not send PCP information on MLTSS enrollees. DMAS will send claims and service authorization data, which should be used by the Contractors when determining PCP assignments.
184.	Section 3.5.7, pg. 52	How will members with dual eligibility be identified on the 834 eligibility file? Will Health Specific Assessments be provided to aid in identifying a member's preferred PCP?	Members with dual eligibility will be identified by Medicare coverage reported on the 834.  No, Health Specific Assessments will not be provided.
185.	Section 3.5.7, pg. 52	Given the benefits of a medical home, may we assign dual eligible members a PCP? Or, can it be an optional benefit to dual eligible members?	This should be coordinated with the individual’s Medicare plan.
186.	Section 3.5.8, pg. 52	Regarding the statement “ <i>DMAS shall require contractual agreements between NFs and the Offeror,</i> ” please confirm that Offerors are not required to submit said contracts with their Proposal, but if awarded a contract the Offeror is required to contract with NFs.	In response to this RFP, the Offeror shall submit their preliminary provider networks, including LTSS, in the format described in Attachment C. Only providers who have either signed a letter of intent (LOI) or signed a contract may be submitted. The Offeror must indicate this distinction (LOI vs. signed contract) for each submitted provider. The Offeror does not need to provide actual copies of signed LOIs or contracts in response to this RFP. Final networks, including fully executed provider contracts, will be evaluated during the readiness review

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			process.
187.	Sections 3.5.9 & 3.7, pg. 53 & 58	Regarding bullet #3 on page 53, please confirm that Offerors that choose a transportation provider currently not serving VA are not required to submit Attachment C Provider Network Submission Format and instead are allowed to submit network readiness and adequacy as a part of the Plan for Demonstrating Operational Readiness.	This is not correct. Offerors are required to submit a transportation network if they are not using Virginia’s transportation provider, per page 53 of the RFP.
188.	Section 3.5.9, pg. 53	<p>What information sharing will occur between the health plan and the State’s transportation contractor, regarding our members’ utilization of carved out transportation services?</p> <p>Can information about the State’s transportation contractor’s provider network be provided? What services are provided?</p>	<p>We will not provide waiver transportation data to MLTSS Contractors for individuals on the ID, DD, and DS Waivers.</p> <p>DMAS is unable to share the LogistiCare transportation network as this is a fully capitated risk based contract and the network information is considered proprietary. For additional information on NEMT services see <a href="http://www.dmas.virginia.gov/Content_pgs/trn-home.aspx">http://www.dmas.virginia.gov/Content_pgs/trn-home.aspx</a>.</p>
189.	Section 3.5.10, pg. 53-54	“Contractor shall operate a 24 hours per day, 7 days a week, toll free call center” conflicts with 6.3.16 “General customer service (available 8A-8P, 7 days a week. Alternative tech may be used on Sat/Sun and State of VA holidays)”. Please provide clarity on the required hours of operation for all Call Centers, particularly if requirements differ depending upon call center function.	Section 3.5.10 provides a general description for expectations around the call center. Some components of the call center shall operate 24 hours, 7 days a week. These are clarified in Section 6.3.16 of the RFP.
190.	Section 3.5.10 & 6.3.16, pg. 53 & 115	The RFP states in Section 3.5.10 that “The Contractor shall operate 24 hours per day, 7 days per week, toll-free center (for members and providers) to respond to questions, concerns, inquiries, and complaints, in accordance with the requirements details in this RFP and as further defined in the MLTSS Contract resulting form the RFP.” However, the RFP also states in Section 6.3.16 Call Center Requirements ( #1) that “General Customer Service (available 8:00 am - 8:00 pm, seven days a week). Alternative technologies may be used on Saturdays, Sundays, and State of Virginia holidays)”. There appears to be a conflict between these two sections. Is the Contractor required to operate its Call Center 24/7 or 8:00 am – 8:00 pm, seven days a week with alternative technologies on non-work days and holidays?	See response to Question # 189.
191.	Section 3.5.10, pg. 53-54	Does the dedicated queue to assist LTSS and community behavioral health providers to be available for 12 months need to be separate from the standard	It needs to be a separate que and dedicated to respond to these providers.

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		Provider Call Center. If separate, what are the requirements regarding hours of operation?	It can't be the general provider call center line. Hours of operation are the same as the provider services and coverage determination line.
192.	Section 3.5.10 & 6.3.16, pg. 53 & 115	Section 3.5.10 references a 24/7 call center for members and providers, while section 6.3.16 references call center requirements for members and providers with different hours. Please confirm that the Offeror shall follow the more detailed contract requirements in 6.3.16.	See response to Question # 189.
193.	Section 3.5.11, pg. 54	Our experience is that DMAS has previously defined audits and investigations as very distinct processes, yet the terms appear to be used interchangeably in this section. Our understanding is that 'audits' would be rule-based, proactive, limited in scope, and random whereas investigations would be conducted in response to allegations of fraud, waste and abuse and therefore vary in number, frequency and scope. Can you confirm if the numbers presented and the expectations are for 'audits' or 'investigations' or a combination of the two?	"Audits" and "provider investigations" do not have substantively different meanings when used in the Program Integrity section of the RFP. The numbers presented in the table of provider investigations in the fee-for-service program represent medical record reviews for the purpose of identifying overpayments. Minimum expectations that will be set forth in the contract would be for "a minimum number of medical record audits to be conducted annually" regardless of how the plan identifies providers for investigation.
194.	Section 3.5.11, pg. 55	May a Contractor make its own determination of a "credible allegation of fraud" and suspend payment to providers? Or would the direction to suspend payment only come from DMAS/MFCU?	No, for the purposes of payment suspension set forth in 42 C.F.R § 455.23, DMAS in consultation with MFCU makes the determination of whether there exists a credible allegation of fraud. Direction to suspend payment would come from DMAS.
195.	Section 3.5.11, pg. 55	How many members are represented in the audit of the provider investigations conducted by DMAS on its fee-for-service expenditures in state fiscal year (SFY) 2015 table?	Member totals are not tracked.
196.	Section 3.6.2, pg. 56	The RFP stipulates that the Care Management system integrates data and shares information in near real time. Can the state further elaborate on the definition of near real time?	Offerors shall describe their capabilities in this area. The actual required timeframes will be defined in the MLTSS Contract.
197.	Sections 3.6.1 & 3.6.2, pg. 56	Please provide specs on the interface with the VaMMIS and MES.	Offerors shall describe their capabilities in these areas. These specifications are

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		Please provide specs on the interface of our care coordination system with DMAS.	described in Section 6.4 of the RFP.  For the care coordination system, Offerors shall meet the requirements in Section 6.4.7 of the RFP. Offerors also shall describe their system capabilities, including the ability to interface with other systems (i.e., DMAS, other contractors, providers).
198.	Section 3.7 & 2.10, pg. 23 & 57-59	RFP Section 2.10 indicates the work plan is included in the 12-page limit for the response to RFP Section 3.7, Readiness. Given the detail required in each work plan as described in Section 3.7, would the Commonwealth consider excluding the work plan from the 12-page limit?	See page limits guidance table attached to this Addendum.
199.	Section 3.7, pg. 24 & 58	We know, based upon our experience, that implementing MLTSS programs requires significant detail and, therefore, extensive work plans. Knowing the importance of the details in these work plans as evidence of a contractor's preparedness for the MLTSS launch, will DMAS confirm our ability to include the detailed readiness project work plan as a separate attachment?	See page limits guidance table attached to this Addendum.
200.	Section 3.7, pg. 57	Please confirm that Offerors that are selected for negotiation are expected to continue network contracting efforts upon notification of selection, and that network adequacy will be evaluated during readiness review.	Confirmed.
201.	Section 3.7, pg. 58	Readiness- contracting DMAS' fee-for-service non-emergency transportation Contractor. Information on DMAS' fee-for-service non-emergency transportation Contractor. Who are they, what geography do they cover?	See response to Question # 188.
202.	Section 3.7, pg. 58	Can DMAS confirm that any Sample Implementation or Work Plan, if provided in MS Project or a similar program, will not count toward the response page limit?	See page limits guidance table attached to this Addendum.
203.	Section 3.7, pg. 58	RFP Section 3.7, request for documentation 1 states: "For each proposed region, the Offeror shall provide a detailed project work plan." 1. Given the page limits, would one project plan for all proposed region would be sufficient if regional nuances are noted through-out? 2. If one project plan does need to be submitted for each region, would DMAS consider excluding the project plan(s) from the page limit?	See page limits guidance table attached to this Addendum.
204.	Section 3.8.4, pg. 63	Please confirm that specialty plans will be required to meet the accreditation, licensing, D-SNP, and all other requirements of responsiveness and qualification outlined in this RFP to be considered for contract award.	Confirmed.

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		<p>Please confirm that DMAS will not be able to contract with and implement a specialty plan (including at a later date) if the plan does not respond as a qualified and fully responsive Offeror within the requirements and timelines set forth in this RFP.</p> <p>Please confirm Specialty Plan eligible members will follow the standard enrollment procedure, maintaining choice between specialty and non-specialty plans.</p>	<p>Confirmed.</p> <p>Enrollment procedures may be modified for individuals who meet specialty plan criteria. But, members will always have choice.</p>
205.	Section 3.8.4, pg. 63	Will specialty plans be given unique rate cells?	Rate cells will be determined during negotiations and readiness reviews.
206.	Section 3.8.4, pg. 63	If an individual qualifies for the identification criteria of a Specialty Plan, can the Department confirm that individuals will be auto-assigned to the Specialty Plan and then given the ability to change plans, if needed, to protect consumer choice?	See response to Question # 204. The Offeror should describe their criteria in their proposals. All specific processes will be worked out during negotiations.
207.	Section 3.8.4, pg. 63-64	Are Specialty Plan proposals required, or are they purely optional? In other words, may an Offeror submit a proposal for the MLTSS program without submitting a Specialty Plan proposal?	A specialty plan proposal is not required.
208.	Section 3.8.4, pg. 63	Will specialty plans have separately established rate cells?	See response to Question #205.
209.	Section 3.8.4, pg. 63	Understanding the proposal must address the entire RFP, can you please confirm a plan can submit a proposal for a specialty plan only?	Yes, but it must meet all of the RFP requirements.
210.	Section 3.8.4, pg. 63	<p>If a proposal is submitted for a specialty plan only, and awarded as such, would the plan be incorporated in the 'freedom of choice' option for program eligibles to choose from?</p> <p>CMS allows D SNPs, in collaboration with the State Medicaid Agency, to compliantly and appropriately define its covered population based upon the D SNPs Model of Care. Does DMAS desire that the applicant define its proposal for how it would define its covered population?</p>	<p>Yes and the specifics will be determined during negotiations.</p> <p>Yes.</p>
211.	Section 4.0, pg. 65	Please confirm that parent company and sibling organization experience may be utilized in responding to the questions related to Offeror's Past Experience and References.	For Section 4.0 of the RFP, the following should be included for each subsection: 4.1-Parent and Offeror experience may be utilized

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			4.2-Parent and Offeror experience may be utilized 4.3-Parent, Offeror, and sibling experience may be utilized. For this section, siblings that have been owned by the parent company for at least twelve (12) months should be included.
212.	Section 4.1, pg. 65	Please confirm Offerors' relevant experience is limited to Medicaid programs, MLTSS programs, Financial Alignment Demonstrations, and D-SNPs and other Medicare products. Also, please confirm that any other lines of business or experience submitted will not be considered in scoring.	Confirmed.
213.	Section 4.1, pg. 65	Reporting certain experience (such as Medicare Advantage) at the city/county level will be a lengthy and cumbersome process for reviewers when considering National experience. For example, national Medicare Advantage plans could be reporting thousands of cities/counties. Please confirm that Offerors may aggregate enrollment at a higher level (e.g. by contract or state), rather than reporting enrollment across each individual city/county for each line of business.	Offeror shall report by contract level.
214.	Section 4.1, pg. 65	Item #4 states "Average program enrollment size by city/county within the region(s) the Offeror operates." Can the Offeror roll up and submit the enrollment size by the specified region(s), zone(s), or statewide depending on the Program specifications laid out by each state vs. submitting these numbers by city/county?	See response to Question # 213.
215.	Section 4.2.1, pg. 66	<i>"For each past experience example, Offeror's response shall include: 1. Contract name"</i>  For Medicare Advantage and D-SNP experience, please confirm that the Offeror may aggregate multiple contracts in order to provide examples that properly communicate the breadth of applicable experience.	No, information should be submitted at the contract level.
216.	Section 4.2.1, pg. 66	Please confirm that #6-Annual value of contract should exhibit the amount the Health Plan pays to any vendor who provides services offered and not the value of savings to the Health Plan.	The #6 should reflect the annual amount the Offeror is paid by the client.
217.	Section 4.2.2, pg. 66	For Medicare Star Ratings, please confirm DMAS is seeking overall contract ratings and not full detail on Part C or Part D summary ratings, or individual measure ratings (e.g. there are dozens of individual measure ratings per contract).	Confirmed, DMAS is seeking overall contract ratings.
218.	Section 4.2.2, pg. 66	RFP Section 4.2.2 states <i>"The Offeror shall submit its annual Medicare Star Ratings developed by CMS and posted on the Medicare.gov website for the last</i>	See response to Question #217.

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		<i>3 performance years.</i> ” Please describe the desired format for the Medicare Star Ratings. May Offerors provide the Overall Part C and Part D Summary Ratings for each plan for the three years?	
219.	Section 4.2.3, pg. 66	Are there any limitations or restrictions regarding Commonwealth of Virginia employees serving as a State & Local Government reference for the Offeror?	No.
220.	Section 4.2.3, pg. 66	Please confirm that Offerors may redact member personal or identifying information, and other information necessary to maintain appropriate member rights and privacy.	This requirement has been updated; “member” is an “optional” stakeholder reference. If the Offeror submits a member reference, the proposal submission must include the member’s contact information so that DMAS can contact the member. The Offeror shall also include a signed copy of the member’s consent to be included as a stakeholder reference for the Offeror. The Offeror shall redact any member references in the redacted version of its proposal, per Section 2.4 of the RFP. Also see RFP Addendum.
221.	Section 4.3, pg. 67	Please define sibling organizations.	A company which is owned by the same parent company as another company. One parent company can have one or many subsidiaries, which all are sibling organizations to each other.
222.	Section 4.3, pg. 67	The initial part of this requirement limits Offeror’s disclosures of non-compliance to Medicaid and Medicare lines of business only. The next sentence requires Offeror to include the average number of lives "covered by the organization, parent organization, or sibling organization" during a specified time period. Some Offerors, their parent organizations, and/or sibling organizations may conduct multiple lines of business, other than Medicaid and Medicare. Please confirm that the Commonwealth seeks the average number of lives covered by the Offeror, parent organization, or sibling organization for Medicaid and Medicare lines of business only.	Confirmed.
223.	Section 4.3, pg. 67	The initial part of this requirement indicates that non-compliance must be reported for Medicaid and Medicare lines of business only. Please confirm that the part of this requirement stating that the "Offeror must include non-	Confirmed.

