STATE OF WASHINGTON
HEALTH CARE AUTHORITY
626 8th Avenue • P.O. Box 42702 • Olympia, Washington 98504-2702

March 22, 2018

TO: Potential Bidders

From: RFP Coordinator

SUBJECT: RFP 2567-2019/2020 Integrated Managed Care (IMC)-Amendment 3

The purpose of Amendment three (3) to RFP 2567 is as follows:

- HCA's responses to the final submitted questions. Please note a new RFP requirement stated in Question 99 and the amendment RFP.

- Amended RFP 2567, attached as a separate document, to update the RFP in the following section (all edits are in redline strikeout). Section 3 #6, 3.4.3, 3.4.4, 4.3.1, 4.3.2, and Exhibit C Question 7.

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 due April 12, 2018 by 2:00 p.m. PT.

Thank you,

Andria Howerton
RFP Coordinator
contracts@hca.wa.gov

Amendment			
RFP 2567 2019/2020 IMC Question and Answers			
#	RFP Section	Bidder Questions	HCA Response
71	1.1.4	How many American Indian/Alaska Natives have opted in to IMC in the Southwest and North Central RSAs?	In North Central, 53% of the AI/AN population opted in to IMC.
72	1.1.4	Will HCA provide the Exhibit J, referenced in the text below: "The vast majority of Medicaid enrollees in the regions will be enrolled in the IMC program, including all current Apple Health managed care enrollees. A smaller subgroup of enrollees who are not eligible for managed care medical services, as identified in Exhibit J of Attachment 2 of this RFP, will receive Behavioral Health Services Only (BHSO) through the integrated contracts and will continue to receive their medical services through HCA's fee-for-service system."	All exhibits can be found on our external website here.
73	1.1.4	In Section 1.1.4, HCA states that it "reserves the right to limit the number of clients enrolled in any single MCO." Could HCA please confirm that any limitations or conditions on the assignment of enrollees to any single MCO will be addressed in the contract negotiations with that MCO?	No, if this policy is considered for adoption, HCA will establish a policy through its normal process and with appropriate consultation.
74	1.7	In Section 1.7, with regard to the definition of Behavioral Health Organization, does the word "agency" refer to DSHS? If not, please identify the agency to which the definition refers.	Yes, at this time, DSHS holds the BHO contracts.
75	2.6	Can HCA please clarify that Exhibit F: Provider Network Submission should only be submitted electronically? This seems to be the direction given in the provided Geocoding Bidders Instructions. If this is not the case, please clarify.	Exhibit F, should be submitted via USB drive as described in the instructions.
76	3.1	The instructions for the letter of submittal indicate that the Bidder is to provide the information in Sections 3.1.1 through 3.1.8 for any proposed subcontractors. Could HCA please clarify whether a Bidder should identify all subcontractors in its Letter of Submittal, or whether only those subcontractors that are delegated entities will be required to be included with the Letter of Submittal?	Bidders should identify all potential subcontractors that will be working under the resulting contracts.
77	3.1	Will HCA confirm that Exhibit A should only include the information included within sections 3.1.1 - 3.1.6, or will a formal Exhibit A document requiring signature be forthcoming?	Correct, Bidders will create Exhibit A using the information provided in Section 3.1.
78	3.1.6	Section 3.1.6 requires identification of current and former state employees who are employed by the Bidder's organization or serve on the Bidder's governing board as of the date of the proposal. However, unlike other RFPs, this section does not include a time limit for who is considered a former state employee. We respectfully request that HCA amend Section 3.1.6 by adopting the limitation used in previous RFPs, which limited the requirement to identify former state employees to only those individuals who were state employees within the past 24 months.	HCA is not amending this section at this time.

