STATE OF WASHINGTON

HEALTH CARE AUTHORITY

626 8th Avenue • P.O. Box 42702 • Olympia, Washington 98504-2702

March 23, 2017

TO: Potential Bidders

From: RFP Coordinator

SUBJECT: RFP 1812 – Integrated Managed Care-Mid Adopter-Amendment 2

The purpose of Amendment two (2) to RFP 1812 is:

1. Update Section 2.4, Data Book and Rates to the following:

   2.4 Data Book and Rates

   Bidders who submit a Letter of Intent to Propose will receive the Mental Health and Substance Use Disorder Services Data Book for the state of Washington, Behavioral Health Organization (BHO) ~~and Apple Health Rates~~, and non-Medicaid regional Funding Allocation. The Behavioral Health (BH) data book supporting the behavioral health rate development will include summaries by rate population, as well as by key conditions. Data is limited to services provided to Medicaid/SCHIP clients in calendar year 2016, with payments made through May 2016, and based on data received from Regional Service Networks (RSN) and counties, HCA, and participating MCOs. Bidders are instructed to rely upon the data book in assembling their proposal.

   All potential Bidders should already have their current CY2017 AHMC medical rates for the entire state.

2. HCA's responses to all submitted RFP questions. Please see attached Q&A document and corresponding attachment.

Please note:

- All communication regarding this RFP must be directed to the RFP Coordinator at contracts@hca.wa.gov. All other communication will be considered unofficial and non-binding on HCA. Communication directed to parties other than the RFP Coordinator may result in disqualification of the potential Bidder.