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		compliance for itself, its parent organization, and sibling organization..." is not intended to expand the Compliance History section beyond Medicaid and Medicare lines of business and that the entirety of Section 4.3 is limited to those two lines of business only.	
224.	Section 4.3 (f), pg. 67	Please confirm that subpart f regarding termination and non-renewals is limited to terminations and non-renewals of Medicaid or Medicare contracts with state or federal agencies and does not relate to terminations or non-renewals of contracts with medical providers (e.g., doctors, nurses, hospitals, etc.)	Confirmed.
225.	Section 4.3 (f), pg. 67	Please confirm that "Disruptive Mutual" refers to situations where the decision to terminate or not renew a Medicaid or Medicare contract held with a state or federal agency was mutual as between the state/federal agency and the contractor but where the termination or non-renewal was "disruptive" because members were transitioned to other Medicaid or Medicare contractors in the absence of significant time and transition planning. If this is not the intended meaning, please provide a definition of "disruptive mutual," including examples.	Disruptive terminations put stress on members and/or federal and state programs by providing less than the contractually required notice to effectuate a smooth transition.
226.	Section 4.3 (f), pg. 67	Subpart f relating to terminations and non-renewals is included in the Compliance History section, where the Offeror is to list the "types of non-compliance issued," including "terminations and non-renewals." Therefore, please confirm that for subpart i, ii, and iii of this requirement, the Commonwealth is seeking only terminations and non-renewals of Medicaid or Medicare contracts with a state or federal agency where the termination or non-renewal was the result of some poor performance or non-compliance on the part of the contractor.	Confirmed.
227.	Section 4.3, pg. 67	The second paragraph states that DMAS reserves the right to disqualify an Offeror, if an Offeror is under sanction. Can DMAS provide a definition of "sanction"? For example, we believe it would not include actions such as a standard notice of noncompliance?	It means under sanction as enumerated in 42 CFR § 438.702, 42 CFR § 422.750, and 42 CFR § 423.750.
228.	Section 4.3, Bullet d, pg. 67	Does the Performance Audit bullet refer to a comprehensive, end-to-end review (program audit)?	This refers to all completed performance audits.
229.	Section 4.3, pg. 68	For purposes of reporting non-compliance across Medicaid and Medicare lines of business, how far up the Offeror's corporate ownership structure must be considered? Should we include only the Offeror's immediate corporate parent organization, or would we need to continue up the ownership structure to include the ultimate parent organization?	All Medicare and Medicaid lines of business regardless of Offeror's corporate ownership structure.
230.	Section 5.2, pg. 70	1) Please provide either (a) the relative number of points assigned to each section or (b) the relative priority of each section in this score, so that Offerors understand those areas of greatest importance to DMAS.	A) In accordance with the Agency Procurement and Surplus Property Manual (APSPM), Section 7.2, d., "the

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		2) Will the oral presentation of the Vignettes be separately scored, and if so, what is the relative weighting of that presentation?	weights assigned to the evaluation criteria shall also be posted in the location used for public posting of procurement notices prior to the due date and time if the weights were not included in the RFP. <u>A breakout of subcomponent weights need not be listed</u> ". DMAS will not be posting subcomponent weights.  2) Oral presentation of the Vignettes are being done to allow Offerors to clarify and further elaborate on their written responses. Evaluators will be allowed to take this additional information into consideration when scoring the Vignette criteria.
231.	Section 5.3, pg. 70	Since rates not included in scoring criteria or negotiation phase, please verify that there will not be a rate bid during the negotiation phase.	Confirmed.
232.	Section 5.3, pg. 70	Will risk adjustment be applied to the LTSS population?	DMAS is currently developing a risk adjustment model for the LTSS population for LTSS services. For non-LTSS services, DMAS may use CDPS where appropriate.
233.	Section 5.3, pg. 70	If risk adjustment will apply to the LTSS population, when will it be introduced?	We plan to introduce the risk adjustment process at the MLTSS program start date.
234.	Section 5.3, pg. 70	Due to the potential changes in population risk, will the SSI risk adjustment process be delayed after the initial enrollment period or applied retroactively?	This is has not been determined.
235.	Section 5.3, pg. 70	Since this is a new program with potential enrollment, data, and cost uncertainty, will DMAS please consider a risk corridor for the LTSS population?	DMAS will consider a risk corridor.
236.	Section 6.1.1, pg. 71	Assurances must include an assessment, performed by an independent Contractor/third party, that demonstrates proper interconnectivity with the Department and that firewalls meet or exceed the industry standard.  Please specify the "industry standard" to be used in this assessment.	Industry standards may vary depending on the scope of the subcontract proposed by the Offeror. DMAS will work with the selected Offerors to review any TPA proposals during the readiness review process.

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237.	Section 6.1.5, pg. 72	Please confirm that DMAS means the following in the last sentence in first paragraph of 6.1.5: “... <i>HEDIS measures required for credentialing (Medicaid products), and, in addition to NCQA Health Plan Accreditation categories, CAHPS survey results.</i> ”	Yes, that is correct. The health plan accreditation required for MLTSS health plans is NCQA Medicaid Health Plan accreditation. Corresponding CAHPS survey requirements are Medicaid Adult and Child Surveys.
238.	Section 6.1.6 & 6.3.20, pg. 73 & 121	With respect to the requirement to include licensure and certification standards in participating provider contracts – may the Contractor meet this requirement by including those standards in its Provider Manual, which is incorporated by reference to its participating contracts?	This is acceptable.
239.	Section 6.1.6, pg. 73	Are Transportation providers required to have an NPI?	For the Offeror’s preliminary provider network submission, the Offeror may use the API or NPI number. However, the NPI is required for MLTSS and will be required for final network submissions.
240.	Section 6.1.6, pg. 73	The RFP states providers must have a NPI however atypical providers are not required to do so, generally. 1. Does DMAS require all atypical providers in VA to have a NPI or an API? a. If so, has this been communicated to all atypical providers previously?	See response to Question #239. DMAS will communicate this to all VA providers in the next Medicaid Memorandum on the MLTSS Program.
241.	Section 6.1.6, pg. 74	Are we required to include Magellan providers (the DMAS BHSA) with our Provider Network Submission (Attachment C)?	Yes.
242.	Section 6.1.6, pg. 77	RFP Section 6.1.6 states: “...RTC services will be transitioned to the MLTSS Program and the Contractor...” Is there a best-guess timeline that VA is looking to make this transition?	This is unknown at this time.
243.	Section 6.2.6, pg. 78	Please provide the current foster care data exchange in which we are required to work. How does the state identify members for selected services? Using foster care as an example, are children who are in foster care identified on the enrollment file?	Foster care children are identified on the 834 and by aide category and refer to the RFP (Section 6.2.7) for specific services that need to be provided to foster care children. Any additional requirements will be outlined in the MLTSS Contract.
244.	Section 6.2.10, pg. 83	RFP Section 6.2.10 states: “The Contractor shall work with SUD providers to develop and implement SUD value-based payments that drives high-quality care and improves member outcomes.” Does DMAS have a desired timeline for the implementation of this type of program?	The desired timeline begins at MLTSS program implementation.
245.	Section 6.2.13, pg. 83	Since the proposed drug formulary is different from the current formulary for ABAD and ALTC members please confirm that in the rate assumptions and methodology output, an explicit adjustment for this change will be made with	Adjustments will be developed in accordance with all applicable actuarial standards of practice and the

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		sufficient documentation of assumptions and basis?	assumptions will be transparent.
246.	Section 6.2.13, pg. 83	In regard to RFP Section 6.2.13, Prescription Drugs and Formularies, does the Commonwealth allow the MCO to submit and collect drug rebates with pharmaceutical manufacturers for outpatient drugs dispensed at our network pharmacies?	Section 1927(b)(1)(A) of the Social Security Act directs the Commonwealth to collect rebates on drugs dispensed to individuals enrolled in a MCO. The Commonwealth will collect rebates on eligible covered outpatient drugs. The MLTSS Contract will include annual reporting requirements for any drugs on which the Contractor collects a credit/rebate/bonus/refund/et al from the manufacturer, distributor or any other source for MLTSS members, including outpatient drugs dispensed to network pharmacies. This information may be used to amend the capitation rates accordingly.
247.	Section 6.2.13, pg. 84	For particular non-preferred agents where the state's criteria require the preferred agent be used, do we need to assert the same criteria for that non-preferred drug?	42 CFR §438.210, services covered under Medicaid managed care contracts (with MCOs, prepaid inpatient health plans, and prepaid ambulatory health plans) must be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services for beneficiaries under FFS Medicaid. The MCOs may assert the same criteria but can opt to use less restrictive criteria. The MCOs cannot impose more restrictive criteria.
248.	Section 6.2.15, pg. 87	Do telemedicine providers count toward provider network adequacy standards?	No.
249.	Section 6.2.15, pg. 87	1a) Under current Medicaid regulations and/or for the purposes of this Contract is the members home considered an acceptable originating site for the purposes of providing a telemedicine service?  1b) Other than having a valid Virginia License are there any other restrictions on the type of provider or provider location for providers rendering telemedicine services under this contract?	1a) Under current FFS Medicaid regulations home is not considered an originating site. However, for the MLTSS Contract it could be considered an acceptable originating site. More details will be provided in the MLTSS Contract.

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			1b) MLTSS Contractors may use the following types of providers for Medicaid-covered telemedicine services: physicians, nurse practitioners, certified nurse midwives, clinical nurse specialists-psychiatric, clinical psychologists, clinical social workers, licensed and professional counselors, licensed marriage and family counselors, and licensed substance abuse practitioners. Offeror's may propose additional provider types for DMAS to take into consideration.
250.	Section 6.2.15, pg. 87	Telemedicine Services: Are we required during the RFP stage to denote availability at the provider group/ individual practitioner level? How does the state identify these services.	Offerors may describe the availability of telemedicine services when describing their provider recruitment strategy (3.5.4 of the RFP) and/or they may include providers of telemedicine services with their provider networks under the "other provider designation" category.
251.	Section 6.2.16 & 6.2.21, pg. 87 & 92	Must bidders use the entire UAI assessment or just incorporate selected parts of the tool in its program?	MLTSS health plans will not complete UAIs. But, they must use the entire UAI assessment when available.
252.	Section 6.2.17 & 6.7.1, pg. 88 & 135	In the course of capitation rate development, will DMAS consider the inclusion of an adjustment to account for higher claims costs resulting from out-of-network services during the 90-days continuity of care period?	Yes, it will be considered.
253.	Section 6.2.17, pg. 88-89	Would DMAS consider the ability to change providers within the 90 day continuity of care period if the provider's Service Authorization ends prior to the 90 days and the provider does not want to contract with the MCO?	Yes, refer to RFP Addendum.
254.	Section 6.2.18, pg. 90	Please confirm that member healthy initiatives are limited to \$50 per goal, unless higher value approved by DMAS, but that there are no fiscal/calendar limits for any one individual.	Confirmed, there are no fiscal/calendar limits for any one individual.
255.	Section 6.2.19, pg. 90	The RFP states "DMAS strongly encourages Contractors to work with Department of Aging & Rehabilitative Services (DARS) to cover innovative services like the Chronic Disease Self-Management Program (CDSMP), as it aligns with the Department's priorities to empower individuals to take steps to improve their overall health and maintain an active and fulfilling lifestyle." Are	DMAS encourages Offerors to work collaboratively with DARS.

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		Contractors expected to implement programs that replace DARS' innovative services? Or, are Contractors to simply leverage the existing programs administered by the DARS?	
256.	Section 6.2.21, pg. 91	The RFP mentions both "care manager" and "care coordinator" in different sections (for example, care coordinator is used later in this section as well as in Section 3.3.3). Is the Department using the terms interchangeably? If not, please define each term.	Yes, but care coordinator is the preferred term.
257.	Section 6.2.21, pg. 92	When will DMAS identify the specific elements to be included in the MCO's HRAs?	These will be available in the MTLSS Contract.
258.	Section 6.2.21, pg. 92	Does the Commonwealth specifically require that the Contractor use the UAI for the LTSS membership or may the Contractor incorporate all aspects of the UAI into its assessment tool of choice (for example, the InterRAI HC)?	Initial LTSS membership is determined by the Pre-admission Screening Teams.
259.	Section 6.2.21, pg. 92	Would DMAS consider the HRAs conducted with member's telephonically (i.e. Community Well, Vulnerable Pops - excluding Tech, EDCD and NF) be conducted via a trained Member Services team member instead of a Care Coordinator?	No.
260.	Section 6.2.21, pg. 92-93	We have reviewed the UAI and Manual, and DMAS assessments 99, 108 and 109. Are MCOs to create assessment tools that incorporate all elements of these tools for applicable members, or will the state provide standard tools to be used by all MCOs for LOC assessments, reassessments and HRAs.	<ul style="list-style-type: none"> <li>• LOC assessments-see response to Question #258.</li> <li>• Annual LOC Reassessments-MLTSS Contractors may either use the DMAS standardized tools or incorporate all the elements of the DMAS standardized tools into their own tool.</li> <li>• HRAs-see response to Question # 257.</li> </ul>
261.	Section 6.2.21, pg. 94	Please clarify whether LTSS members are to be contacted at least monthly or every 90 days?	All enrolled members must be contacted at least monthly (including LTSS members) unless the member requests less frequent contact. Contact with LTSS members shall occur at least every 90 days even if the LTSS member requests less frequent contact.
262.	Section 6.2.21, pg. 94	Please confirm minimum frequency of contact (by phone and in person) for members, including NF LOC (waiver and facility) and Community Wells.	See response to Question # 261.
263.	Section 6.2.21, pg. 94	Please clarify the verbiage "Robocalls or automated telephone calls that deliver recorded messages are not an acceptable form of contacting individuals." Does	This requirement applies to care coordination contacts.