79	3.4	Is it allowable for the Bidder's work together on the MOUs with BHO that are converting into ASO's, so that there is alignment across the MCOs in the MOUs?	Yes, that would be allowable however each Bidder must still include a copy of their MOU with a BHO as part of the response to the RFP.
80	3.4	In Section 3., Proposal Contents, #6, states: "6. If bidding on King or North Sound RSA, the agreement described in 3.4.9 below." However, 3.4.9 refers to Greater Columbia and Spokane. Should the reference instead to be to sections 3.4.10 (King County) and 3.4.11 (North Sound)?	Yes, King county requirements are found in 3.4.10; North Sound are found in 3.4.11. Please see amended RFP.
81	3.4	Newport Hospital & Health Services represents greater than 20% access for both Hospital and OB specialty categories in Pend Oreille County – we have been informed that NHHS has submitted a letter to the HCA expressing they will contract with only two MCOs. Will a scoring exception be granted for this county considering 3 of the 5 of MCOs will not meet passing criteria for network requirements in this region without a contract with Newport?	Please see amended RFP Section 4.3.1.
82	4.1.1	Will the evaluators have access to the Draft Sample IMC Contract and the Draft Sample Behavioral Health Services Wraparound Contract during the scoring and evaluation period?	Yes
83	4.1.4	Due to the distinct needs of each Region, and the variation in the questions for each Regional Addendum, we believe it makes sense to have regional representatives participate in the evaluation team for their respective regions. However, the regional connections and experiences of the regional evaluators could also increase the risk of bias or conflicts of interest. In selecting the evaluation team, how will HCA address potential conflicts of interest, particularly with respect to the Regional Addenda?	HCA is aware of potential conflicts and is taking appropriate steps in selecting the evaluation team.
84	4.1.4	With respect to the evaluation team, will representatives from the regions be scoring a Bidder's responses to Exhibit C, the Statewide RFP Evaluation Questions, or will regional representatives be scoring only the responses to the Regional Addendum for their region?	There are regional evaluators represented for both exhibits.
85	4.2.1	With respect to the scoring table that appears in Section 4.2.1, could HCA please confirm that evaluators will not be limited to the end and midpoints appearing in the table, and could award scores of any integer between 0 and 10?	No, evaluators must only use the numbers in the table.
86	4.2.1	In the event that an evaluator gives a Bidder a score of zero (0) on a Scored requirement, how will HCA determine whether or not the entire proposal is eliminated from further consideration?	HCA will determine on a case by case basis.
87	4.3.1	HCA states in a multi-county region a passing score may be awarded even if there is one county for which the Bidder falls below the 80% threshold for one category of critical medial providers. What about the probability of the bidder following below 80% in more than one county in a specific region?	Please see the amended RFP Section 4.3.1.

88	4.3.1	In a multi-county region, if there is a single provider that covers more than 1 critical medical provider type and will only contract with a limited number of plans, will HCA consider on a case-by-case basis, an exception to Section 4.3.1	Please see the amended RFP Section 4.3.1
89	4.3.2	Lourdes Health Network has stated the are not prepared to enter into any binding agreements at this time. How will HCA account for BH providers who refuse to contract with MCOs due to individual circumstances?	HCA is aware Lourdes Health Network has stated they are not prepared to enter into any binding agreements with the Bidders at this time. If this occurs, Bidder should amend the attestation and include a list of any BH provider the Bidder attempted to contract with but the provider declines. Section 4.3.2 will be amended to reflect this.
90	4.4.1.1.	In Exhibit C, we are happy to provide background information and explanations in response to individual questions if that will help evaluators, but we also recognize that reading the same information over and over can quickly become boring and tiresome. So that we can ease the burden on the evaluators, could HCA please clarify whether a complete copy of the Bidder's response to Exhibit C will be provided to evaluators, or will the evaluators receive only certain sections or questions of the Bidder's response?	Bidders should respond to each question separately and individually. Evaluators will only receive the sections they are assigned to evaluate.
91	4.4.1.1; 4.4.1.2	In what ways will the state and regional portions of a Bidder's proposal be scored differently, if any?	The state and regional portion will be scored separately using the same 0-10 scale as described in the RFP section 4.2.1.
92	4.4.2 and 4.4.3	For the 2019 regions, can HCA please clarify how it will calculate whether a Bidder's score is less than 65% of the total awarded points per region? Specifically, does "total awarded points per region" mean the total available points for the region or is it a relative score calculated based on the total number of points awarded to other Bidders for that Region?	Total awarded points per region equals the Bidder's statewide score plus the Bidder's regional score. The score will be calculated by the Bidder's score for the region (Bidder's statewide score + Bidder's regional score) divided by the total points possible (statewide total + regional total). If this is less than 65%, it is at HCA's discretion whether to announce that Bidder as an ASB.
93	4.4.2 and 4.4.3	Does "total awarded points per region" mean the points awarded for the Bidder's responses to the Regional Addendum only or does it mean the sum of the points awarded for the Bidder's responses to Exhibit C, the Statewide RFP Questions, and the Regional Addendum responses?	At stated in RFP Section 4.4.1.3, "The Regional score in 4.4.1.2 will be added separately to the total Statewide Score in 4.4.1.1. This will be the Bidder's final score in that Region."
94	4.5	In determining whether two scores are substantially similar, how will HCA calculate whether two scores are separated by two percent or less in total points?	This will based on the total awarded points.
95	4.5	For purposes of Section 4.5, does "total points" mean total points available or total points awarded?	Total awarded points.
96	Attachment 1	The Table of Contents of Attachment 1, the Draft Sample IMC Contract, lists an Exhibit H titled "Value-Based Purchasing." Section 5.2.4 of the Draft Sample IMC Contract references an Exhibit I titled "Value-Based Purchasing." However, neither is provided. Will the State please provide the specified Exhibit, including quality measures to be used in the VBP program?	All exhibits can be found on our external website here.