- Proposals are now **due April 14, 2017**

Thank you,

Andria Howerton
RFP Coordinator
contracts@hca.wa.gov

Amendment 2 RFP 1812_Questions and Answers			
#	**RFP Section**	**Bidder Questions**	**HCA Response**
1	RFP 2.2	I wanted to clarify the due date for this RFP. On the email sent below, the due date is listed as April 13, 2017 but on the actual RFP PDF, it's listed as April 5th, 2017. Please let us know which date is accurate.	The email was a typo. The proposals are due April 14, 2017 as indicated RFP 1812, Amendment 1.
2	RFP 2.2	According to the schedule of procurement activities outlined in RFP Section 2.2, HCA plans to provide responses to bidders' questions on March 23. Since this date is only nine (9) business days prior to the April 5th proposal submission deadline, and considering that bidders require time to adjust their responses based on HCA's responses to questions, will HCA consider moving the proposal submission deadline to a later date? Additionally, HCA has been stating for the past several months that MCOs would have 60 days to respond to this RFP, and the current April 5th submission deadline gives MCOs less than 50 days to respond.	Please refer to RFP 1812, Amendment 1 for an updated RFP Schedule.
3	RFP 2.2	Can HCA please confirm that there is a negotiation period for Apparently Successful Bidders?	Per RFP Section 2.2 and RFP Amendment 1, contract negotiations will begin after the ASB is announced and the final contract will be completed and signed by July 1, 2017.
4	RFP 2.4	The RFP indicates that, "Bidders who submit a Letter of Intent to Propose will receive the Mental Health and Substance Use Disorder Services Data Book for the state of Washington, Behavioral Health Organization (BHO) and Apple Health Rates, and non-Medicaid regional Funding Allocation." The Mental Health and Substance Use Disorder Services Data Book and the Behavioral Health Organization (BHO) rates were provided on the SFT site. Can the HCA confirm the following: a) Will the integrated (behavioral health + physical health) rates and rate-setting methodology for the contract period be provided, as well? If so, when does the HCA anticipate that this will be available? b) Will additional data be provided for the physical health populations? c) Is the information in "Attachment 1 Non-Medicaid Funding Allocation" on page 40 of the RFP the most current available information on the non-Medicaid regional Funding Allocation? Or will another file be provided?	a) January 2018 physical health rate setting for CY2018 will be done this summer. The July 2017 BHO rate for North Central will be converted into a BH segment to be integrated into the FIMC rate and a BHSO rate for clients that receive their physical health services FFS. b) A break down of the current enrollment in NC will be provided that shows the program level enrollment for both FFS and MC physical health. c) The 2017-2019 Biennial Budget will set the final non-Medicaid allocation for the entire state. The allocation amount specific to NC will be available following enactment of a final state budget.
5	RFP 2.4	How does the HCA and Milliman intend to blend the Apple Health rates with the BHO rates for the contract period? Will the resulting rates be a pure sum of the two rate components, or will there be any assumed savings or other adjustments for the fully integrated program?	An Integration Savings Factor may or may not be applied to the rates. Final decisions regarding rate factors have not yet been made.
6	RFP 2.4	This section states Bidders will receive "the Mental Health and Substance Use Disorder Services Data Book for the state of Washington, Behavioral Health Organization (BHO) and Apple Health Rates, and non-Medicaid regional Funding Allocation". We received Attachment 1 Non-Medicaid Regional Funding Allocation and the documents "Exb E_WA BHO Rate Methodology SFY1718" and "Exb E_WA-BHO Databook_CY 2015_021817 (1)" as Exhibit E which all address behavioral health rates. Is there additional documentation regarding medical or pharmacy costs which will be made available as part of the RFP? If so, will the state be releasing additional data and when can bidders expect to see the additional data?	January 2018 physical health rate setting for CY2018 will be done this summer. The July 2017 BHO rate for North Central will be converted into a BH segment to be integrated into the FIMC rate and a BHSO rate for clients that receive their physical health services FFS.
7	RFP 2.5	If the bidder wishes to hand deliver their proposal, is there a different address for delivery (other than the P.O. Box listed)?	Yes, if Bidders wish to hand deliver their proposal, please use the address below: Health Care Authority Attn: Andria Howerton 626 8th Avenue Olympia, WA 98504
8	RFP 2.5	Please clarify whether one or two flash drives are required with submission. The RFP states "…one (1) hard copy of their proposal with original signatures and two (2) identical copies of their entire proposal on a USB Flash or Thumb Drive…"Is it HCA's intent that 2 copies of the proposal are included on 1 Flash Drive or that we include 2 Flash Drives with the entire proposal loaded onto each. Should this read "on 2 separate Flash drives"?	The Bidders proposal should include one (1) hard copy of their entire proposal and two (2) identical copies on two (2) separate flash drives.
9	RFP 2.5	This section indicates that the proposal must be sent to the RFP Coordinator at the address noted in Section 2.1, however, the address is a P.O. Box number. Can HCA please provide a physical address for proposal delivery?	Please see Question 7.
10	RFP 2.5	Directions state that the proposals may be hand delivered, however the address noted in 2.1 is a P.O. Box. Will the HCA please clarify where proposals can be delivered if not mailed?	Please see Question 7.