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		this only apply to the Care Coordination requirement of monthly/quarterly calls? For example, if the Contractor wanted to remind members of a needed service such as a flu shot, would it be acceptable to use an automated telephone call?	
264.	Section 6.2.23, pg. 95	<p>The RFP states that the contractor must contract with the F/EA that DMAS has selected in each of the regions.</p> <ol style="list-style-type: none"> <li>1. Does DMAS plan to re-bid for an F/EA vendor or does the current contract with the F/EA remain in place through 2018 or longer?</li> <li>2. What are the contract limitation timeframes?</li> </ol>	<ol style="list-style-type: none"> <li>1. DMAS will not re-bid at this time. DMAS has elected to extend a 1 year option period to the current vendor (PPL). The option period is from January 1, 2017 to December 31, 2017.</li> <li>2. The Contractor shall contract with the FEA until otherwise specified by DMAS.</li> </ol>
265.	Section 6.2.23, pg. 95	<p>Please confirm the following regarding Section 6.2.23:</p> <ol style="list-style-type: none"> <li>1. Please provide additional information on what is included and excluded in the administrative fee that DMAS pays to the F/EA.</li> <li>2. Will that remain the same as it is currently?</li> <li>3. How is Workers Compensation handled under the program?</li> </ol>	<ol style="list-style-type: none"> <li>1. The Per Member Per Month (PMPM) fee is a capitated payment made by the Department, for administrative services provided by the F/EA for unduplicated, active Medicaid Individuals who have had an approved service activity paid during the PMPM month. This administrative fee is used to offset the operating costs incurred by the F/EA's management of the population. DMAS pays a PMPM fee with the understanding that the contractor will use the funds to remain compliant in all technical, corporate, and operational areas specified in the F/EA contractual agreement.</li> <li>2. Yes.</li> <li>3. Attendants are not covered under Workers' Compensation Insurance in the Commonwealth of Virginia.</li> </ol>

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			Guidance may be found in the DMAS Consumer-Direction Employer Manual.
266.	Section 6.2.23, pg. 95	RFP Section 6.2.23 states: "...pay rates and other necessary data to ensure accurate payroll. The Contractor shall have two employee pay rates: a higher rate for employees of individuals residing in Northern Virginia localities...and a base rate for employees of individuals residing elsewhere in the state....." With the DOL Rules and Regulations, does DMAS plan to make changes to their existing approach for establishing pay rates for self-direction and allow the member/employer to negotiate rates with the worker (up to a pay limit amount that DMAS would set)?	No. Pay rates are determined by the General Assembly.
267.	Section 6.2.23, pg. 95	With regard to F/EA services, how many agencies will the State contract with, and who will that agency(ies) be?	At the time of MLTSS implementation, Public Partnerships, LLC will be the sole F/EA.
268.	Section 6.2.23, pg. 95	Payment for background checks of Consumer-Directed employees carries might in some circumstances be seen as evidence of an employer-employee relationship between the Contractor and the Consumer-Directed employee. Will DMAS consider any other payment arrangement for reimbursing fees paid by the F/EA for background checks?	Review the Department of Labor Administrator's Interpretation No. 2014-2 related to employer relationships, available at: <a href="https://www.dol.gov/WHD/opinion/adminInt/rprt/FLSA/2014/FLSAAI2014_2.pdf">https://www.dol.gov/WHD/opinion/adminInt/rprt/FLSA/2014/FLSAAI2014_2.pdf</a>
269.	Section 6.2.23, pg. 95	Please clarify why F/EA costs for background checks are the responsibility of the MLTSS contractor and are not included in the F/EA administrative fees paid by the Department directly to the F/EA.	F/EA costs for criminal, child abuse and neglect background checks are excluded from F/EA administrative fees. These fees are non-negotiable yet, subject to change as established by Virginia State Police and the Department of Social Services. The F/EA's PMPM accounts for administrative service payments from DMAS and any other contractor account.
270.	Section 6.2.24, pg. 96	Will DMAS please provide the difference in eligibility requirements between what is in the RFP vs. the current disabled SSI population?	This question is unclear. DMAS maintains the sole responsibility for determining eligibility of an individual for Medicaid funded services and enrollment with the Contractor. SSI is determined through the Social Security Administration.

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271.	Section 6.2.26, pg. 96	<p>"The contractors need to become Dual Eligible Special Needs Plans (D-SNPs) and enroll beneficiaries who are entitled to both Medicare (Title XVIII) and Medical Assistance from a State Plan under Title XIX (Medicaid), and offer the opportunity of enhanced benefits by combining those available through Medicare and Medicaid. <a href="https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/DualEligibleSNP.html">https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/DualEligibleSNP.html</a></p> <p>This includes QMBs, QMB+, SLMB, SLMB+, QI, QDWI, and FBDE, how can these individuals be excluded from MLTSS yet the contractors are required to include them in their D-SNP?</p> <p>If they are to be included how do contractors identify them and ensure they are either excluded or available for participation in MLTSS? Where are they located, in what regions and at what numbers? What special considerations does the state wish the contractors to consider for these populations? Are their co-insurance and non-Medicare related expenses included in the rate books? "</p>	<p>Reference the Draft D-SNP contract at: <a href="http://www.dmas.virginia.gov/Content_pgs/mltss-dsnp.aspx">http://www.dmas.virginia.gov/Content_pgs/mltss-dsnp.aspx</a>.</p> <p>QMBs, SLMB, QI, QDWI are not included in the DMAS MLTSS or D-SNP contracts.</p>
272.	Section 6.2.26, pg. 96 & 97	Please confirm that there is no missing heading or dividing language between RFP page 96 and RFP page 97. Please confirm that the items listed as 1-12 on RFP page 97 are intended to be numbers 7-18, as a continuation of the items listed 1-6 on RFP page 96 under the heading 6.2.26 Exclusions from MLTSS Participation.	Confirmed.
273.	Section 6.2.26, pg. 97	Please confirm that the list that begins at the top of page 97 is a continuation of the list on page 96, and thus "item1" on page 97 is actually "item 7", etc.	See response to Question # 272.
274.	Section 6.3.1, pg. 98	Regarding the requirement to immediately notify DMAS if a "key staff member" vacates the assigned position – Please clarify what DMAS considers to be a <i>key staff member</i> that would trigger this notification requirement.	See 3.2.6; Key Staff include: Virginia MLTSS Project Director, MLTSS Project Manager, MLTSS Care Coordination Manager, Virginia licensed Medical Director, and top leadership positions including individuals responsible for network recruitment, credentialing and management, medical oversight, behavioral health oversight, long-term services and supports oversight, pharmacy oversight, quality, financial management, claims payment, utilization management, and IT management.
275.	Section 6.3.1, pg. 98	The RFP states "The Contractor shall immediately notify DMAS whenever a key staff member vacates the assigned position." Can DMAS define "key staff member"?	See response to Question # 274.

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276.	Section 6.3.1, pg. 98	Please confirm that, similar to best practices used in other states, Care Coordinators for individuals who meet nursing facility level of care (in facilities or in the community) also can be licensed social workers.	No. An RN is required for NF, EDCD, and Tech Waiver.
277.	Section 6.3.3, pg. 101	May a Contractor representative participate in the Enrollee Advisory Committee, especially in an administrative support capacity?	Confirmed.
278.	Section 6.3.4.4, pg. 130	"Since Members enrolled in Medicaid, determined by the DMAS as having comprehensive health coverage including Medicare, will remain enrolled in MLTSS. Does the Contractor have the ability to cost avoid all health related insurance claims as the payer of last resort and Coordinate Benefits with the primary insurer?"	Per 6.3.4.1, the Contractor is responsible for coordinating all benefits with Medicare and other insurance carriers (as applicable) and following Medicaid "payer of last resort" rules.
279.	Section 6.3.5, pg. 103	The RFP states that "The Contractor shall have adequate resources to support MLTSS reporting needs as required by DMAS. Examples of reports will include, but are not limited to, behavioral health, pharmacy claims, provider network, (etc.)" What is the frequency of the pharmacy claims and provider network reports; i.e., monthly, quarterly?	The MLTSS Draft Reporting Manual is available on the DMAS website at <a href="http://www.dmas.virginia.gov/Content_pgs/mltss-ihp.aspx">http://www.dmas.virginia.gov/Content_pgs/mltss-ihp.aspx</a> . The Reporting Manual will be finalized with the MLTSS Contract.
280.	Section 6.3.7, pg. 104-106	The reporting and notification requirements for Program Integrity and Oversight are quite rigorous and inclusive. Will DMAS consider further refining the reporting/notification obligations, so as to allow Contractors a degree of discretion in undertaking investigation and recovery activities?	No.
281.	Section 6.3.7, pg. 105	The Contractor will be required to notify DMAS before initiating any recoupment or withholding of any program integrity related funds to ensure that the recoupment or withhold is permissible.  Does this mean we will need permission from DMAS before placing a provider on Pre-Payment review?	No.
282.	Section 6.3.7, pg. 105	Where can the MCOs obtain the standard forms referenced in this section for Fraud/Waste/Abuse?	Forms will be provided during the readiness review process.
283.	Section 6.3.8 & 6.1.13.3, pg. 153 & 106	This section states that the Contractor must have a formal Program Integrity Plan to detect, correct, and prevent fraud waste and abuse. Section 6.1.13.3 Fraud and Abuse Compliance Plan (page 153) States that the Contractor shall have a written Fraud and Abuse compliance plan.  Can the Department confirm that the Contractor is to maintain 2 plans? Or is the intent if for one plan and it is simply referred to by different names in the RFP.	The Contractor is expected to maintain two separate plans as they serve separate purposes.
284.	Section 6.3.13, pg. 111	How are " <i>adverse decisions</i> " defined, for purposes of Providers' exercise of their right to appeal?	Adverse decision for providers is defined as an action taken by the Contractor to

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			deny, terminate, suspend, reduce services and/or date range(s) for services, or partially approve a covered service. An adverse decision also includes any denial of payment (in whole or part), as well as any attempt to recover or retract payment already made to a provider. Additional details are in the VAC per 6.3.12 and 6.3.13 of the RFP.
285.	Section 6.3.16, pg. 115	Specific to Hours of operations for members and providers call centers, please clarify if the member services and providers call center hours are correct in section 6.3.16 (Call Center Requirements), Or are they correct in section 3.5.10 (Call Center).	See response to Question #189.
286.	Section 6.3.16, pg. 115	<p>The Contractor’s call center must answer 85% of all member and provider calls within 30 seconds or less. The Contractor must limit average hold time to two (2) minutes, with the average hold time defined as the time spent on hold by the caller following the IVR system, touch tone response system, or recorded greeting and before reaching a live person. The Contractor must limit the disconnect rate of all incoming calls to five (5) percent. The Contractor must have a process to measure the time from which the telephone is answered to the point at which a member reaches an Enrollee Service Representative (ESR) capable of responding to the Member’s question in a manner that is sensitive to the member’s language and cultural needs.</p> <p>Are these requirements daily, weekly, or monthly?</p>	Monthly.
287.	Section 6.3.16, pg. 115	<p><i>“The Contractor shall provide the capacity for the Department to timely monitor calls remotely from DMAS offices at no cost to the Department.</i></p> <p><i>The Contractor shall record 100% of incoming calls to its member and provider helplines using up-to-date call recording technology. Call recordings must be searchable by provider NPI, member ID # (if available), phone number (when identified) and date and time of the call. Recordings will be made available to the Department within one (1) business day upon request, and stored for a period of no less than fifteen months from the time of the call.”</i></p> <p>Please confirm that the scope of this requirement applies only to Member and Provider helplines and not others such as the Pharmacy Technical Help Line.</p>	Confirmed.

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288.	Section 6.3.16, pg. 115-118	In the General Call Center Components, the RFP states that customer service shall be available 8 am to 8 pm, 7 days a week (pg. 115) with nurse triage/advice, BH crisis, Care Coordination, and Pharmacy Tech support available 24/7. Under Member Call Center, the RFP states that the member call center shall be staffed 24 hours a day, 7 days a week with qualified nurses to triage calls and facilitate transfer of calls to care coordinators and that the Contractor may meet this requirement via a separate nurse advice line. Please confirm that the interactive voice response (IVR) system can be used to route calls to the appropriate support outside of the general customer service hours (as opposed to a customer service representative needing to be available 24/7 to answer and route the call).	Confirmed.
289.	Section 6.3.17, pg. 118	Can DMAS please provide the top providers by region with their claim volumes for medical, BH, NF, and HCBS?	See the “Medicaid Fee-For-Service Providers Utilized by MLTSS Target Population” file at <a href="http://www.dmas.virginia.gov/Content_pgs/mltss-ihp.aspx">http://www.dmas.virginia.gov/Content_pgs/mltss-ihp.aspx</a> .
290.	Section 6.3.17 & 6.3.18, pg. 119 & 119-120	Do the stated access to care standards and travel time distance standards also apply to the Contractor’s network pharmacies?	Yes.
291.	Section 6.3.18, pg. 119	Given that CMS has well established medical network adequacy requirements for Medicare Advantage (which provides primary medical coverage to dual eligible members), please confirm DMAS will only apply the medical network adequacy requirements outlined in the RFP for non-dual eligible membership in the MLTSS program.  If so, please confirm DMAS will release a membership file that distinguishes between duals and non-duals.	Confirmed. Please see <a href="http://www.dmas.virginia.gov/Content_pgs/mltss-ihp.aspx">http://www.dmas.virginia.gov/Content_pgs/mltss-ihp.aspx</a> for a breakdown of duals and non-duals by MLTSS region.
292.	Section 6.3.18, pg. 119	Throughout certain sections of the RFP, there appears to be conflicting language regarding “Private Duty Nursing” requirements, which is typically a service provided in the member’s home. Attachment D lists Private Duty Nursing as one of the provider types that require a Mapped Version to be submitted. However, the time and distance access standards in RFP sections 6.3.17 and 6.3.18 specify that time and distance standards apply only to enrollees’ travel and <u>do not apply to providers that travel to provide a service (e.g., home health, personal care, respite, etc.)</u> . Can DMAS please clarify what the expectations of Offerors are regarding the mapping requirements for Private Duty Nursing services?	DMAS recognize that Private Duty Nursing providers travel to members’ homes. The purpose of the mapped version for PDN is to assure member choice of at least two (2) per region. See Exhibit 3 in the PNADS.