97	Exhibit B	Please confirm that Letter of Submittal Requirement 3.1.6 and Exhibit B - Certifications and Assurances Requirement #4 apply to former employees of state agencies and does not include former county employees such as those that may have worked for the county coordinating behavioral health services under the Regional Support Network before transitioning to BHOs or to former employees of BHOs.	Correct.
98	Exhibit C	For Questions 1 and 2 of Exhibit C, will Bidders receive a passing score simply for completing and submitting the tables required by those sections? If not, please clarify what is required to receive a passing score for Questions 1 and 2 of Exhibit C.	Yes, complete answers to the questions will be considered a passing score.
99	Exhibit C	Does the HCA consider the BH-ASOs to be delegated entities for purposes of responding to Questions 2 and 3 in Exhibit C?	Bidder should be providing all prospective BH-ASOs (other than Pierce County) what the Bidder considers the minimum set of standard requirements the Bidder would delegate to the BH-ASO. Bidders must send this information to the prospective BH-ASOs by March 27, 2018. Bidders must submit proof (i.e. Letter to BHO, email with date stamp, etc.) with their required attestations that this has taken place. Please see the amended RFP Section 3.4.3 and 4.3.2 for this new requirement.
100	Exhibit C	For Question 3 of Exhibit C, how will the evaluators and/or HCA determine whether a Bidder receives a passing score?	Complete answers to the questions will be considered a passing score.
101	Exhibit C	Can HCA confirm that, for purposes of Question 3, a "delegated entity" is any subsidiary, affiliate, or subcontractor of the Bidder that performs or will perform one or more of the Essential Behavioral Health Administrative Functions (identified in Exhibit C, Question 2) pursuant to a written agreement with the Bidder?	Yes.
102	Exhibit C	If an MCO uses a claims processor that is a corporate entity separate from the entity that holds the business license for Washington State, but the MCO controls and establishes the rules and procedures that govern the processing of claims, will HCA consider the claims processor to be a delegated entity or a subcontractor? In this example, should the Bidder list the claims processor in the letter of submittal, in the response to Question 3, or both?	If the MCO holds an official "agreement" (i.e. contract, mou, etc.) describing the work with the corporate entity, then they would be considered a subcontractor.
103	Exhibit C	Section 5(a) asks "How the customer service line will be staffed 24 hours a day, 7 days a week, 365 days a year." However, the Draft Sample IMC Contract does not require customer service staff to be available 24/7/365. (See Section 6.8, which requires customer service staff to be available between 8:00pm and 5:00pm, Monday through Friday.) But the Draft Sample IMC Contract does require that an MCO have certain services available 24/7/365 through a toll-free telephone number. Can HCA please confirm that it does not expect a Bidder to have customer service staff available 24 hours a day, 7 days a week, 365 days a year?	The services required to be available 24/7 are outlined in Attachment 1, Draft Sample Contract, Section 6.7, 24/7 Availability.