11	RFP 2.6	Section 2.6 of the RFP instructs bidders to identify pages with confidential/proprietary information with the words “Proprietary Information” in the lower right hand corner of the page. Exhibit A, section G Confidentiality asks bidders to include the word “Confidential” on the lower right hand corner of pages containing confidential/proprietary information. Can HCA please clarify what word(s) bidders should include on the lower right hand corner of pages containing proprietary/confidential information?	Bidders may use either Confidential or Proprietary in the lower right hand corner.
12	RFP 2.13.2.1	Could HCA please provide the definition of a "no fault claims submission"? Can the state provide a list of provider types that are considered behavioral health providers for no fault claims submission?	Please refer back to section 2.13.2.1. "The requirement applies to claims/encounters submitted by behavioral health providers during the first three (MCO) months of the Contract, when those claims are for an assigned and eligible member and using a code that identifies a covered service.” The “behavioral health providers” refers to any essential behavioral health provider (3.4.3) with whom you entered into new agreements with or expanded previous agreements for the purposes of fulfilling the network requirements under FIMC.
13	RFP 3.1	The RFP states: “Proposals must be written in English and submitted on eight and one-half by eleven inch (8 ½” x 11”) paper” Is it permissible to use 11x17 foldouts for diagrams and organization charts?	Yes.
14	RFP 3.1	In section 3.1, Proposal Format Lists the five major sections as 3.1.1, 3.1.2, 3.1.3, 3.1.4, 3.1.5, and indicates that proposal must provide information in the order presented in this document with the same headings. Can HCA Please confirm that these headings are correct, and should not read 3.1, 3.2,3.3,3.4, 3.5, as presented later in the document?	The headings are referring to the name of the headings, i.e. Exhibit A, Letter of Submittal.
15	RFP 3.4	Can HCA confirm that submission of a network for Wraparound Services is not required in Mid-Adopter RFP? Section 3.4 of the RFP does not reference Wraparound services requirement and a Wraparound Services spreadsheet was not included in Exhibit D.	Correct, a submission of network for wraparound services is not required.
16	RFP 3.4.1	In the “Request for Proposal” document, Section 3 “Proposal Contents”, 3.4.1 paragraph 3 “At proposal submission, an 80% minimum threshold on Medical providers and community mental health agencies in Chelan, Grant and Douglas Counties must be achieved to continue review of RFP.” a. If there are some medical provider categories that are below 80% even with all available providers contracted, will closest qualified provider count toward adequacy? If so, how would HCA like closest qualified provider information called out/highlighted?	HCA's expectation is that the Bidders will be able to achieve 80% in all counties.
17	RFP 3.4.1	What is the minimum threshold specified for SUD and specialty mental health services specified in the RFP?	There is no minimum threshold for SUD and specialty mental health services. HCA will be looking for “presence of service in the network” when evaluating SUD networks.
18	RFP 3.4.1 & 3.4.3	Please confirm that 3.4.3 and 3.4.4, and 3.4.5 are the Essential Behavioral Health Providers that HCA defines as "SUD and specialty MH services"? Per Section 3.4.1 of the RFP, "No minimum threshold on SUD and specialty MH services is required to continue review of the RFP."	Yes, the “SUD and specialty mental health services” in 3.4.1 refers to the treatment provider types/programs outlined in 3.4.3, 3.4.4, and 3.4.5. However, the network submission for the SUD and specialty mental health services will be evaluated simultaneously with the entire proposal. Contracts with essential BH providers is a requirement of the RFP.
19	RFP 3.4.2	Can HCA please define "reasonable" in terms of access?	Please refer to Attached 2, Draft Sample IMC Contract, Section 6.11, Provider Network - Distance Standards.
20	RFP 3.4.2	Can HCA please define "unnecessary" as it relates to travel time and wait times? What standard is the State using to review "unnecessary travel time" and "unnecessary wait times" with regard to each provider type called out in the RFP?	Please refer to Attached 2, Draft Sample IMC Contract, Section 6.11, Provider Network - Distance Standards.
21	RFP 4.5.2	Question: Section 4.5.2 states that “[t]he two Bidders with the highest combined scores will be invited to begin contract negotiations” and that a third bidder may also be invited to negotiate if certain criteria are met. Section 4.6 states that “[i]f multiple Proposals receive a Substantially Equivalent Score, HCA may leave the matter as scored, or select as the Apparently Successful Bidder the one Proposal” that is in HCA’s best interest. Can HCA please confirm that the ultimate outcome of this procurement will be for HCA to contract with more than one Bidder?	That is correct. Per Section 4.5.2 there will be more than one (1) ASB.
22	RFP 4.6	If there are two Apparently Successful Bidders and a third Bidder that scored within 2% of one of the Apparently Successful Bidders, could the third place Bidder replace the Bidder whose score is within 2%?	Per section 4.6, "…HCA may leave the matter as scored, or select as the Apparently Successful Bidder the one Proposal that is deemed by HCA, in its sole discretion, to be in HCA's best interest relative to the overall purpose and objective as stated…"
23	Exhibits A, B, & G	Will the State provide Exhibits A, B and G as stand-alone forms to be completed, or can the bidder recreate the form for the response?	Bidders may recreate Exhibit A and G. Exhibit B does not need to be recreated, only signed by an authorized signer.
24	Exhibit C	Related to Exhibit C question 9, could HCA please provide a definition for "provider agency level"?	The intent of this question is specific to the Bidder's ability to credential at the organizational provider level, consistent with NCQA Standard CR 7.