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293.	Section 6.3.18, pg. 119	Throughout the RFP and related documents, the requirements make reference to “provider type” or “service type.” For example, RFP subsection 6.3.18 states “The Contractor shall ensure that each enrollee has a choice of at least two (2) providers of each service type located within no more than thirty (30) minutes travel time...” and Attachment D (Mapped Version of Providers) states “Offerors shall submit maps separated by region and by provider type.” Please confirm what is meant by the term “service type” and the specific RFP document/point of reference where this listing can be obtained.	Service type generally refers to provider type or specialty. For LTSS and community behavioral health refer to Exhibits 3-5 of the PNADS.
294.	Section 6.3.18, pg. 119	Other State Medicaid programs require that 90% to 95% of members have access to providers within time and distance for any given locality. Will DMAS follow a similar standard in its network adequacy measurement criteria?	This will be outlined in the DMAS MLTSS Contract.
295.	Section 6.3.18, pg. 119	What is the analytical software that DMAS will use to assess and measure the Offeror’s network adequacy?	DMAS will use a variety of analytical software, such as GeoNetworks Software.
296.	Section 6.3.18, pg. 119	Please confirm that DMAS will take into account Primary Care and Mental Health Professional Shortage Areas (HPSA) when assessing network adequacy.	Offerors should describe these areas in their proposals and innovative strategies to address them.
297.	Section 6.3.18, pg. 119	Will DMAS release a list of urban and rural locality designations?	DMAS will follow the CMS MA HSD reference guide, available at: <a href="https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index.html">https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index.html</a>  DMAS defines rural as micro, rural, and CEAC areas. Urban is defined as metro and large metro. DMAS will post a table that identifies VA rural and urban localities at: <a href="http://www.dmas.virginia.gov/Content_pg/mltss-ihp.aspx">http://www.dmas.virginia.gov/Content_pg/mltss-ihp.aspx</a>
298.	Section 6.3.18, pg. 119-120	The RFP outlines travel time <u>and</u> travel distance standards for enrollee access to providers. NCQA requires health plans to establish time <u>or</u> distance standards. The Medallion 3.0 contract (which includes ABD) also requires time <u>or</u> distance standards. Please confirm time <u>or</u> distance standards are required (as opposed to both time <u>and</u> distance standards).	Time and distance standards, unless an exception is granted by DMAS.
299.	Section 6.3.18, pg. 119	Please clarify which counties the State considers Urban. Please clarify which counties the State considers Rural.	See response to Question # 297.

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300.	Section 6.3.18, pg. 119	(2 providers of each service type) Would "each service type" refer to those providers a member may potential need or is it limited to the 24 provider types outlined in the Provider Network Adequacy Data manual.	See response to Question # 293.
301.	Section 6.3.18, pg. 119-120	How does DMAS define 'service type' for network adequacy?	See response to Question # 293.
302.	Section 6.3.18, pg. 119-120	The Network Adequacy dictates a specific drive time requirement for members to certain provider types. Without any member addresses, how should we determine this requirement?	See response to Question # 171.
303.	Section 6.3.19, pg. 120	Regarding the requirement for subcontractors and providers to make ownership & control disclosures, business transactions and persons convicted of crimes against Federal health care programs – Are those disclosures to be made by providers and subcontractors to the Contractor, or to DMAS directly? If to the Contractor, is there also an expectation that the Contractor will in turn provide such reports to DMAS?	Yes, these procedures will be outlined in the MLTSS Contract.
304.	Section 6.3.21, pg. 121	Do all member changes (moving to/from a plan) occur on the first of the month, or should we expect to see mid-month eligibility changes also occur? Does the file also include information about the member's previous PCP, to facilitate continuity of assignment where possible?	The MLTSS enrollment begin date will occur on the first day of the month. Generally member terminations will not occur mid-month, however, there will be a few instances where mid-month disenrollments may occur, such as death or admission to an excluded facility, e.g., admission to a level C psychiatric residential treatment facility. Details regarding mid-month disenrollments will be outlined in the MLTSS Contract. DMAS does not assign a primary care physician under the fee-for-service program, therefore, the Contractor would be expected to utilize its D-SNP Medicare data and the DMAS MTR data to determine member PCP assignment. DMAS will communicate enrollment changes on a weekly basis.
305.	Section 6.3.21, pg. 121	When will Open Enrollment occur for each one of the regions and will the intelligent assignment process be utilized if a member does not self-select?	All MLTSS regions will have the same open enrollment (OE) date; between October and December 18th for a January 1 effective date (similar to the Medicare OE timeframe). Intelligent

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			assignment will be used for initial plan assignment. Members will have the ability to change their default plan assignment prior to the effective date.
306.	Section 6.3.21, pg. 122	Contractors are instructed to send MTR files on the 9th, 16th, 22nd and 3rd. Please clarify that this applies even when the dates fall on a weekend.	Confirmed
307.	Section 6.3.22, pg. 123	Section 6.3.22 indicates that whenever possible, DMAS will maintain a HAP and CCC member's Contractor membership to reduce disruption. Will this same logic apply to the ABD members who are moving from the Medallion 3.0 program?	This has not been determined.
308.	Section 6.3.23, pg. 123	To maintain continuity of care, will DMAS consider MA/D-SNP enrollment within its Intelligent Assignment process?	DMAS will consider this.
309.	Section 6.3.23, pg. 123	Based on auto-assignment rules, it is possible that an MCO may end up with an average NF daily cost that is higher than average for a region purely based on the randomness of assignment of members. Since MCOs cannot be expected to change the NF unit cost basis for members already residing in facilities, nor are they expected to move members to lower cost facilities, will a separate risk adjustment or reconciliation process be considered if material differences between MCOs are detected based on member assignment?	DMAS believes the LTSS risk adjustment mechanism will address this.
310.	Section 6.3.23, pg. 123	Based on auto-assignment rules, it is possible that an MCO may end up with an average NF daily cost that is higher than average for a region purely based on the randomness of assignment of members. Since MCOs cannot be expected to change the NF unit cost basis for members already residing in facilities, nor are they expected to move members to lower cost facilities, how will this risk be considered and addressed in the rate setting process?	See response to Question # 309.
311.	Section 6.3.25, pg. 124	<p>This requirement specifies that "The Contractor shall provide the following information to new individuals...a provider network listing...information regarding how to access and/or request a provider directory."</p> <p>Does DMAS intend that two different provider network documents be provided to new members? If so, what is the format for each? Or, was the intent to provide either one or the other? Please clarify.</p>	No. The information must be provided in accordance with the with the Federal managed care regulations per 42 CFR 438.10.
312.	Section 6.3.25, pg. 124	The RFP states that the Contractor shall provide a provider network listing and information regarding how to access and/or request a provider directory. Please confirm that Contractors will provide members with printed information on where the provider network can be accessed, searched, and printed as needed (as opposed to requiring Contractors to disseminate hard copies of the entire provider network).	Confirmed as long as this is provided in accordance with the Federal managed care regulations per 42 CFR 438.10.

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313.	Section 6.3.34, pg. 126	Please clarify whether the word “by” should be changed to “from” in the following sentence: “Any moneys recovered <i>by</i> third parties shall be retained by the Contractor and identified monthly to the Department.”	Confirmed
314.	Section 6.4.1, pg. 127	If an Offeror uses an EVV system, will they be required to utilize the EVV system that Virginia develops?	If DMAS develops and implements an EVV system, the MLTSS contractor could either use the DMAS EVV system, or establish an interface and connectivity with DMAS’ EVV system to share data as set forth by DMAS at no additional cost.
315.	Section 6.4.2, pg. 127-128	Please confirm that Offerors may accommodate the Secure e-Mail requirement (6.4.2) by either suitably secured web browser support (greater than 128 bit SSL) – or – via TLS secured connectivity between DMAS and the Offeror’s e-mail system.	This requirement has been updated in the RFP.
316.	Section 6.4.3, pg. 128	Please define the acronym “HTS.”	High-Throughput Satellite transmission or reception of data/voice/images in a wired or wireless network
317.	Section 6.4.7, pg. 129	Please confirm that the phrase “ <i>Inbound Interfaces</i> ” means data that the Contractor must supply DMAS (that is: data that goes FROM the Contractor TO DMAS). Similarly, please confirm that “ <i>Outbound Interfaces</i> ” means data that goes FROM DMAS TO the Contractor.	Confirmed.
318.	Section 6.7.1, pg. 135	When capitation rates are updated for 2018, does DMAS intend to rebase rates using more recent Medicaid data? Or will it base 2018 rates on an adjustment to 2017 rates?	DMAS intends to use more recent data.
319.	Section 6.7.1, pg. 135	Will the capitation be risk-adjusted for each MCO? If so, what is the expected risk adjustment methodology?	See response to Question # 232.
320.	Section 6.7.1, pg. 135	Will DMAS provide the capitation rate development, including methodology and base data, to the MCOs? Will the CMS-approved rate ranges also be shared with the MCOs?	DMAS will provide the capitation rate development it typically provides for other rate setting. The rate ranges are governed by the new Federal Managed Care Regulations.
321.	Section 6.7.1, pg. 135	Will Hip-C pricing for the ABD population and adjustments for specialty Rx trends for ABD populations be transparently illustrated in the final methodology and assumptions document?	Individual adjustments and trend calculations will be transparent.
322.	Section 6.7.1, pg. 135	Will DMAS please consider paying nursing home rates for six months instead of four months after a member transitions from nursing home to HCBS? This is more consistent with other states and gives more incentive for MCOs to generate savings and more incentive to transfer patients. This will also help	DMAS will consider it.

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		with any additional costs of moving a member out of a nursing home that will further cut in to the four month benefit.	
323.	Section 6.7.1, pg. 135	<p>Will there be an explicit consideration for risk and profit margin for this program that will account for data book and program uncertainties as well as existence of min MLR and need to provide sufficient margin for MCO viability?</p> <p>Actuarial Standard of Practice #49 states that "The actuary should include a provision for underwriting gain, which is typically expressed as a percentage of the premium rate, to provide for the cost of capital and a margin for risk or contingency. The underwriting gain provision provides compensation for the risks assumed by the MCO. These risks may include insurance, investment, inflation, and regulatory risks, as well as risks associated with social, economic, and legal environments."</p>	The rates will be developed in accordance with all applicable actuarial standards of practice.
324.	Section 6.7.1, pg. 135	<ul style="list-style-type: none"> <li>• How many capitation rate cells does DMAS intend to create?</li> <li>• Will the rate cells be risk adjusted and, if so, which model will be used?</li> <li>• Will Specialty Plans have separate cap rates created for their populations?</li> <li>• Will managed care factors take into account the continuity of care requirement?</li> <li>• When will capitation rates be established?</li> <li>• What are the VBP expectations and benchmarks that DMAS intends to implement?</li> </ul>	The number of rate cells has not been finalized. We intend to risk adjust rates. We anticipate providing draft capitation rates in the mid-summer of 2016. Rate cells have not been determined. Managed care savings factors have not been determined. VBP benchmarks and expectations have not been determined.
325.	Section 6.7.1, pg. 135	Will DMAS provide initial draft rates prior to final rates similar to the process in place now?	Yes.
326.	Section 6.7.1, pg. 135	Will DMAS allow for sufficient Q/A period after initial draft rates released similar to the process in place now?	Yes.
327.	Section 6.7.1, pg. 135	Can DMAS please hold a separate Q/A period on the data book and rates assumptions since rate methodology and rate assumptions not disclosed yet.	DMAS may consider this.
328.	Section 6.7.1, pg. 135	Will State actuaries still be transparent in sharing their rating methodology and rating assumptions similar to how they do so now?	Yes.
329.	Section 6.7.1, pg. 135	Will there be a final sign-off from MCO on rates similar to process in place now?	Rates are included in the annual contracts signed by the Contractors.
330.	Section 6.7.1, pg. 135	Will there be sufficient opportunity for MCOs to participate in Q/A during negotiation phase of RFP?	Yes.
331.	Section 6.7.1, pg. 135	Will there be sufficient time for MCOs to evaluate rates during the negotiation/presentation phase of the RFP?	Yes.
332.	Section 6.7.1, pg. 135	How far in advance of effective date does DMAS plan to submit rates to CMS during RFP process?	10 Months.

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333.	Section 6.7.1, pg. 135	How does DMAS timeline to submit rates to CMS affect the expected timeline when rates and methodology will be shared with MCOs with opportunity to discuss during RFP process?	DMAS anticipates presenting draft rates to Contractors before formally submitting them to CMS, but the timing may depend on CMS requirements.
334.	Section 6.7.1, pg. 135	Will there be an explicit consideration for the cost of capital component for this new significant expansion of existing managed care program in development of administrative loads and components? Actuarial Standard of Practice #49 states that "The actuary should include a provision for underwriting gain, which is typically expressed as a percentage of the premium rate, to provide for the cost of capital and a margin for risk or contingency. The underwriting gain provision provides compensation for the risks assumed by the MCO. These risks may include insurance, investment, inflation, and regulatory risks, as well as risks associated with social, economic, and legal environments."	The rates will be developed in accordance with all applicable actuarial standards of practice.
335.	Section 6.7.1, pg. 135	Is LTSS rate structure expected to remain separate for HCBS and NF with transfer payments or is it going to be different in the future?	Separate.
336.	Section 6.7.1, pg. 135	Are rebalancing or transfer payments structure subject to change in renewal years?	Yes.
337.	Section 6.7.1, pg. 135	We understand this to mean that Contractor has an opportunity to approve the annually established capitation rates in advance in accordance with Section 7.8 and with 6.9.5 of the Special Terms, and that Contractor is not agreeing to an open-ended rate established unilaterally by the Department. Is this correct?	See the response to question # 329.
338.	Section 6.7.1, pg. 135	How far in advance of effective date does DMAS plan to submit rates to CMS during renewal process?	DMAS will comply with any CMS requirements.
339.	Section 6.7.1, pg. 135	How does DMAS timeline to submit rates to CMS affect the expected timeline when rates and methodology will be shared with MCOs with opportunity to discuss during renewal process?	See the response to question # 333.
340.	Section 6.7.2, pg. 135	Will actual Health Insurer Fee payments be settled at the end of the following year? How will the timing work?	We expect to settle the HIF amounts at the end of the contract year in which the HIF is paid by amending the capitation rates retrospectively.
341.	Section 6.7.3, pg. 136	"The Contractor is required to report a MLR annually based on 42 C.F.R. § 438.8." Please confirm that the reference to 42 CFR 438.8 is the regulatory citation that DMAS intends.	Confirmed.
342.	Section 6.7.3, pg. 136	Please confirm enhanced benefits will be considered as "expenditures for activities that improve health care quality" for MLR calculations.	This will be evaluated based on the nature of the benefit and compliance with 42 CFR 438.8.
343.	Section 6.7.3, pg. 136	"Please clarify that ""(ii) adjusted premium revenue"" is consistent with adjusted premium revenue contained in the CMS Mega Rule 42 C.F.R. § 438.8?"	DMAS will comply with 42 CFR 438.8.