104	Exhibit C	Based on the above, could HCA please also confirm that a Bidder can use subcontractors, such as a Nurse Line, to provide the services that are required to be available 24 hours a day, 7 days a week, 365 days a year?	Yes.
105	Exhibit C	For Exhibit C, Question 6, could HCA please confirm that the page limit applies only to subparts (c), (d), (e)?	Yes.
106	Exhibit C	We believe this RFP question references two distinct CAQH initiatives in Exhibit C, Question 7b. The first is the Committee on Operating Rules for Information Exchange (CORE), which includes federally mandated eligibility operating rules that apply when a HIPAA covered entity uses the HIPAA mandated eligibility transaction. The second initiative is COB Smart which, as described in the RFP, allows physicians to log on one time and reach into every participating payer's database to verify complete eligibility and coverage information. Could HCA please clarify which initiative it would like the Bidders' response to address?	Please see the amended RFP Exhibit C, Question 7, b. Bidder should address the initiative mentioned in the question.
107	Exhibit C	Exhibit C, Question 10(a) appears to be missing a word. Can HCA please confirm that Question 10(a) should read "referral processes to facilities"?	Yes.
108	Exhibit C	Exhibit C, Question 14(b) requires submission of a comprehensive code set and will be scored pass/fail. Can HCA clarify what is required to obtain a passing score for this question?	A complete response to the question will be considered a passing score.
109	Exhibit C	For Exhibit C, Question 14(b), will HCA require the code set to be submitted in a particular format?	No.
110	Exhibit C	Can HCA please confirm that Exhibit C, Question 17(b) (ii) is asking for a description of the data analytics tools and reports provided to the ACH and the data analytics tools and reports provided to providers that have a VBP arrangement? If that understanding is incorrect, could HCA please clarify what information HCA expects to be shared with ACHs?	Question 17 b ii refers to data analytics tools and reports produced and shared with providers under a VBP arrangement with the Bidder, and to any reports shared with ACHs.
111	Exhibit C	The question provides two sets of data (2015 and 2016), could HCA confirm that Bidders are to focus on the 2016 data? Also, the example of 88.3 appears in both the 2015 WA State Average and the 2016 NCQA 60th percentile columns. Could HCA clarify that the 2016 NCQA 60th percentile is the controlling threshold for Bidders to use to determine whether they are required to respond about individual HEDIS measures?	Yes, focus on 2016 data. Use the 2016 NCQA 60th percentile.
112	Exhibit C	For Exhibit C, Question 18, could HCA please confirm that if a Bidder has a HEDIS measure that is equal to the NCQA 60th Percentile in CY 2016, the Bidder is not required to respond to the question?	Yes.
113	Exhibit C	In Exhibit C, Question 18(i), could HCA please confirm that a Bidder should reference the table column titled NCQA 60th Percentile (CY 2016) in order to determine whether any of a Bidder's measures fell below "60% for the national average rate for Medicaid MCOs"?	Yes.

114	Exhibit C	For Exhibit C, Question 19, the page limit for this response refers to policies and procedures but the question does not request or mention policies and procedures. Does HCA expect the Bidder to submit policies and procedures as part of its response for this question? If so, could HCA please identify which policies and procedures must be submitted?	The Bidder may choose to supplement the requested description of "your authorization and re-authorization processes" with policies and procedures.
115	Exhibit C	Exhibit C, Question 24 asks Bidders to describe efforts to include the elements and minimum standards of the Bree Collaborative Model for Behavioral Health Integration regardless of the setting of care. However, our understanding of the Bree Collaborative Model Report and Recommendations, adopted on March 22, 2017, is that the elements and minimum standards are focused on integrating behavioral health care services into the primary care setting. Could HCA please clarify what it means by "regardless of the setting of care" and whether it intends for Bidders to address the elements of the Bree Collaborative Model outside of the primary care setting?	The Bidder should apply their understanding of which elements can be applied in settings outside primary care and respond appropriately.
116	Exhibit C	The requirement reads: Submit a comprehensive code set that the Bidder will implement with your providers for claims/encounter submission. This code set should be inclusive of all codes and modifiers that the Bidder will implement for Medicaid behavioral health services, as identified in Section 16 of IMC Contract. Please confirm the code set should include only behavioral health services as identified in the four subsections of the IMC contract-sections 16.9.13 through 16.9.16.	The codes should reflect any Medicaid services you will provide through contracts with BH providers.
117	Exhibit C	Exhibit C, 8.b. Will HCA provide more context regarding this requirement? To ensure that we are fully responsive, are there specific planned examples or potential scenarios that HCA would like MCOs to address?	Bidders should use their best judgment.
118	Exhibit C	Can you please provide more specific information about the recently launched CAQH Initiative to standardize operating rules for eligibility and coverage information for all payers. The initiative is described in 7.b as “allowing physicians to log on one time and reach into every participating payer’s databased to verify complete eligibility and coverage information). We specifically need to understand if the new CAQH initiative is different than the single-sign-on (SSO) access currently available to participating network providers via OneHealthPort.	Please see the amended RFP Exhibit C, Question 7, b.
119	Exhibit C	Please clarify if the ACH Domain investments referenced in this question are specific only to workforce development.	The ACH Domain 1 investments includes the move to Value Based Purchasing and IT infrastructure.
120	Exhibit C	For question 1, to use a table for each location, in every regional service area, we will be repeating a lot of information. May we have latitude to modify the tables for our response to streamline the review so information is not repeated multiple times?	Bidder's should use their best judgement and to make sure their responses are clear to all evaluators.