25	Exhibit C	Question 52 on page 17 of Exhibit C asks applicants to respond to a series of vignettes and limits the overall response to 6 pages. However, the table the describes the vignettes on page 18 of that same document indicates there is a 1 page limit per vignette for the Elements of Care Plan. Can you clarify the correct page limit for the question 52 response and also indicate if there are any restrictions on responses to sub-items within the question (i.e., if the summary of the proposed Elements of Care Plan for each vignette is limited to 1 page within the 6)?	The correct page limit is six (6). Two (2) pages per vignette.
26	Exhibit C	With regard to Exhibit C, Section E, Question 26, "For the following HEDIS measures below, as reported in the 2016 WA State Apple Health Annual Report, please respond to the following questions:" - Can HCA provide a copy of the "2016 WA State Apple Health Annual Report"?	The 2016 Annual Technical report produced by Qualis Health was sent to the plans on February 14, 2017.
27	Exhibit C	In Question 26, in Section E. CAHPS rating results, including: (i) "Were any of these measures below 60% for the national average rate for Medicaid MCOs?" a. How would HCA like the MCOs to determine if HEDIS and CAHPS meet the 60% threshold? b. Is this a national or state threshold? c. Should MCOs respond if the measure is below 60% OR below the national average instead?	For HEDIS measures (26. A through d), please use the thresholds, attached below as Attachment A, to determine if you are required to respond on individual HEDIS measures. For example, if your Hemoglobin A1c testing rate is lower than 87.3, you are required to respond to the question. (Obviously, for Poor HbA1c control, only respond if your result is HIGHER than 46.5). For CAHPS submit a quality improvement plan to HCA aimed at improving CAHPS responses. MCO improvement plans must address, at a minimum, the following two measures, thought to have the most impact on improvement efforts to positively impact all eight measures: • Getting Needed Care • Getting Care Quickly
28	Exhibit C	The way the question is written, we are uncertain whether the sub-questions (i - iii) only apply to e or to a-e. Can the HCA please clarify?	i, ii, and iii all apply to HEDIS (see also response to question 27 below) ii and iii only apply to CAHPS
29	Exhibit C	Can HCA please clarify the intent of question 26.i? Is HCA asking whether a given HEDIS measure rate for an MCO falls below the 60th percentile? (NCQA's Quality Compass provides 50th, 66th, and 75th percentile cut points). Or is HCA asking whether the HEDIS rate falls below 60% of the 50th percentile?	For HEDIS measures (26. A through d), please use the thresholds, attached below as Attachment A, to determine if you are required to respond on individual HEDIS measures. For example, if your Hemoglobin A1c testing rate is lower than 87.3, you are required to respond to the question. (Obviously, for Poor HbA1c control, only respond if your result is HIGHER than 46.5). For CAHPS submit a quality improvement plan to HCA aimed at improving CAHPS responses. MCO improvement plans must address, at a minimum, the following two measures, thought to have the most impact on improvement efforts to positively impact all eight measures: • Getting Needed Care • Getting Care Quickly
30	Exhibit D	With regard to Exhibit D, GeoCoding NC PHMC Bidders Instructions, under "Geographic Network Analysis RFA Submission" number 1 says to submit a "Network analysis written report" a. In the 2015 Early Adopter RFP an additional document named "Exhibit D Network Narrative" was also provided with the GeoCoding documents to specify the requirements of the "Network Analysis written report". b. Will a "Network Narrative" guide be provided for the this RFP response or will there be any other specific requirements for the "network analysis written report"?	This was an oversight within Exhibit D. The narrative is not necessary for this RFP.
31	Exhibit D	Will HCA please confirm that per page 10 of the Exhibit D instructions, all provider files (less those narrative questions in EXHIBIT C) are to be provided electronically only? Further, can HCA please confirm that they are to be provided as a separate USB, and not included in the two proposal copy USBs? If this is not the case, can HCA please clarify?	That is correct. Exhibit D should be included as separate USBs.
32	Exhibit D	Can HCA please clarify the title of appropriate Specialists outside of MD, DO, ARNP and PA (EX: CNM - Certified Nurse Midwives for Obstetric Care)?	Any licensed professional certified to serve within the discipline in question and is currently carrying a panel in that discipline.
33	Exhibit D	Can the HCA define "active panel" for specialists and mental health professionals that don't traditionally carry a "panel" like a PCP?	A licensed professional that is currently seeing clients in the discipline attributed to him/her by the submitting Bidder.
34	Exhibit D	Can HCA please Clarify the PedCare definition for Mental Health provider (is the practitioner serving as a PCP for children <19)?	Is this provider seeing clients that are aged 19 or younger.