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		In the CMS Mega Rule, 42 C.F.R. § 438.8, adjusted premium is defined as the MCO's, PIHP's, or PAHP's premium revenue (as defined in paragraph (f) (2) of this section) minus the MCO's, PIHP's, or PAHP's Federal, State, and local taxes and licensing and regulatory fees (as defined in paragraph (f) (3) of this section) and is aggregated in accordance with paragraph (i) of this section."	
344.	Section 6.7.3, pg. 136	Please clarify that "(ii) adjusted premium revenue" is consistent with NAIC MLR formula and CMS Mega Rule and excludes HIF	DMAS will comply with 42 CFR 438.8.
345.	Section 6.7.3, pg. 136	Please clarify that the minimum medical loss ratio is consistent with the NAIC MLR definition and the CMS Mega Rule and incorporates a credibility adjustment based on the MCOs enrollment.	DMAS will comply with 42 CFR 438.8.
346.	Section 6.7.3, pg. 136	RFP does not state whether the 85% MLR is combined or separate for SSI and LTSS. We recommend that it be combined similar to most other Medicaid programs, which will increase the credibility of the results and is consistent with CMS guidance on credibility adjustments.	MLR will be determined on a combined basis.
347.	Section 6.7.3, pg. 136	Please confirm that DMAS will follow the Federal guidelines for expenditures that should be included within the MLR calculation.	DMAS will comply with 42 CFR 438.8.
348.	Section 6.7.3, pg. 136	MLR is calculated using the <u>adjusted premium revenue</u> . Please define adjusted premium revenue.	As defined in 42 CFR 438.8.
349.	Section 6.7.3, pg. 136	How will the DMAS define "activities that improve healthcare quality plus expenditures on fraud reduction activities..."? Will the MLR calculation be based on only paid claims data (assumed to be fully run-out and no IBNR)?	As defined in 42 CFR 438.8.
350.	Section 6.7.3, pg. 136	<ul style="list-style-type: none"> <li>• How will the \$150K reinsurance attachment point work in 2017, the first year of the program, when the membership will be phased in through-out the year?</li> <li>• Is the plan required to purchase Reinsurance through the Commonwealth?</li> </ul>	It will be prorated based on months of coverage during 2017. The Rx reinsurance will be provided to all plans and all plans will receive capitation payments net of the Rx reinsurance premium.
351.	Section 6.7.4, pg. 137	Are Contractor's required to participate in the stop-loss program provided by Virginia DMAS?	See response to Question # 350.
352.	Section 6.7.4, pg. 137	Is the Commonwealth-provided reinsurance mandatory OR may MCOs obtain their own reinsurance from a different party?	See response to Question # 350.
353.	Section 6.7.4, pg. 137	The deadline for final quarter submission is in March for the 4 <sup>th</sup> quarter of the CY. Will the MCO be permitted to revise reinsurance submission if additional claims are submitted after March?	No.
354.	Section 6.7.4, pg. 137	Does DMAS expect to keep this reinsurance program in the future for the ABD population?	The reinsurance program could be eliminated but DMAS expects to keep it in the future. Factors included in the reinsurance program such as the

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			attachment point may be re-determined.
355.	Section 6.7.4, pg. 137	Please clarify if the stop-loss program is applicable to prescription drug costs only.	Yes.
356.	Section 6.7.6, pg. 138	Is this withhold the same as the PIA in the current Medallion 3.0 contract and where the PIA is designed as a “zero sum” approach where the total MCOs’ awards are equal to the total MCOs’ penalties? Will it be designed where the end result is a gain or a loss or no change for each payer (MCO) and no gain or loss for the purchaser (DMAS)? Will the maximum amount at risk for each MCO be 2% or is it 0.2% of the total annual MCO capitation amount (i.e., per member per month (PMPM) capitation rate times the total annual member months), and the maximum award is 2% or 0.2% of the total annual MCO capitation amount? Is the amount of loss or gain for each MCO is contingent upon two factors: 1) MCO performance on each of the six quality measures, and 2) the total capitation paid to each MCO for the fiscal year?	No. The withhold is not a “zero sum” approach and is not the same as the PIA in Medallion 3.0. The maximum amount at risk would be 2.0% of total annual capitation. Yes, the amount of loss or gain for each MCO is contingent upon two factors: 1) MCO performance on quality or performance measures, and 2) the total capitation paid to each MCO for the rate year.
357.	Section 6.7.6, pg. 138	Since expansion efforts and the introduction of managed care do not show immediate financial savings immediately upon implementation and requires additional administrative resources from MCO's for the first year of expansion, will DMAS please consider delaying and/or postponing the withhold application until the new statewide LTSS program is more mature and established? In introducing a material withhold in the first year of the program (especially as it applies to the LTSS component including NF costs which are high), this will put additional strain on MCO resources at a time when they are needed for successful program adjustment and launch.	DMAS may consider.
358.	Section 6.7.6, pg. 138	Please confirm our understanding that the 2% withhold is the maximum percentage to be used during any of the annual periods of the entire contract period including renewal years.	Yes.
359.	Section 6.7.6, pg. 138	If you plan on using a withhold in the first year, can you please indicate the likely withhold percentage to be used in the first year and how quickly it is expected to increase to 2%?	This has not been determined.
360.	Section 6.7.6, pg. 138	Please explain how the withhold is to be incorporated in to the minimum MLR formula?	Premium revenue will include withhold amounts that are earned by and paid to the MCO. Premium revenue will not include withhold amounts that are not paid to the MCO.
361.	Section 6.7.6, pg. 138	<ul style="list-style-type: none"> <li>• Will the Commonwealth have a withhold in place for year 1 of the contract?</li> <li>• What is the timing of the withhold phase in?</li> </ul>	There will be a withhold in place in year one of the contract but all the details have not been determined.

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362.	Section 6.7.6, pg. 138	What is the anticipated timeline, amount at risk and criteria to phase in the withhold/award program?	This has not been determined.
363.	Section 6.7.6, pg. 138	Actuarial Standard of Practice #49 states that "The capitation rates should reflect the value of the portion of the withholds for targets that the MCOs can reasonably achieve." Please verify that the rates will be certified as "Actuarial Sound" net of the implementation of the withhold. If not, can you please explain and verify that the withhold recovery can be reasonably achieved by MCOs?	Rates will be certified as actuarially sound and CMS will review and approve rates. We will ensure that the quality measures can be reasonably attained and, therefore, the withhold recovery amounts can be reasonably achieved by the Contractor.
364.	Section 6.7.8, pg. 139	Would DMAS consider the contractor to submit drug utilization encounter data on a monthly basis rather than weekly?	No.
365.	Section 6.7.9, pg. 140	Is there any requirement to pay out of state providers at a certain fee schedule?	Yes. In the absence of an agreement between the Contractor and the provider, the Contractor shall pay out of network providers, including out of state providers at the prevailing DMAS rate in existence on the date of service.
366.	Section 6.7.9, pg. 140	Are there any requirements to contract with non-participating providers or out-of-state providers at a certain fee schedule?	In the absence of a contract, Contractors pay the DMAS rate.
367.	Section 6.7.9, pg. 140	How is the pass through of Medicaid fee schedule rate increases by DMAS expected to work in relation to the VBP methodologies established?	This has not been determined.
368.	Section 6.7.9, pg. 140	Will the MCO be required to obtain confirmation of completed UAI for NF members from the NF or the local/hospital organization that completed the UAI? Can the UAI be accessed electronically through a system - if not, how is it accessed?	The MLTSS Contractor will utilize the MMIS (MES) to verify that a UAI has been completed prior to enrollment in a nursing facility.
369.	Section 6.7.9, pg. 141	Will DMAS set the rates for LTSS benefits? Will DMSA provide LTSS HCPCS Codes, Revenue Codes, or Modifiers, if applicable?	Contractors will be required to use DMAS rates for LTSS benefits as the floor unless they negotiate other rates with the provider. DMAS procedure codes, rates and fees are available at <a href="http://www.dmas.virginia.gov/Content_pgs/pr-rsetting.aspx">http://www.dmas.virginia.gov/Content_pgs/pr-rsetting.aspx</a>
370.	Section 6.7.9, pg. 141	How does DMAS plan to adjust the NF and HCBS provider fee schedules in the future and will fee schedule increases be reconciled during the rate setting process?	Changes to NF and HCBS rates will be used on regulations or authorization in the budget. Rate changes will be considered as adjustments in the rate setting process.

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371.	Section 6.7.9, pg. 141	Will fee schedule changes and adjustments for NF and HCBS be calculated and incorporated in rates on a regional basis? Since there can be quite drastic differences in costs by region, this can have a very material impact on the LTSS costs by region and thus MCOs viability. The CMS 2016 Medicaid rate guide specifies that for rate certifications "To be acceptable, the rate certification submission, as supported by the assurances from the state, must include the final and certified capitation rates or the final and certified rate ranges for all rate cells and regions."	For the most part, base data used for each region will adequately incorporate regional cost differences and any adjustments for rate changes will reflect the underlying regional cost differences. There may be limited situations that the adjustments themselves need to be modified by region in order to meet CMS requirements for rate certification. CMS has to review and approve the final rates.
372.	Section 6.7.9, pg. 141	How will mid-year NF and HCBS fee schedule adjustments be considered in rates and will there be a retroactive or interim midyear adjustment done to MCOs rates on a regular basis to catch up to cost and fee schedule increases not known at the time of the rate setting? Given the significant proportion of NF and HCBS rates and material impact of even small increases in daily costs of these categories, not adjusting for interim midyear increases will significantly jeopardize the actuarial soundness of the rates – per CMS Rule and Mega Rule Guidance.	Mid-year adjustments to capitation rates will only be made if the annual rates did not anticipate NF or HCBS fee schedule changes and such changes are deemed material by DMAS.
373.	Section 6.7.11, pg. 141	Does the plan liability change if member loses eligibility and we are reimbursing facility on a per diem rate versus a DRG methodology?	Yes.
374.	Section 6.7.13, pg. 141 & 142	Please provide further details on the method, and frequency, of communicating the patient pay amount for members where a patient pay amount applies. Will we receive a separate file or will this information be combined on the 834.	The Patient Pay amount will be sent via the 834, in the AMT segment. The Patient Pay begin and end dates are sent in the 834 in the “DTP” segment. Additional reports generated by DMAS will be provided to assist the Contractor with patient pay reconciliation activities. The current 834 Companion Guide provides additional information and is available at the link below. The guide will be updated prior to MLTSS implementation. <a href="https://www.ecm.viriniamedicaid.dmas.virginia.gov/WorkplaceXT/getContent?vslid={08377F46-D152-4F0C-82A4-FD7B03774F4D}&amp;impersonate=true&amp;objectType=document&amp;id={D0A8CFEA-">https://www.ecm.viriniamedicaid.dmas.virginia.gov/WorkplaceXT/getContent?vslid={08377F46-D152-4F0C-82A4-FD7B03774F4D}&amp;impersonate=true&amp;objectType=document&amp;id={D0A8CFEA-</a>

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			<a href="#">B06E-436D-BC93-CD298429CA3D}&amp;objectStoreName=VAPRODOS1</a>
375.	Section 6.7.13, pg. 141 & 142	Do any VA providers currently collect patient pay?	Yes.
376.	Section 6.7.13, pg. 142	For member patient liability, it is recommended that each MCOs experience and rates be adjusted for actual MCO patient liability similar to how it is done in other states. We believe that MCOs should not be expected to take risk on this item vs. the regional or statewide average as this is not an item the MCO can control.	DMAS will not adjust rates for this circumstance.
377.	Section 6.8, pg. 143	Section 6.8 Enforcement, Remedies, and Compliance starting on pg. 143 has many mentions of “in contract” or “outlined in contract” throughout RFP.  When will the draft contract be ready? Will DMAS be publishing a draft contract for Offerors to review prior to the deadline for submission of proposals?	We expect the draft MLTSS contract to be available by mid-summer 2016.  No, DMAS will not publish a draft contract for Offerors to review prior to the deadline for submission of proposals.
378.	Section 6.8.2, pg. 144	What is the basis for calculation of damages? Are there objective standards to which specific dollar amounts are attached?	This information will be outlined in the MLTSS contract.
379.	Section 6.9.2, pg. 146	Will there be a maximum number of MCOs per region?	DMAS anticipates that it will enter into contracts with no fewer than two (2) Contractors per region.
380.	Section 6.9.2, pg. 146	Is there a targeted number of MCOs per region that is higher than the 2 MCO minimum?	See response to Question # 379.
381.	Section 6.9.2, pg. 146	Does the targeted number of MCOs vary by region?	See response to Question # 379.
382.	Section 6.9.2, pg. 146	If there is a targeted number of MCOs per region, can you please clarify the targeted number of MCOs per each region?	See response to Question # 379.
383.	Section 6.9.2, pg. 146	Is there a maximum number of MCOs per region? If so, can you please clarify the maximum number of MCOs for each region?	See response to Question # 379.
384.	Section 6.9.2, pg. 146	Is there a maximum number of MCOs statewide? If so, can you please clarify the maximum number of MCOs statewide?	See response to Question # 379.
385.	Section 6.9.3.1a, pg. 146-147	Please clarify what is meant by “owner” – “Upon such termination, the Contractor shall take such steps as <b>owner</b> may require to assign to the <b>owner</b> the Contractor’s interest in all subcontracts and purchase orders designated by <b>owner</b> .”	“Owner” is reference to the controlling body/entity assuming control of the terminated contract. In most instances, this would be DMAS.
386.	Section 6.9.3.1, pg. 147	Can DMAS please clarify if performance bonds are applicable and if so, the amount? If not applicable, can DMAS please remove this from the RFP?	There are no payment or performance bonds associated with this solicitation. This is DMAS standard language

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			included in all DMAS contracts to protect the interests of the Commonwealth. If the requirement does not apply, it is not enforced but the terms need to be included.
387.	Section 6.9.3.1, pg. 147	Can you please clarify what you mean by the Contractor's surety on its payment and performance bonds?	Payment and performance bonds are not part of this solicitation. See response to question 386.
388.	Section 6.9.3.2, pg. 147	Please confirm that Capitation Rates established by the Department during the initial rate setting process are subject to mutual agreement of the parties, such that if the Capitation Rates established by the Department are not viable for the Contractor and the Contractor is unwilling or unable to perform services at those rates, the Contractor is not bound to renew the contract.	Confirmed.
389.	Section 6.9.3.2, pg. 147	Please confirm that Capitation Rates established by the Department during the contract renewal process are subject to mutual agreement of the parties, such that if the new Capitation Rates established by the Department are not viable for the Contractor and the Contractor is unwilling or unable to perform services at those rates, the Contractor is not bound to renew the contract.	Confirmed.
390.	Section 6.9.5, pg. 149	Please clarify that rates will be reviewed annually?	Rates will be reviewed at least annually.
391.	Section 6.9.5, pg. 149	Please clarify that the state will release information annually and/or hold rate setting meetings annually?	Confirmed.
392.	Section 6.9.6, pg. 150	Please specify when the BAA needs to be in place with DMAS. Is this needed now to protect member information during readiness and process reviews? Does a BAA need to be submitted with the proposal response? If not, when is the BAA submitted?	DMAS is not requiring Offerors to execute a BAA and submit with their proposals. However, Offerors should be prepared to execute a BAA anytime during readiness review or during contract award.
393.	Section 6.9.9, pg. 151	Link to standards is not operational. How can we access information? <a href="http://cfr.regstoday.com/42cfr495.aspx">http://cfr.regstoday.com/42cfr495.aspx</a>	<a href="http://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42cfr495_main_02.tpl">http://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42cfr495_main_02.tpl</a>
394.	Section 6.9.10, pg. 151	RFP Section 6.9.10 states, "At the contractor's central facility, placement of software controls that establish separate files for lists of authorized user access and identification codes." Can DMAS please clarify the types of controls that are considered within the scope of this statement?	This requirement has been deleted. The RFP has been updated.
395.	Section 6.10.16.1, pg. 155	Please confirm this subsection should be title, "RFP 6.9.16.1" given the title of the subsection immediately preceding and the subsection that follows.	DMAS confirms that this subsection is numbered incorrectly and should be numbered 6.9.16.1. See Addendum No. 3