121	Exhibit C	In consideration of the size and volume of the codes requested in Question 14 of the statewide Exhibit, would HCA consider allowing bidders to include the codes only in the electronic version of the proposal?	Yes.
122	Exhibit C	The King County region has expressed the desire for the King County BHO to transition to the King County BH-ASO with the intent for the Contractor to delegate Essential Behavioral Health Administrative Functions. Question 2 requires us to describe delegated functions. Given the scope of the King County BH-ASO is in development, we recommend the HCA agree to the concept of delegation of Essential Behavioral Health Administrative Functions for King County for the purposes of answering this question consistent with the draft contract requirements.	Yes, in principle, HCA agrees that essential functions can be delegated to a BH-ASO. Also, please refer to the new requirements regarding delegation in the amended RFP Section 3.4.3.
123	Exhibit C	With respect to the detailed staffing plan to be submitted for each of the 2019 regions, could HCA please confirm that the staffing plan should include, at a minimum, the job titles and number of staff for each position that will be hired if awarded the contract for the region? Does HCA expect that a Bidder's staffing plan will also include the timing and sequence of hiring for individual roles in each region? We appreciate any additional information HCA can provide regarding the level of detail required for the staffing plans to be submitted in response to Question 6.a.	Bidder response should include as much specificities needed to give the evaluators a complete understanding of how you expect to adequately staff all regions you are bidding on.
124	Exhibit C	Can HCA please confirm that it does not expect Bidders to have VBP arrangements with ACHs?	Yes
125	Exhibit C	Question 17.a.i indicates Bidders may submit their response to HCA's VBP Survey as a response to this question. Will HCA confirm that, if Bidders submit their VBP Surveys as an attachment to Question 17, the VBP Survey will not count against the five pages allowed for Question 17 responses?	Correct; the VBP survey response will not count against the page limit.
126	Exhibit C	For question 10, letter A references "Referral processes facilities." Please confirm and/or clarify if Letter A is asking for the referral processes to access to necessary evaluation, treatment and inpatient psychiatric services.	Yes, HCA confirms that the response is calling for referral processes to E & T and inpatient psychiatric facilities.
127	Exhibit C	Question #2 requests that we define entities that we delegate Essential BH Functions. As you are aware, there are potential delegated relationships that will be negotiated post-RFP. Please advise how to report on delegated functions that will be negotiated after RFP submission.	Report the arrangements that are in process as in process and report the ones that are final as final.
128	Exhibit C	Please confirm that BH-ASO functions are not included as Essential Behavioral Health Administrative Functions and should not be reported as a response to Question #2.	If the Bidder is delegating any services to the BH-ASO(s), then it should be reported as a delegated entity in Question 2. Please see the new requirements for delegation in the amended RFP Section 3.4.