35	Exhibit D	(a) Will the HCA be relying upon the rate methodology developed by Mercer for the 7/17-6/18 for the Medicaid capitation rate projection for MH/SA for developing the FIMC rates for the North Central region? (b) Will this be the same methodology that was used to develop the rates for the SW region? (c) If there are any planned changes in the rate development, can you share that with us?	a) Yes. b) Yes, with the exception that an Integration Savings Factor may or may not be applied to the rates. Final decisions regarding rate factors have not yet been made. c) January 2018 physical health rate setting for CY2018 will be done this summer. The July 2017 BHO rate for North Central will be converted into a BH segment to be integrated into the FIMC rate and a BHSO rate for clients that receive their physical health services FFS.
36	Exhibit D	Will the first year experience of FIMC in the SW region have any influence on the rates for the North Central region?	No.
37	Exhibit D	What kind of assumptions will be made based "on savings due to managed care", especially for administrative expenses? These types of adjustments to the rates should be seen in the data after a new program has been implemented and in place for at least the first year rather than assuming that it will happen. Much time and effort is used to implement a new program and those administrative costs should be reflected in the rates.	Final decisions regarding Integration Savings Factors have not yet been made. Your comments are noted.
38	Exhibit D	How will the most recent Mental Health and Substance Use Disorder claims for the North Central region be incorporated into the risk scores for 2018?	Risk scores are only applied to the physical health portion of the rates.
39	Exhibit D	Are MCOs supposed to submit the individual chemical dependency counselors on the Mental Health tab? We ask because we think we saw language that implied we were supposed to start submitting them but we don't see them on the license type list or specialty type list in the provider file.	Individual practitioner data is not collected for your network submission.
40	Exhibit D	Can HCA please confirm that hospital swing beds qualify under the State's SNF access requirements?	No, hospital swing beds do not qualify as SNF facility beds.
41	Exhibit G	If a business is both a State Certified Minority Business and a State Certified Women's Business, when calculating the percentage of work should Bidders include the estimated spend for this business twice- in both the Minority and Women categories? If not, how does HCA suggest this be handled?	Yes
42	Exhibit G	Can HCA please confirm that Exhibit G does not refer to provider agreements, but only non-medical services? Can the state please clarify their expectation around "percentage of work" to be completed by these firms. Can this be represented by the anticipated percentage of spend (in relation to the total anticipated spend) around a product or service?	Participation may be either on a direct basis or on a subcontractor basis, as defined in RFP Attachment 2, Draft Sample Integrated Managed Care Contract. Yes, the percentage can be represented by the anticipated spend.
43	6.14	"The Contractor shall contract with mental health providers as described in Exhibit H, Designation of Behavioral Health Providers to ensure that Enrollees have access to the provider that most appropriately meets their mental health needs" Can HCA please confirm that FIMC Exhibit H is the same as Exhibit E in the restated 2017 AHMC contract?	Yes.
44	Attachment 2	Under Attachment 2 Section 16.10.20.1, can the State confirm "MAR" used at the end of 16.10.20.1.1 is a typo and it should read "MAT"?	Yes
45	Attachment 2	Section 1.29 of the Sample Integrated Care Managed Care Contract identifies business hours as 8-6 p.m., however section 6.8 of the contract identifies customer service hours as 8-5. Can HCA please confirm that customer service hours are 8-5?	Yes, customer services house are 8-5.
46	General	Will the Provider Based Rural Health Clinic Medicaid reimbursement model remain the same with the initial contracts?	HCA is required to ensure that Rural Health Clinics receive their full PPS/APM rate for all eligible services, regardless whether the service was provided in the fee-for-service or the managed care environment. For payments made in the managed care program, HCA will perform an annual reconciliation to ensure each RHC was paid appropriately.
47	General	Will the Rural Health Clinic Medicaid reconciliation process with the Health Care Authority remain the same?	HCA will continue to utilize the current Agreed Upon Procedures (AUP) reconciliation process to "true up" managed care enhancements for Rural Health Clinics.
48	General	Will the Critical Access Hospital Inpatient Weighted Cost to Charge (IWCC) and Outpatient Weighted Cost to Charge (OWCC) rate process based on the Medicare Cost Report remain the same?	HCA will continue to calculate interim IDWCC & ODWCC payment rates per the current WAC until it is changed.
49	General	Because some areas in North Central Washington are tourist areas (Leavenworth and Chelan) we anticipate that the MCO's that do not win the contract for the region may still want to maintain contracts with us for services. For example, we have delivered babies for individuals from places like Spokane (unexpectedly) when they were on vacation and our ER visits and urgent care visits are about double in the summer as in the winter due to tourism. Will the MCO's that do not win the region be able to maintain their existing contracts with us as providers? I assume so and that they just cannot sell to residents in the area.	Yes, they will be able to maintain existing contracts with you for residents outside Grant, Chelan and Douglas counties as they do today, or execute single-case-agreements with you if desired.
50	General	We currently have a psychologist, psychiatrist, behavioral health PA and behavioral health NP working for us. They are currently not located at the Rural Health Clinic where our primary care physicians are. If we co-locate them at the RHC would they be paid under the Rural Health Clinic rules assuming we are in compliance with all the other RHC requirements?	HCA uses the Medicare Rural Health Clinic cost reports in setting individual RHC rates. As long as this change is in compliance with the Medicare cost report rules, we don't see an issue.