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396.	Section 7.0	Please confirm that all solicitation requirements and contract terms applicable to this bid can be found in RFP 2016-01, including the General Terms and Conditions, the Special Terms and Conditions, and any attachments to the RFP, and that there are no additional solicitation requirements in the Vendors Manual, or contract terms in the two terms and conditions documents attached to the Vendors Manual, that would apply to this bid.	for update. All requirements and contract terms (including General and Special Terms and Conditions) are listed in solicitation RFP 2016-01. Although subject to the provisions of the Vendors Manual, as referenced under RFP Section 7.1, the Vendors Manual only sets forth rules and regulations applicable to the purchase of nontechnology goods and nonprofessional services by the Commonwealth. General and Special Terms and Conditions listed in the Vendors Manual as Appendices are there as reference to educate Vendors on the various terms and conditions typically used in agency contracts and are not included in the solicitation as additional terms and conditions.
397.	Section 7.1	4.11 Bonds. A bid bond may be required in a solicitation and must accompany the bid. When the state requires a bid bond, it shall not exceed 5% of the amount bid (Code of Virginia, § 2.2-4336).  Please confirm that Offerors are not required to submit a bid bond with their proposals. If our understanding is incorrect, please tell us the dollar amount of the bid bond required to be submitted.	There are no requirements in the solicitation for a bid bond and Offerors are not required to submit a bid bond with their proposal.
398.	Section 7.1	Please confirm that consistent with Section 4.13 of the Vendors Manual, if Offerors have questions concerning specifications or solicitation requirements after the May 13, 2016 due date for questions, they may submit additional questions after that date until June 23, 2016, which is five (5) working days prior to the proposal due date.	Per Vendors Manual Section 4.13 and <i>Code of Virginia</i> , § 2.2-4316, DMAS has established a procedure whereby <u>comments or questions</u> concerning specifications in the RFP can be received, reviewed and responses given prior to receipt of proposals. The deadline for questions was 5:00 PM on May 13, 2016. In addition, and consistent with Section 4.13 of the Vendors Manual, Offerors may submit <u>suggestions</u> concerning new products or

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			improvements to specifications to the purchasing office but this should be done as early as possible before the schedule receipt date.
399.	Section 7.1, pg. 160	<p>This requirement indicates that the Virginia Vendor’s Manual applies to this procurement. Section 2.1.b of the Vendor’s Manual indicates that a Small Business Subcontracting Plan is required for all procurements over \$100,000.</p> <p>Please clarify whether a Small Business Subcontracting Plan applies to this procurement. If so, are there any special provisions for that plan? Where shall Offerors include the plan in their proposals? What is the evaluation criteria (weighting) for the plan (reference Section 5.2, Proposal Evaluation Criteria)?</p>	DMAS made a written determination to omit the Small Business Subcontracting Plan submission requirement for this procurement. No Small Business Subcontracting Plan submission is required or scored.
400.	Section 8.0, pg. 170	With regard to item “(iv) The failure to provide services in a timely manner, as defined by the State”, what are the timeframes to get services in place?	Per MLTSS contractual standards, to be outlined in the MLTSS Contract.
401.	Section 8.0, pg. 171	Please confirm that the “Auxiliary Grant” benefit for assisted living is not part of MLTSS.	Confirmed, this program has been discontinued.
402.	Section 8.0, pg. 173	The term “integrated care plan” is not used anywhere else in the RFP, although the acronym “ICP” is used to stand for “individualized care plan.” Please confirm that “ <i>integrated care plan</i> ” in the definition of “Care Coordination” is actually “ <i>individualized care plan</i> .”	Confirmed.
403.	Section 8.0, pg. 183 & 191	Please define the difference between Individualized Care Plan (ICP) and Plan of Care (POC). Please confirm that ICP is the term used for MLTSS and/or the difference between the two concepts.	The terms are used interchangeably; however, ICP is the term generally used for MLTSS.
404.	Section 8.0, pg. 188	Please confirm that "Medicaid Works" (Medicaid Buy-In) is not included in the MLTSS population.	Individuals in Medicaid Works will be included in MLTSS.
405.	Section 8.0, pg. 192	The Pre-Admission Screening (PAS) Team is the entity contracted with DMAS that is responsible for performing pre-admission screening. If the MCO identifies a member not receiving but in need of LTSS, does the MCO conduct the PAS, or refer the member to the PAS Team entity?	The MCO would refer the member to the Preadmission Screen Teams.
406.	Section 8.0, pg. 201	Please confirm the role of the Preadmission Screening Team (Team) within MLTSS (when compared to the role of the Offeror), more specifically the Team’s role in assessment, waiver service authorization, re-assessment, and eligibility determination.	The Preadmission Screening Teams will conduct the initial assessments for eligibility for LTSS (including nursing facility, EDCD Waiver, Tech Waiver, and PACE). Preadmission screening services will continue to be covered through Medicaid fee-for-service within DMAS established criteria and guidelines.

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			<p>Other assessments (e.g., HRAs), re-assessments, and waiver service authorizations will be the responsibility of the MLTSS Contractors.</p> <p>DMAS will have responsibility for determining the eligibility of an individual for Medicaid-funded services, also for determining enrollment with MTLSS Contractors.</p>
407.	Attachment A, pg. 202	FIPS code 515 (BEDFORD CITY) is absent from this region listing although it is on prior region listings from DMAS. 019 (BEDFORD COUNTY) is included. Does 019 (BEDFORD COUNTY) now include 515 (BEDFORD CITY)?	Use 019 for Bedford. Bedford City, 515 is no longer a valid FIPS.
408.	Attachment B, pg. 203	<p><a href="http://www.dmas.virginia.gov/Content_pgs/mltss-ihp.aspx">http://www.dmas.virginia.gov/Content_pgs/mltss-ihp.aspx</a></p> <p>What is the timeframe for the “Medicaid Fee For Service Providers Utilized by MLTSS Target Population” data?</p>	The data is from service dates January 1, 2015 through June 30, 2015 (6 months) allowing for claims run out (paid dates) through 3/31/2016.
409.	Attachment C & D, pg. 206 & 211	Please confirm that DMAS will allow Offerors to submit copies of the network required by way of Attachment C and D via electronic media only (vs. hard copy) to reduce printed material and be more efficient in allowing "searchable" media?	Confirmed
410.	Attachment C, pg. 206	Does “Hospital Affiliation” mean the group’s hospital system they are contracted through, if applicable?	This should be “Y” (yes) or “N” (no). The PNAD has been corrected.
411.	Attachment C, pg. 206	Provider Designation of Nursing Facility – Intermediate Care. Does this include both physical health and intellectually disabled (ICF/ID) facilities?	No. Individuals in state or private ICF/ID facilities are excluded from MLTSS participation at this time.
412.	Attachment C, pg. 206	Provider Designations of Nursing Facility – Skilled and Nursing Facility – Intermediate Care. Are hospitals that provide beds/unit for these services to be included? If a facility offers both, are they to be listed in each category?	Yes. If the facility offers multiple levels of care, each should be listed separately, per instructions in the PNADS. Page 12 of the PNADS provides an example of a provider with more than one provider designation.
413.	Attachment C, pg. 206	In the PNAD’s data file requirement document there is not a field for Facility provider names. Can the Department please provide direction regarding how to submit the names of these provider types?	For facility, use the last name field and leave the first name field blank. See page 7 of the PNADS instructions.

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414.	Attachment C, pg. 207	Define “24 hour access”. May a provider employ an answering service to meet a 24-hour access requirement? If answering service meets requirements, may the Contractor determine which provider types can employ the answering service to meet the 24-hour requirement? If not, and if an answering service is permitted, please specify which provider types would be permitted to meet the 24-hour access requirement with an answering service.	For the purposes of the Offeror’s network submission, an on-call answering service would be acceptable, and the Offeror may determine the provider types that can employ the answering service to meet the 24 hour requirement.
415.	Attachment C (PNADS Guide), pg. 207	<p>PNADS data must be submitted in a MS Excel format by the Contractor and matched against the Department’s Fee-For-Service (FFS) provider database and claim utilization of members.</p> <ul style="list-style-type: none"> <li>• Do or will we have access to the Fee for service provider database referenced?</li> <li>• If we get the database and are unable to locate a match, would the provider be excluded from the file and other reporting?</li> <li>• What specifically is the State looking for when referencing the MCO must “match against the FFS database and claim utilization of members” – does this simply mean the providers must be present in both files, or is it requested that specific provider data elements must match precisely (and if so, which elements for each file?)</li> </ul>	<p>The PNADS is revised. The provider must submit the network data in a MS Excel format by the Contractor.</p> <p>DMAS shared a provider database with providers in Tableau format, per Attachment B to the RFP. The Medicaid Fee-For-Service Providers Utilized by MLTSS Target Population is available at: <a href="http://www.dmas.virginia.gov/Content_pgs/mltss-ihp.aspx">http://www.dmas.virginia.gov/Content_pgs/mltss-ihp.aspx</a>. The link for the complementary Tableau Reader is also provided at this location.</p> <p>Providers who are in the Offeror’s network but are not in the DMAS fee-for-service network would not be excluded unless the entry includes errors.</p> <p>PNAD instructions have been revised to delete the reference stating that the MCO must match against the FFS database and claim utilization of members. DMAS will compare the Offeror’s network submission against the FFS database for accuracy of information and to for comparison with member patterns of utilization.</p>

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416.	Attachment C, pg. 207	(Reference to Exhibit 6): FIPS codes. For providers that provide services outside of VA, can they be included in Geo Access Maps and PNADs file? If so, what should be placed in this column?	Yes, use the correct 5 digit FIPs code for the area outside of Virginia. The PNAD instructions have been corrected.
417.	Attachment C, pg. 207	(Reference to Exhibit 6): FIPS code Bedford City (515) is not listed in RFP, but found in other places. As this may be an oversight or error, can this be included?	Use 019 for Bedford. Bedford City, 515 is no longer a valid FIPS.
418.	Attachment C, pg. 207	<p>Attachment C lists provider network file requirements including 11 required data fields that must be included for every record in the provider network file. Most providers, however, will typically only provide general demographic/identification information as part of an LOI. For example, they will not typically provide “Primary Taxonomy” or detailed “Procedure Codes Performed” as part of a non-binding LOI process. This information is usually captured later during the full contracting phase.</p> <p>Since most providers will only sign LOIs at this point (given DMAS program requirements), will the department consider eliminating the requirement to include “Primary Taxonomy” and “Procedure Codes Performed” from the required network submission data fields in order to ensure a level playing field for non-incumbent bidders?</p>	Offeror’s should use the most appropriate taxonomy for the provider. DMAS will relax the requirement for procedure codes for the initial network submission; however, procedure codes will be required for provider designations 06, 08, and 09 during readiness.
419.	Attachment C, pg. 207	<p>“Physical location FIPS Code - Submit FIPS Code appropriate for each unique service location(s). See Exhibit 6 for the valid value FIPS code”.</p> <p>The exhibit 6 lists the codes for VA only and it is noted that you are using the last three digits of the FIPS code to distinguish the counties. Can we confirm that we should use this same format for counties in neighboring states that we might contract with?</p>	See response to Question # 416.
420.	General Network Adequacy Question	If a CSB or other mandatory entity is abstaining from signing a LOI but agrees to work with the RFP winning bidders, how would they like us to present that information? (Would they accept a letter signed by the agency stating such a position in lieu of the LOI/contract?)	No. However, DMAS recognizes that some providers may refuse to provide a LOI or a signed contract. The Offeror should include this type of information in their provider recruitment strategy submission, per Section 3.5.4 of the RFP.
421.	General Network Adequacy Question	If a named mandatory service is not currently operational or not adequately represented across the state (such as in SUD services), how will adequacy be judged in such an instance?	The Offeror should include this type of information in their provider recruitment strategy submission, per Section 3.5.4 of the RFP.

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422.	Attachment E, pg. 209	What entity will do the medical necessity review for abortion (danger to mom's life)? Currently carved out to DMAS.	The Contractor; this will be included in the MLTSS Contract and must follow the Federal /State guidelines.
423.	Attachment E, pg. 209	Will DMAS please provide the difference in acute care benefits between what is in the RFP vs. the current ABAD population in Medallion 3.0 program?	<p>The MLTSS covered services are outlined in the Attachment E of the RFP. Covered services under the Medallion 3.0 program are included in the Medallion 3.0 contract, which is available at <a href="http://www.dmas.virginia.gov/Content_attachments/mc/Medallion%203%200%20Contract%20for%202015-2016%20-%20FINAL%20Clean%20Copy%206-18-2015.pdf">http://www.dmas.virginia.gov/Content_attachments/mc/Medallion%203%200%20Contract%20for%202015-2016%20-%20FINAL%20Clean%20Copy%206-18-2015.pdf</a>.</p> <p>Acute care benefits for MLTSS are described in Attachment E of the MLTSS RFP.</p>
424.	Attachment E, Table 2A, pg. 221	Given the publication of the Medicaid managed care regulation and the new rules around IMDs that allow States the option of authorizing managed care plans to use IMDs for members ages 21-64, please confirm that based on Attachment E – Table 2A, that inclusion of freestanding psychiatric hospital admission for individuals ages 21-64 is not a covered service but rather a potential enhanced benefit?	DMAS is continuing to examine the Federal Managed Care Regulations for IMD settings. Requirements related to IMD coverage for members who are between the ages of 21-64 will be provided in the MLTSS Contract.
425.	Attachment E, pg. 248-252	Could the Department confirm that LTSS benefits can be provided within at least equal amount, duration, and scope as under Medicaid FFS? For, example, per current FFS, Respite Care could be provided in one hour increments, not to exceed 480 hours per individual, per calendar year. However, the MCO may choose to increase the benefit limit at their discretion – is this correct?	Correct.
426.	Attachment E, pg. 259	Please clarify the hospice and ESRD benefit within MLTSS. Please confirm when individuals are ineligible for MLTSS, when each benefit is carved out, and when each benefit is a covered service under MLTSS.	<i>Hospice:</i> Individuals enrolled in a Medicaid-approved hospice program at the time of MLTSS enrollment will be excluded (not enrolled) in MLTSS. However, if an individual is enrolled in MLTSS and subsequently enters a hospice program, that member will remain enrolled in MLTSS.