129	Exhibit D	For the Regional Addenda for Transition Year regions, does HCA expect that the responses reflect both 2019 and 2020?	Please use your best judgement. HCA would like to see answers that reflect the Bidder's long-term approach in the region, however we understand in some questions it may also make sense to reference the Bidder's plan for the transition year.
130	Exhibit D	Question 5. This question asks Bidders for "a description of models the bidder has already used in other states..." CHPW is solely focused on providing managed care to residents of Washington State, and therefore does not have any out-of-state experience. Can HCA please confirm that, for purposes of this question, if CHPW describes models it has used in other areas of Washington that its response will be considered responsive and that CHPW will not be penalized for a lack of out-of-state experience? Additionally, we respectfully request that HCA consider replacing the term "states" with "areas" to clarify the intent of the question.	Yes, the Bidder can respond with models employed within or outside Washington state.
131	Exhibit F	To our knowledge, HCA has not previously required that MCOs report information on their providers' access to Telehealth, E-Health, and Telemedicine technologies, and we are concerned that multiple MCOs collecting this additional information from essentially the same provider network within the relatively short timelines set forth by the RFP may cause frustration among providers, which we would like to avoid or minimize. Consequently, we would like to know whether the information in the Telehealth, E-Health, and Telemedicine fields will be used to determine whether a network passes or fails? If so, how will access to Telehealth, E-Health, and Telemedicine technologies factor into the pass/fail methodology?	Telehealth/telemedicine will not affect the score of the network.
132	Exhibit F	The Exhibit F Provider Network Submission GeoCoding RFP Bidders Instructions reference a report named Geo2017Combined – Distance.rpt that was not included. When will we receive this report and the appropriate enrollee file to use?	This was uploaded to the SFT site on March 16, 2018.
133	Exhibit F	In the past there has been an Access database file, (extension of .mdb or .accdb) included, or direction as to the membership file we should be using. Should that be found within the site as well?	Please use the enrollee file that you have been using on your regular submissions.
134	Exhibit F	In the GeoCoding RFP Bidders Instructions for Integrated Managed Care, 2019 Regions (non-transition), Pierce, Spokane, Greater Columbia, Southwest Washington and North Central RSA's, section 2. Create and Self-Audit Bidder's Provider Files states that "all provider type sheets other than PCPs, CHMA, SUDF, Beds and E&T MUST use 9999999 exactly in each provider capacity field". However, in the capacity fields for CMHA, SUDF, Beds and E&T list CAPACITY as "9999999". PCP capacity is listed as "Not to exceed 1200 for any one practitioner. Total capacity for the practitioner from all locations must not exceed 1200. No more than 5 locations for a single provider'. Can HCA clarify if the capacity for CMHA, SUDF, Beds and E&T should be different from 9999999?	That is a typo in the leading paragraph for the instructions CMHA, SUDF, Beds and E&T pages. The "capacity" field should be 9999999.

135	Exhibit F	The CMHA tab is populated with data. Is the expectation for MCOs to remove this data or will HCA provide an updated template?	Yes
136	Exhibit F	Can HCA provide additional details on their expectation for the columns related to Access to Telehealth, E-health, and Telemedicine? If these are required fields, can we populate "YES" for some providers, without answering for all providers in the network? It was our understanding at the Pre Bidders Conference that telemedicine and telespych providers wouldn't be collected until the quarterly network submissions in July, and would not be included in the RFP medical network submission.	Telehealth is not a scored element in the RFP. If the information is available we would like it included. As for how to populate the fields HCA recognizes that some providers will have access to one, two or all three technologies listed while others may have access to none.
137	Exhibit F	There are tabs for Urgent Care and ABA, which were not called out in the RFP (section 4.3.1). Is HCA expecting us to complete these tabs? Will HCA be reviewing these tabs as part of the RFP? There are more specialties on the Specialist tab than are called out in the RFP (section 4.3.1). Is HCA expecting us to complete these tabs? Will HCA be reviewing these tabs as part of the RFP?	1) Yes. Filing a Urgent Care and ABA sheet is a requirement. 2) Yes. It is required that the bidder report on all provider types listed in the Provider Submission workbook.
138	Exhibit F	In the bidder instructions, MCOs are told to use the standard file "Geo2017 Combined - Distance.rpt". For our quarterly network submissions we use "GeoCombinedV2.rpt". Please confirm if we are able to use the v2 document, which we submit our quarterly network with, or if we should we using the "Geo2017 Combined - Distance.rpt".	This document was uploaded onto the SFT site on March 16, 2018.
139	Exhibit F	In the "2019 Non Transition" and "2020" network files, there is a combined provider and page calculation file. Can we combine the files for the 2019 Transition year to mirror the same format? Having both the provider submission excel files (Medical and IMC) and page calculation files (IMCMedical and IMCSUD) in a single "combined" excel file is consistent with how we submit our quarterly network.	Each of the three (3) segments should submitted separately.
140	Exhibit F	Please confirm that Opiate Substitution Treatment column is intended to refer to methadone programs, not suboxone	This is correct; suboxone certified providers are identified on the medical network.
141	Exhibit F	Please confirm HCA is looking for us to report secure withdrawal management and stabilization facilities for the Adult ITA column on the SUDF tab.	The existence of the service in the network (specific facility) is recorded on the SUDF Adult ITA column, the beds associated with the facility is recorded on the Beds sheet.
142	Exhibit F	Is there somewhere we report Youth ITA? There is a column for Adult ITA only.	Bidders should report Youth ITA on the Beds tab.
143	Exhibit F	Can HCA define "Youth Residential"? For the purpose of the network reporting is the term intended to encompass both "Youth Intensive Inpatient" and "Youth Long Term Residential"?	Yes