51	General	We may find it more cost effective to lease space in the clinic to outside behavioral health providers. If we do this in the Rural Health Clinic will each entity bill separately?	Yes, each entity will bill separately unless you are employing the BH provider as part of your clinic or unless you enter into a formal legal partnership arrangement.
52	General	How does the successful bidder plan to keep current behavioral health providers whole, moving forward, while introducing new providers into the network without reducing funding?	The successful Bidders are expected to maintain an adequate network, including negotiating adequate payments to providers.
53	General	How will the MCO's be collecting the "native" transactions required by the current DBHR Data Dictionary? These are not elements of an 837P or HCFA1500 billing process. How will they be submitting the native DBHR data dictionary elements to HCA?	A long-term technology solution for submitting BH data is currently being researched; this section of the contract is also being reviewed.
54	General	Is it acceptable to include additional attachments to supplement responses to questions? If so, will the attachment be included as part of the Technical proposal question page limit or can it be in addition to the page limit?	Unless otherwise stated, the extra attachments will count against page limits.
55	General	Can the state please clarify that they consider MCO contracts with Health Homes to be provider contracts, not delegated contracts?	Yes, the Health Home is a contracted provider of the MCO. They are only considered "delegated" if the MCO is not a Health Home Lead themselves.
56	General	Can HCA please confirm that it does not consider Foster Parents to be employees of Washington state?	This question is not relevant to this RFP.
57	General	Could the state please define The term "Certified Substance Abuse Provider", as it does not appear in the RFP or contract?	This question is not relevant to this RFP.
58	General	Is it possible to have a second round of Q&A, given that draft CY18 rate information has not been made available?	No, HCA does not yet know what the integration factors will be and does not have CY2018 FIMC rates.
59	General	Can the state host a bidders' conference where the state actuary can walk through how rates will be developed? This would help bidders understand the steps Milliman will take to blend the Apple Health MCO rates and the BH MCO rates. To date, this information has not been made available so bidders' do not know the methodology that will be followed or the draft/final rates .	At this time no bidder conferences are scheduled for this RFP.
60	General	Please describe the methodology the state actuary will follow to develop the CY18 rates, starting with the various data sources provided as part of the procurement thus far and describing how they will be adjusted. As part of the methodology, please list and quantify the base data, trends, program changes, non-medical load and other assumptions.	January 2018 physical health rate setting for CY2018 will be done this summer. The July 2017 BHO rate for North Central will be converted into a BH segment to be integrated into the FIMC rate and a BHSO rate for client that receive their physical health services FFS. Final decisions regarding Integration Factors have not yet been made.
61	General	When does the state intend to release either a) draft or b) final FIMC capitation payment rates effective January 1, 2018?	January 2018 physical health rate setting for CY2018 will be done this summer.
62	General	Please provide the current Southwest FIMC rates, rate development documents, and CY16 financial results.	Uploaded onto the SFT site are the current 2017 SWW rate sheets in a generic (non-plan specific) format, the rate development memo and appendix A.
63	General	Please provide Mercer's previous rate development for the BH MCO rates (e.g. SFY2015 & SFY2016).	Uploaded onto the SFT site are the April 2016 rates. The final amounts changed after the methodology was written but the methodology didn't change. Documentation for any period prior to April 2016 is not relevant.
64	General	We understand that Mercer used salary and annual productivity assumptions to develop PMPM budgets for certain mental health categories. Please explain how Mercer reconciled the results to actual experience.	Please refer to the data book.
65	General	In the exhibit "IMD_Analysis_022417" there was an amount of approximately $25 million labeled "unallowable dollars". Under the FIMC program, what is the funding source for these expenses going forward? How does this IMD exhibit reconcile with the PowerPoint presentation that shows a 6.4% increase overall due to IMD repricing?	The state has requested funding for the change to the IMD rule. There was an increase in the non-IMD projected expenditures to compensate for the loss of access to IMDs under Medicaid.
66	General	What level of incremental managed care savings (if any) going to be assumed in the CY18 FIMC rates? Please provide the sources of data used for this assumption.	An Integration Savings Factor may or may not be applied to the rates. Final decisions regarding rate factors have not yet been made.
67	General	During the rate conferences held prior to the RFP release, many of the BH providers and other stakeholders were concerned that the BH MCO rates were too low. Please explain how the state/Mercer/Milliman will adjust the rates to deal with this concern/issue.	If changes occur that increase capacity and evidence is provided supporting a change, adjustments can be made to the rates. Other adjustments can be made to reflect increased local fees for services and policy changes.
68	General	If MCOs incur financial losses because member access to services increased but that access was not built into the rates, how does the state intend to mitigate these losses?	If changes occur that increase capacity and evidence is provided supporting a change, adjustments can be made to the rates.
69	General	Please provide an estimate of the actual cost (vs. funding provided in Attachment 1) of providing BH wraparound and BH ASO services.	Uploaded on the SFT site is utilization data for non-Medicaid services in North Central Washington. Information on the cost of non-Medicaid services may be obtained by the North Central BHO, as the non-Medicaid funds are contracted between the North Central BHO and the providers. BH-ASO services are mental health crisis services and utilization/cost data related to this particular service can be found in the behavioral health data book.