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			<i>ESRD</i> : Individuals with end stage renal disease (ESRD) at the time of enrollment into MLTSS will be excluded (not enrolled) in MLTSS. However, an individual who develops ESRD while enrolled in MLTSS will remain in MLTSS.
427.	Attachment E, pg. 268	<p>The second sentence of the first paragraph says “She is a dual eligible enrolled in Medicare fee-for-service.” The last sentence of the third paragraph says “Because Ella now has a managed Medicare plan and Medicaid”.</p> <p>Please clarify whether Ella is in Medicare fee for service or in a Medicare Advantage plan or D-SNP.</p>	When Ella first moved into the nursing facility she was enrolled in Medicare fee-for-service, but soon after she moved she got enrolled in a managed Medicare plan and Medicaid.
428.	Attachment J, pg. 275	<p>The Controlling High Blood Pressure measure as listed is not consistent with the updated HEDIS guideline that reads as follows:  The percentage of members 18-85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled during the measurement year for:</p> <ul style="list-style-type: none"> <li>- Members 18-59 years of age whose BP was &lt;140/90</li> <li>- Members 60-85 years of age with a diagnosis of diabetes whose BP was &lt;140/90</li> <li>- Members 60-85 years of age without a diagnosis of diabetes whose BP was &lt;150/90</li> </ul> <p>Will the measure be revised to mirror the updated HEDIS definition?</p>	Yes, the measure specification will mirror most current year’s HEDIS measure specifications.
429.	Attachment J, pg. 275	Pharmacotherapy Management of COPD Exacerbation notes that two rates are reported, but does not appear to contain the information on the two rates. Will this measure be updated with the full information?	Additional performance measure specifications will be outlined in the MLTSS Reporting Manual. This measure specification will mirror most current year’s HEDIS measure specifications.
430.	Attachment J, pg. 275	On page 275, Attachment J: MLTSS CORE QUALITY MEASURES," on the Comprehensive Diabetes Care measure, the second column includes language that states "...who had each of the following:" but includes nothing below. Is it to be assumed that these measures include the following: Rate—BP Control <140/90, Rate—HbA1c Control (<8.0%), HbA1c Poorly Controlled (>9.0%), Eye Examination, Medical Attention for Nephropathy)?	Yes. This measure specification will mirror most current year’s HEDIS measure specifications.
431.	Attachment J, pg. 275	Regarding the Description for the top item in the table on page 275 (for NQF #0731), please confirm that the text after “... who had each of the following:”	The following should be: (Rate—BP Control <140/90, Rate—HbA1c Control

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		<p>should be: The percentage of patients 18–75 years of age with diabetes (type 1 and type 2) who had each of the following:</p> <ul style="list-style-type: none"> <li>- Hemoglobin A1c (HbA1c) testing (NQF#0057)</li> <li>- HbA1c poor control (&gt;9.0%) (NQF#0059)</li> <li>- HbA1c control (&lt;8.0%) (NQF#0575)</li> <li>- HbA1c control (&lt;7.0%) for a selected population*</li> <li>- Eye exam (retinal) performed (NQF#0055)</li> <li>- LDL-C screening (NQF#0063)</li> <li>- LDL-C control (&lt;100 mg/dL) (NQF#0064)</li> <li>- Medical attention for nephropathy (NQF#0062)</li> <li>- BP control (&lt;140/90 mm Hg) (NQF#0061)</li> <li>- Smoking status and cessation advice or treatment</li> </ul>	<p>(&lt;8.0%), HbA1c Poorly Controlled (&gt;9.0%), Eye Examination, Medical Attention for Nephropathy). This measure specification will mirror most current year's HEDIS measure specifications.</p>
432.	Attachment J, pg. 276	<p>Will the Plan All-Cause Readmission use the HEDIS methodology for calculating continuous enrollment? This measure within MMP used a MMP plan continuous enrollment guideline which varied from guidance given by HEDIS/NCQA auditors to include enrollment in any previous health plan of the MCO.</p>	<p>This measure specification will mirror most current year's HEDIS measure specifications.</p>
433.	Attachment J, pg. 280	<ol style="list-style-type: none"> <li>1. Will DMAS provide additional clarity on the Recovery Oriented Measure for Severe Mental Illness? As some services will be provided by CSBs and processed by BH vendor, Anthem will not have access to all the required information.</li> <li>2. Also, how will intensity of care management be measured and what type housing and employment data is anticipated?</li> </ol>	<p>Yes, detailed performance measure specifications will be outlined in the MLTSS Reporting Manual.</p>
434.	Attachment J, pg. 280	<p>How will the intensity of member Care Manager encounters be defined and measured?</p>	<p>The intensity of member care manager encounters will measure meaningful encounters between a member and the member's care manager, such as face-to-face meetings and phone conversations. Detailed performance measure specifications will be outlined in MLTSS Reporting Manual.</p>
435.	Attachment J, pg. 281	<p>How will Advance Planning Directives Counseling be measured and what are the documentation requirements around this measure?</p>	<p>This is a Medicare NCQA SNP measure. This measure specification required for MLTSS will mirror NCQA measure specifications.</p>
436.	Attachment J, pg. 282	<p>Will the Breast Cancer Screening measure be consistent with the HEDIS measure that evaluates screening during the past two years? The measure</p>	<p>Yes, that is current. This measure specification will mirror most current</p>

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		currently does not reference a specific time period.	year's HEDIS measure specifications.
437.	Attachment J, pg. 284	The Screening for Clinical Depression and Follow-up Plan measure has been currently suspended for MMP per further review by CMS. How will the inclusion of this measure be impacted by that review and potential results?	As of now, this measure has been designated a MLTSS core quality measure and will be required for MLTSS health plan performance measure reporting.
438.	Attachment J, pg. 285	How is the denominator for the Fall Prevention measure determined, specifically around identifying beneficiaries at risk of future falls?	The measure details for this measure have not been finalized yet. The following initiative will further inform this measure development: Reducing fall risks: screening, assessment and plan of care (revised PQRS) measure testing by Mathematical Policy Research and National Committee For Quality Assurances.
439.	Attachment J, pg. 285	Will further definition be provided for the Injury Prevention measure? It references unexplained injuries - how will this be defined or determined?	Yes, detailed performance measure specifications will be outlined in the MLTSS Reporting Manual.
440.	Attachment J, pg. 285	Will health plans have an opportunity to be involved in the determination of quality of life/member satisfaction survey tools, methodology, and timelines using an approach similar to what occurred for MMP?	Yes, as directed by DMAS, MLTSS health plans will have opportunities to be part of the quality of life/member satisfaction survey tool and methodology development.
441.	PNADS, pg. 2	<p><i>“1. Provider Eligibility Assessment PNADS data must be submitted in a MS Excel format by the Contractor and matched against the Department’s Fee-For-Service (FFS) provider database and claim utilization of members.”</i></p> <p>Please confirm that ABD membership claims utilization is not included in the FFS database.</p> <p>If so, please provide the ABD populations’ claims utilization.</p>	The Tableau data is based upon fee-for-service claims. It does not include claims for members in managed care (CCC or Medallion 3). The intent of the Tableau is to provide information about the providers MLTSS members are utilizing by region. The Tableau does include data for fee-for-service members in the ABD coverage group. Also see the response to Question # 491. The MLTSS Databook includes claim utilization information for all ABD covered groups, including those in managed care.

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442.	PNADS, pg. 2	<p><i>“1. Provider Eligibility Assessment            PNADS data must be submitted in a MS Excel format by the Contractor and matched against the Department’s Fee-For-Service (FFS) provider database and claim utilization of members.”</i></p> <p>To promote continuity of care, quality and access, please confirm that providers who are currently CCC program providers but are not located in the FFS database will be considered eligible for the MLTSS program.</p>	Confirmed.
443.	PNADS, pg. 2 & 5	Please consider updating the FFS database records that contain APIs or Medicaid IDs in the NPI field with the required NPI’s.	DMAS will take this under consideration.
444.	PNADS, pg. 2	Please provide the time period for the FFS claims utilization.	PNADs page 2, 1. Provider Eligibility Assessment will be revised as follows: PNADS data must be submitted in a MS Excel format by the Contractor. <del>and matched against the Department’s Fee-For-Service (FFS) provider database and claim utilization of members.</del>
445.	PNADS, pg. 3, 4, 49	<p>Please confirm that multiple FIPS codes will be accepted for a single physical location for Home Health, PDN, DME, and LTSS provider types (Respite, Personal Care, PERS, Assistive Technology, etc.) that travel to members’ homes</p> <p>If so, will DMAS accept FIPS codes that do not match the zip code?</p>	Confirmed. Multiple FIPS will be accepted if the provider has separate address for each business in a different FIPS. The zip code should be included in the FIPs, per PNAD instructions.
446.	PNADS, pg. 3, 45, Exhibit 2	Will DMAS provide an all-inclusive list of provider types that fall under Provider Designation "03 - Specialist"?	The list on page 45 is meant to provide an example. Offerors should submit the file using provider designation 3 for any specialist contracted (by contract or LOI) with the Offeror.
447.	PNADS, pg. 3, 13, 47	Please confirm that "Procedure Codes Performed" is required for Provider Designation 08 – SUD.	Confirmed, per Exhibit 4, page 47 of the PNAD; page 13 has been corrected.
448.	PNADS, pg. 20	The PNADs document states that the “PROC_CD” field cannot be left blank. Please provide the default characters that should be entered for provider designation that do not require procedure codes.	PNAD instructions on page 13 have been corrected to reflect that proc cd is required for provider designation codes 06, 08, and 09. It can be left blank for providers in designations other than 06, 08, and 09.
449.	PNADS, pg. 20 & 21	Please confirm that the numeric response length for PNAD data fields “OTH_LANG1” and “OTH_LANG2” is two digits because the language codes	Confirmed; PNAD instructions have been corrected.

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		on Exhibit 7 range from 1 to 15 and range from one to two digits.	
450.	PNADS, pg. 23	Please confirm that the data length for DMAS data field "CNTC_PROV" is 3 digits because the two valid character values are either "Y" or "LOI".	Confirmed; from one to three digits; PNAD instructions have been corrected.
451.	PNADS	PNADS requires taxonomy for all records. Taxonomy is typically selected by a provider who registers for an NPI. For providers who have not yet registered for an NPI, does the Commonwealth expect the Contractor to select the most appropriate taxonomy for the provider or does the Commonwealth prefer this field to be left blank?	Confirmed, use the most appropriate taxonomy for the provider. DMAS may require that all providers obtain an NPI in the future.
452.	Provider Network Reporting Requirements, p. 13,	Explanation: If the provider listed provides Community Based Mental Health service code 'H', then the valid value is "T1019"  How is the code "H" referenced back to "T1019". Also, the notes show Community Based Mental Health Service Provider, please refer to valid value list in Exhibit 5. Value T1019 is shown in Exhibit 3, but not in Exhibit 5. Please explain?	The PNAD instructions have been corrected to reflect an accurate example for provider designations 08, and 09.
453.	Databook, pg. 6	Since the Duals demo (CCC) data is excluded from the data book, how will their rates be developed when they are part of the MLTSS program?	This has not been determined.
454.	Databook, pg. 6	Can DMAS please provide a narrative with methodology and program change adjustments (i.e. benefits, enrollment, eligibility, policy changes, and fee schedule changes) to the data book data?	These will be presented along with the rates mid-summer 2016.
455.	MLTSS Databook, pg. 7	Service Category Units  The coded units service category includes the actual unit count recorded on each claim. Can you specify if this reflects billed units, approved units or paid units?	Paid units.
456.	Databook, pg. 11	DMAS' MLTSS databook is based on Calendar Year 2013 and 2014 Medicaid data. In the course of capitation rate development, will DMAS incorporate 2015 Medicaid data for MLTSS capitation rate development?	Yes.
457.	Databook, pg. 13	In the course of capitation rate development, will DMAS develop and provide detail on coding (CPT codes, DRG codes, etc.) used to define each service category?	Yes.
458.	Databook, Exhibit 4, pg. 427	Only 120 localities are assigned to MLTSS regions in the "MLTSS County Listing by Region" table. Please provide the MLTSS regional assignment for all Virginia localities.	Nick --
459.	Databook, page i	Have there been any changes in the state's processes for enrollment and eligibility determination or criteria (including changes to wait list status and processes) between the beginning of the data book period (January 1, 2013) and the expected effective date of this RFP?	This information is publically available but it has not been summarized. See the response to question # 461.