144	Exhibit F	Which tab should MH residential, crisis stabilization beds and crisis triage be reported on?	Adult and youth Mental Health beds should be tracked on the Beds tab. E&T is on the E&T tab. Crisis stabilization is not tracked as a separate provider type or facility on the network submission; please note provider contracts for crisis stabilization on your attestation form.
145	Exhibit F	Beds Tab - Should this tab be limited to SUD beds (not MH)?	No, the Beds tab reflects both MH and SUD residential and inpatient beds. Depending on the column
146	Exhibit F	Beds Tab - Is Column O (Number of Available Adult Residential Beds) meant to capture all the types of adult residential beds, including those reported on the SUDF tab (intensive inpatient, recovery house and long term residential)? Is Column Q (Number of Available Youth Residential Beds) meant to capture all the types of youth residential beds, including those reported on the SUDF tab (residential and recovery house)?	Yes
147	Exhibit F	If a provider has a total of 23 PPW beds that they shift between pregnant and parenting women, depending on the need, should we be reporting 23 beds in both column U and W or should we split the count and report 12 beds in column U and 11 beds in column W?	HCA allows for using a historical average in these cases.
148	Exhibit F	Our understanding is that youth are exempt from the IMD exclusion. For the purpose of network reporting should we report Youth Detox non-IMD and Youth Detox IMD based on the facility where the services are taking place rather than whether or not the youth is subject to the IMD exclusion?	Yes
149	Exhibit F	Could HCA please clarify whether access to telehealth technologies, e-health and telemedicine technologies columns in Exhibit F are for providers who are able to receive telehealth, or provide it?	There are 3 forms of telehealth technologies listed. They include both receiving and providing. Choose the one appropriate to the provider listed.
150	Exhibit F	Can HCA please clarify how telehealth/e-health/telemedicine information will be used in the scoring of the network section.	Telehealth is not a scored element in the RFP. If the information is available we would like it included. As for how to populate the fields HCA recognizes that some providers will have access to one, two or all three technologies listed while others may have access to none.
151	Exhibit F	The GeoCoding instructions references “Geo2017Combined - Distance.rpt” which doesn’t appear to be in our SFTP site. When can we expect to receive this template?	This document was uploaded onto the SFT site on March 16, 2018.