70	General	Please clarify the plans' responsibility with respect to the BH wraparound payments - will MCOs be at risk for these payments or will they be "pass through" payments (i.e., no risk to the MCOs). Will this rate be certified by the actuary as actuarially sound?	MCOs will not be at risk for costs that exceed the allocation of non-Medicaid funds. MCOs are expected to monitor expenditures to ensure that utilization of funds are managed throughout the fiscal year. No, these are not "rates" that qualify for certification. They are a set allocation that is distributed to the MCO and spending against the allocation is tracked and reported to HCA.
71	General	Please clarify the level of admin and other payments that will be loaded on top of the BH wraparound and BH ASO portions of the rate paid to the plans.	A maximum of 10% of General Fund State funding provided can be retained for admin.
72	General	Please clarify the plans' responsibility with respect to the $40,000 payment (part of the General Fund State) made to the TBD - Regional Entity.	There is no responsibility to the ASBs.
73	General	Please clarify how the Non-Medicaid funds will be split across the MCOs (e.g., based on only membership or also acuity/cost).	Funds will be divided based on proportion of Medicaid enrollment in the region.
74	General	How will the Foster Care population BHSO services be managed after 1/1/18?	Our expectation is that behavioral health services will be included in foster care services
75	General	Regarding the BH MCO SFY17/18 rate development, Mercer indicates that the CY15 base data was over $3.50 PMPM lower than the base data used in the prior year's rates. This contributed to a rate that was between 6.5% and 9.3% lower than the prior year. How did Mercer justify that the reduction was reasonable? Please document the validation process and describe how Mercer ensured that data was not missing. Also, explain why multiple base data years were not used in the rate development.	This information can be found in the data book.
76	General	Please provide current and project enrollment for the NC region and separate by Apple Health rate cell and those members that would be added because they only have BH services covered by the state. Please provide the count split by the categories indicated in the RFP: • Dual eligible (Medicare – Medicaid). • Apple Health foster children, foster alumni and adoption support. • American Indian/Alaskan Native (Voluntary) • Medically needy (spenddown). • Non-citizen pregnant women. • Institution for Mental Disease (IMD) and other Medicaid eligible long term or residential care. • Clients with comparable medical coverage who are eligible for behavioral health services.	This information is not available at this time.
77	Exhibit D	Discrepancies have been found in the Geo .rpt file. We need direction from the State on how to proceed . There are discrepancies within the Geo .rpt file that will cause the Geo to populate inaccurate results; we would like to know if the State will be re-creating a new .rpt for us to use that remediates these identified discrepancies. We do not believe that geo data will report accurately without remediation of the .rpt file.	The differences in spelling, punctuation and spacing have no effect on the process of running the program. This is the same process that all Managed Care plans have been using since 2012. The documents and Geo rpt program for this RFP have been tested a number of times and do run as designed. If you use the documents provided the process will run. Do not change any spelling or create new documents. The SUD facilities and Services (From Opium Sub forward) are not designed to calculate capacity percentages only to establish “presence of service” within the network. We have included them in the geo process only to help identify locations throughout the state to assist HCA determine the depth (or lack thereof) of the SUD services infrastructure. The “Y” in the field sort is a place holder.