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Question Number	Section	Question/Comment	DMAS Response
460.	Databook, page i	Can DMAS describe the steps it took to validate results in data book to financials, etc.?	The Databook information has not been compared to the “financials.”
461.	Databook, page i	Have there been any changes in the state’s processes and/or changes in authorizing care since the data book period (end of 2014) or changes expected in authorizing care by the go live date of the program?	Significant changes are announced through DMAS Medicaid Memos and provider manual updates available on the Virginia Medicaid web portal under the Provider Services tab.
462.	Databook, page i	Have there been any changes in the state’s processes for eligibility between the beginning of the data book period (January 1, 2013) and the expected effective date of this RFP?	See response to Question # 461.
463.	Databook, page i	Is DMAS aware of any changes in processes since or during the data book period to be used in LTSS pricing and will they adjust pricing if material differences vs. assumptions used in premium rates are detected after the program go-live date?	Any material changes in processes or unit costs during the base period will be addressed in the final capitation rate development.
464.	Databook, page i	Does DMAS have any plans for any changes in processes since or during the data book period to be used in LTSS pricing and will they adjust pricing if material differences are detected?	Any material changes in processes or unit costs after the base period will be addressed in the capitation rate development.
465.	Databook, page 20-148	Mental health costs appear to be much higher in VA compared to other states. Can you tell us what all is included in the Community Behavioral Health category of expense?	See Exhibits 4 & 5 included in the PNADS.
466.	Databook, page 20-148	Over 20% of total VA costs are in the Personal Care category. What HCPCs codes are in the Personal Care Category?	Agency personal care (T1019) and consumer directed personal care (S5126)
467.	Databook, Exhibit 1, page 20-148	Can you please share the volume of out of state providers by region?	This has not been broken-out separately.
468.	Databook, Exhibit 1, page 20-148	Can you please provide the assumed unit cost for out of state providers by region? Is it VA State Medicaid?	This has not been broken-out separately.
469.	Databook, Exhibit 1, page 20-148	Can you please provide all out-of-state fee schedules listed that are embedded in the data book values, both current and historical, starting from the beginning of the data book period (January 1, 2013)	In general DMAS pays Virginia Medicaid rates to out of state providers. For hospitals, DMAS pays the lower of the Medicaid rate in the home state or the statewide average. In a few cases DMAS has negotiated rates.
470.	Databook, Exhibit 1, page 20-148	Can you please provide all LTSS fee schedules since the beginning of the data book period (January 1, 2013) so that program changes and impact on data book costs and trends can be evaluated?	Historical information on fees is available from the procedure fee file at: <a href="http://www.dmas.virginia.gov/Content_pg/pr-ffs_new.aspx">http://www.dmas.virginia.gov/Content_pg/pr-ffs_new.aspx</a> Current rate information and limited historical

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			information is available at: <a href="http://www.dmas.virginia.gov/Content_pgs/pr-rsetting.aspx">http://www.dmas.virginia.gov/Content_pgs/pr-rsetting.aspx</a>
471.	Databook, Exhibit 1, page 20-148	Can you please provide the distribution of spend by providers by region?	See the “Medicaid Fee-For-Service Providers Utilized by MLTSS Target Population” file at <a href="http://www.dmas.virginia.gov/Content_pgs/mltss-ihp.aspx">http://www.dmas.virginia.gov/Content_pgs/mltss-ihp.aspx</a> .
472.	Databook, page 20-148	Respite Care costs appear to be much higher in VA compared to other states. Can you tell us what all is included in the Respite Care category of expense?	Agency respite care (T1005) and consumer directed respite care (S5150).
473.	Databook, page 20-148	Please describe the methodology for Medicare cross-over reimbursement. Does DMAS require full reimbursement of Medicare cost sharing, the minimum of Medicaid/Medicare reimbursement, something different?	Total payment including the Medicaid crossover payment is limited to the Medicaid allowed amount.
474.	Databook, page 20-148	Can DMAS please provide average hourly rates for Personal Care Attendants?	Rates for personal care are available at: <a href="http://www.dmas.virginia.gov/Content_pgs/lrc-wvr.aspx">http://www.dmas.virginia.gov/Content_pgs/lrc-wvr.aspx</a>
475.	Databook, page 20-148	Can DMAS please provide the state fee for service fee schedules for nursing facility, HCBS providers, and Hospice for all periods used during the data book period and time period since then?	Current rate information and limited historical information is available at: <a href="http://www.dmas.virginia.gov/Content_pgs/pr-rsetting.aspx">http://www.dmas.virginia.gov/Content_pgs/pr-rsetting.aspx</a>
476.	Databook, page 10	Can DMAS please provide a narrative description or criteria that define how membership or member month counts or claims were allocated between data book categories? For example, with members in LTSS, there are often members that have some NF and HCBS dollars at the same time and a criteria must be used to allocate these members and claims to respective data book categories (sometimes with retroactive adjustments and sometimes just prospectively).	In Virginia Medicaid a member cannot have incurred NF costs and HCBS costs at the same time.
477.	Databook	The VA MLTSS databook contains no pharmacy assumptions. As an example, there is no reference to the RFP requirement to follow DMAS mandated PDL (found in the Terms and Conditions section (section 6) of the RFP). Will the databook be updated to include assumptions related to the pharmacy requirements that DMAS plans on implementing for this population (e.g., state mandated PDL, MTM)?	The Databook will not be updated but an adjustment will be developed for the capitation rates.
478.	MLTSS Databook and ‘Medicaid Fee-For-Service Providers Data	Please clarify what MLTSS Populations are included in the Tableau data for Medicaid Fee for Service Providers	See the response to Question # 491.
479.	Other	When will the Rates for the MLTSS Program be released?	Final rates are expected to be provided by the end of August of 2016. Draft

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			rates are expected to be provided by mid-summer of 2016.
480.	Other	Could a sample MLTSS Contract please be provided?	Not at this time.
481.		<p>“DMAS will send a Medical Transition Report (MTR) File to the Contractor (with the 834) on the 6th, 13th, 19th, and at the end of each month (EOM).”</p> <p>Will the MTR files that the plans will receive from DMAS include cross over claims, claims with zero balance, and claims that were denied whether crossover or Medicaid?</p>	The Full MTR data (Claims data) will contain crossover claims and approved claims with zero balances/payments. No denied claims will be sent, only approved claims for services paid.
482.		For members that the contractors receive initially who had not been enrolled in a MCO but receiving LTSS services, will the Department send a copy of their authorizations when the members transition from Fee for Service into MLTSS managed care? If so, can the Department specify the file format e.g. will this be a standard authorization file format? What data from the original services authorization form will be included?	Yes. We have posted the draft layouts at for the medical transition files at: <a href="http://www.dmas.virginia.gov/Content_pgs/mltss-ihp.aspx">http://www.dmas.virginia.gov/Content_pgs/mltss-ihp.aspx</a>
483.		For system configuration purposes, what specific forms will DMSA require the MCOs to use (e.g., DMAS 99 - LOC instrument)?	<ul style="list-style-type: none"> <li>• For the MOC Element # 5: Contractor will need to include all elements on the DMAS 99 (LOC Review Instrument) for individuals who are in the EDCD and Tech Waivers. Contractor will also need to include all the elements on the DMAS 109 (Tech Waiver Pediatric Referral Form) and the DMAS 108 (Tech Waiver Adult Referral Form) for Tech Waiver participants.</li> <li>• For MOC Element #7: Contractor will need to include the following elements in the ICP: <ul style="list-style-type: none"> <li>• Elements included in the DMAS-97AB form for individuals enrolled in the EDCD Waiver and</li> <li>• Elements included in the CMS-485 form for individuals enrolled in the</li> </ul> </li> </ul>

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			<p style="text-align: center;">Tech Waiver.</p> <p><i>Note: DMAS does not require Contractor use the specified forms, but all elements need to be included in the Contractor's forms.</i></p>
484.	General	Are there any minority-owned business/women-owned business goals in this RFP?	<p>The goal of the Commonwealth is that more than 42% of its purchases be made from small businesses. "Small businesses" are those which have received certification from DSBSD by the due date for receipt of bids or proposals, including those small businesses (including micro) which also have been certified as women-owned and/or minority-owned certification. Although this procurement has no specified goals, Offerors are highly encouraged to make every subcontracting opportunity available to qualified small businesses. Also see response to question 399 and RFP Addendum No. 2, Attachment 2, page 19, line 4 for additional comment on Small Business Subcontracting Plans.</p>
485.	General	Will the pre-proposal conference attendance list be posted publically?	Yes. See RFP Addendum No. 2, Attachment 1.
486.	General	Can you please send me a copy of the attendee list from the pre bid conference on May 10 <sup>th</sup> ?	See response to Question #485.
487.	General	When will DMAS release initial rates/rate ranges, rate certification, and rate methodology for partial year 2017? Please confirm that Offerors will have the opportunity to submit questions on partial year 2017 rates and methodology at that time.	Draft rates are expected to be provided by mid-summer of 2016.
488.	General	Will capitation rates be subject to risk adjustment? If so, what model (e.g. UCSD MRX Model, UCSD CDPS Model, etc.) does DMAS plan to utilize? Which populations are subject to risk adjustment and at what level are the risk scores budget neutral?	See response to Question # 232.

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489.	General	Will the Department provide a complete list of LTSS and other providers that members are currently using under the FFS system?	Please see <a href="http://www.dmas.virginia.gov/Content_pgs/mltss-ihp.aspx">http://www.dmas.virginia.gov/Content_pgs/mltss-ihp.aspx</a> .
490.	General	Why is it required that Registered Nurse’s provide care coordination for EDCD and NF residents in the MLTSS program. This drives up the cost of the model for contractors. Additionally, social determinates of care are the primary driver in population health and when you have social workers or others with degrees in human services deliver care coordination, it maintains a social model which focuses on these determinates. Lastly, there is also concern regarding the number of RN’s that would be required to meet this requirement. With a nursing shortage, we are concerned that if this requirement remains as documented in the RFP, there will not be capacity across the state to deliver the services as currently outlined.	Section 6.3.1 of the RFP Section related to care coordinator staffing has been updated.
491.	Medicaid Fee-For-Service Providers Utilized by MLTSS Target Population	<p>What is the timeframe for the “Medicaid Fee For Service Providers Utilized by MLTSS Target Population” data?</p> <p>Can you provide a definition for Service Descriptions (Serv Desc)?</p>	<p>The Tableau data is from service dates January 1, 2015 through June 30, 2015 (6 months) allowing for claims run out (paid dates) through 3/31/2016. The Tableau data provides a recent, sufficiently large sample that allows for claims run-out. The dollar amounts are fee-for-service (FFS) funds paid between 1/1/2015 and 6/30/2015. Dollar amounts were provided as a measure of provider utilization. Dollars paid by region tie back to the member FIPs.</p> <p>The “Providers by Service Map” tab in the Tableau lists all service descriptions. Service descriptions equate to service providers.</p> <p>The intent of the Tableau was to provide Offerors with information regarding providers used by the target MLTSS population. It provides greater detail on community behavioral health and community LTSS services. The information for these services provides</p>

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			<p>detail down to the procedure code level</p> <p>The CAT tabs in the Tableau, have one of 3 values. The value “CBH” for community behavioral health services, which are broken out to the procedure code level, and “LTC” which are the community LTSS services, also broken out to the procedure code level, The “Other” category includes non community behavioral health and non-LTSS services (acute care and facility care), generally grouped by type of provider.</p> <p>The Tableau includes the following services: inpatient and outpatient hospitals, agency directed personal care, practitioner/physician claims (including most waiver services), nursing facilities lab and x-ray, emergency transportation.</p> <p>The following services are not included in the Tableau data:</p> <p>Consumer Directed Attendant Services- these services are provided in the home by an attendant who is not on enrolled as a provider with DMAS.</p> <p>Non-Emergency Transportation –DMAS contracts with a transportation vendor for this service.</p> <p>Medicare Crossover claims – DMAS only has sufficient provider information to pay the Medicare co-pays and deductibles, many of these providers are</p>

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			<p>not enrolled as Medicaid providers.</p> <p>Pharmacy – Our pharmacy claims records do not include provider location.</p> <p>The Tableau data is based upon fee-for-service claims. It does not include claims for members in managed care (CCC or Medallion 3).</p>
492.	General and Section 2.7, pg. 21	<p>Section 2.7 of the RFP says, “An Offeror or any of its representatives who communicates with any other employees or Contractors of DMAS concerning this RFP after its issuance may be disqualified from this procurement.” Can DMAS please provide further, specific guidance on what is meant by “Contractors of DMAS” as Offerors are encouraged to work with various entities and organizations such as DARS/AAAs, CSBs, and local DSS offices that may have contracts with DMAS for other programs/services, to develop innovations and enhanced benefits and provide references based on our existing partnerships?</p>	<p>While DMAS encourages Offerors to freely exchange information and ideas with other entities, including DMAS’ Contractors, the prohibition in Section 2.7 of the RFP refers to Offerors communicating with DMAS employees or Contractors who are involved in the development, administration, and evaluation of the MLTSS procurement. DMAS employees and Contractors who are involved in the procurement process have a strict responsibility to maintain the integrity and confidentiality of the procurement process to maintain a level playing field for all Offerors. The concern at which the prohibition is directed is any attempt by Offerors to obtain insider information about the procurement from the employees and/or Contractors involved.</p>
493.	6.2.17, page 88	<p>Individuals in NFs at the time of MLTSS enrollment may remain in that NF as long as they continue to meet DMAS criteria for nursing facility care, unless they or their families prefer to move to a different NF or return to the community. The only reasons for which the Contractor may require a change in NF is if (1) The Contractor or DMAS identify provider performance issues that affect an enrollee’s health or welfare; or (2) the provider is excluded under state or federal exclusion requirements.</p> <p>When it is determined that a NF is not able to safely meet the needs of an enrollee (e.g., due to dangerous behaviors) or because the enrollee no longer</p>	<p>MLTSS plans shall not move members before the results of the VDH findings are final and the health plan has completed all steps of the appeal process. MLTSS plans must also begin conversations with the impacted nursing facilities to ensure that appropriate care coordination is done in the event the members have to be moved to a new</p>

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		<p>meets the NF level of care requirement, the Contractor shall continue to pay the facility until the member is transitioned to a safe and alternate placement.</p> <p>In cases where it is determined that a NF is not able to safely meet the needs of an enrollee, when can the MLTSS Contractor move a member to a new nursing facility.</p>	nursing facility.

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**Guidance on Page Limits Outlined in Section 2.10 of the RFP\***

\*Note: Page limits outlined in Section 2.10 remain regardless of how many regions the Offeror's proposal addresses.

Document Type	Included in Page Limits Outlined in Section 2.10 of the RFP	Excluded from Page Limits Outlined in Section 2.10 of the RFP
RFP question/test/requirement	<ul style="list-style-type: none"> <li>• DMAS requires that the Section # precede the Offeror's response.</li> <li>• DMAS does not require that the RFP question or text be included.</li> <li>• If the RFP question or text is included, it will be included in determining whether the Offeror's response is within the page limit.</li> </ul>	
Work plans	X  <i>Note: High level work plans shall be sufficient. More detailed work plans shall be required of those health plans that are selected for negotiations.</i>	
Dedicated staffing numbers by position or staffing plan	X	
Plan for becoming a D-SNP	X	
Plan for becoming NCQA accredited	X	
List of enhanced benefits	X	
Locations (e.g., business offices)	X	
Description of subcontracts/subcontractors	X	
Oversight and management plan	X	
Approach to staff training	X	
Approach to knowledge transfer	X	
Resumes, no more than two (2) pages each		X
Job descriptions or description of staff qualifications		X
Business licenses		X
Service area approval & certificates		X
Certifications		X
Verification of NCQA accreditation/re-accreditation		X
D-SNP verification (e.g., CMS contract)		X
Organizational charts		X
Sample reports (e.g., QI reports)		X

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Document Type	Included in Page Limits Outlined in Section 2.10 of the RFP	Excluded from Page Limits Outlined in Section 2.10 of the RFP
Tools (e.g., HRAs)		X
Flow charts/flow process charts		X
Diagrams		X
Prohibited Affiliation information via the Disclosure of Ownership and Control Interest Statement (CMS 1513)		X
Financial statements		X
Attachments G, H, and I Forms		X
Supplemental attachments/documentation	Too ambiguous-depends on what is being submitted; follow instructions outlined in this chart.	
Exhibits	Too ambiguous-depends on what is being submitted; follow instructions outlined in this chart.	