Attachment A

Corresponding Table for Questions 27 and 29.

Thresholds

		NCQA 60th Percentile (CY 2015)	WA State Average (CY 2015)
Adult Measures	Comprehensive Diabetes Care - Hemoglobin A1c (HvA1c) Testing	87.3	88.3
	Comprehensive Diabetes Care - Poor HbA1c Control (>9%)*	46.5	49.9
	Comprehensive Diabetes Care - Control (<8%)	48.8	39.0
	Comprehensive Diabetes Care - Eye Exam	56.1	55.5
	Comprehensive Diabetes Care - Medical Attention for Nephropathy	90.9	88.9
	Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	62.2	63.0
	Antidepressant Medication Management - Effective Acute Phase Treatment	55.9	54.2
	Antidepressant Medication Management - Effective Continuation Phase Treatment (6 Months)	40.1	39.4
Access Measures	Adults' Access to Preventive/Ambulatory Health (AAP), 20-44 Years	81.5	71.8
	Adults' Access to Preventive/Ambulatory Health (AAP), 45-65 Years	88.1	80.4
	Adults' Access to Preventive/Ambulatory Health (AAP), Total	84.0	74.8
	Children's Access to Primary Care Practitioners (CAP), 12-24 Months	96.4	92.7
	Children's Access to Primary Care Practitioners (CAP), 25 Months - 6 Years	89.0	81.9
	Children's Access to Primary Care Practitioners (CAP), 7-11 Years	91.7	87.5
	Children's Access to Primary Care Practitioners (CAP), 12-19 Years	90.4	87.5

*Lower numbers indicate better performance for this measure