152	Exhibit F	If a provider is located in one county but supporting and included in a Bidder's network for a neighboring county that is part of a Region that is not the Region in which the provider is located, should a Bidder to submit the signature page for that provider contract with the network submission for each Region for which the provider is counted as part of the network or only with the Region in which the provider is physically located? Specifically, for a King County provider that is included in a Bidder's network for Pierce County, will the signature page for the King County provider be submitted on April 12, 2018 with the Pierce County network submission, on September 15, 2018 with the King County network submission, or on both dates?	Each of the three RFP segments should be submitted separately.
153	Exhibit G	Please provide a mapping of the Mercer rate cells to the Milliman products/rate cells.	This information will be provided with the final rates.
154	Exhibit G	Please provide BH - Only members by county and Mercer rate cell	This information will be provided with the final rates.
155	Exhibit G	Please provide the BHO Revenue and Expense (R&E) reports mentioned in the Trend Development section. Additionally, please provide the Statutory filings, income statements or any other financial reports for the current BHOs for the last 2 years (e.g., any reports summarizing financial results and the reports that Mercer uses to develop the rates) - ideally by region. This information can be provided blinded (so entity name is not public) if necessary.	HCA will consider this request.
156	Exhibit G	How did Mercer account for changes in the mix of membership and services used for trend development?	Trends are projected at the detailed BH service level. These service level trends are applied by rating cohort.
157	Exhibit G	Please provide more detail surrounding the BHO/County Reconfiguration adjustment. What did the data look like before and after the shifting of members?	This information will be provided with the final rates.
158	Exhibit G	Please explain if Mercer made any adjustments for pent up demand. If so, what adjustments were made? If not, what was the justification?	There is no adjustment for pent up demand. Please clarify which service category you would expect to be adjusted for this.
159	Exhibit G	For IMD and Target Service Expansions adjustments, can you please provide an example of how those adjustments were calculated?	Specific logic to calculate Targeted Service Expansions are included in the corresponding sections of the rate narrative that will be provided.
160	Exhibit G	Please confirm that margin is included in the administrative load. If so, please provide the amount of margin in the load. If not, how was margin accounted for in rate development?	Margin is a separate component of the non-medical load in the physical health rates. It is included in the trend applied to the behavioral health rates. The amount varies by region but the amount is generally in-line with the component included on the physical health side.
161	Exhibit G	When can the actual rate certification from Mercer (that combines the BH and Apple Health rates) be made available? Can we receive it before we submit the RFP response?	We expect to have the final July 2018 rate certification from Mercer by the end of March 2018. The certification of the integrated rates will be available by October 1, 2018.
162	Exhibit G	What rate within the BH rate range will Milliman use (e.g., the midpoint of the range) for each RSA and product? If that determination has not been made, what rate should MCOs assume for CY2019 and CY2020 BH rates?	The contract rates within the rate ranges are selected during the budget development. The final contract rates for behavioral health effective July 2018 will be available by the end of March 2018. The contract rates for 2020 have not yet been set.

163	Exhibit G	For the SUD rate, Mercer assumed actual managed care payments instead of what the state was paying under FFS. Please provide a table comparing the managed care payments on a unit cost basis compared to FFS.	The SUD reimbursement rates were repriced to managed care rates for each region. There is no table that compares those rates to FFS for the entire state.
164	Exhibit G	Please provide a table comparing MH reimbursement to the Medicaid Fee Schedule?	The modeled MH unit costs are illustrated in the 2015 databook.
165	Exhibit G	Please provide an estimate of the number WISe members expected to receive a case rate statewide by RSA - and note the time period assumed.	This information will be included in the documentation of the behavioral health rates.
166	Exhibit G	Regarding crisis services, please explain: A) Which services are covered by the MCOs and which are covered by the BH-ASOs? B) Which services are covered in the capitation rate? C) Which services are pass-through? D) Which services will the BHOs bill directly to the State?	The listing of covered services and exclusions is included in the contract.
167	Exhibit G	Please provide the number of months used for the Member Months in the Rate Range Development by BHO tables.	This information will be provided with the documentation of the behavioral health rates.
168	Exhibit G	Please confirm that the member months included in the Rate Range Development by BHO tables include BH-Only membership.	The BHO rate range development includes all eligible Medicaid enrollees. This includes BH only members.
169	Exhibit G	Please provide a split between current MCO managed care membership vs other programs, including BH only program?	This information will be provided with the final rates.
170	Exhibit G	Will the State consider a risk corridor given the uncertainties in the underlying data used to develop the rates?	No. For both the physical and behavioral health rate development, the data periods used to develop the rates are stable. The uncertainties around more recent data drove the decision to continue to leverage credible 2015 data through a rate update.
171	Amendment 2	In clarifying the network submission requirements, HCA stated that it will accept signature pages that have current dates of 2017 or 2018 (See Question 17 of Amendment 2). If an MCO operating in SWWA has IMC contracts with providers in neighboring counties or regions that are dated 2015 or 2016, will HCA accept these signature pages as current?	If relying on a contract signed for SWWA, the Bidder will need to ensure the signed contract covers new transition regions.
172	Amendment 2	We have EBH provider contracts (including but not limited to BH contracts with the RSN/BHO providers) in place with signature pages that date back prior to 2017/2018 that are active/current Agreements. Can HCA confirm all signature pages will be permitted, and that the contents of those contracts can be reviewed during the on-site?	HCA expects that signature pages submitted with the RFP reflect terms and specific rates pertaining to the IMC population. They will be further examined during the readiness review.

173	Amendment 2	In Amendment 2, question #64 lists the 6 provider types that will be held to the 80% adequacy, consistent with the discussion at the Pre Bidders conference. (Hospitals, Pharmacies, PCP, Peds PCP, OB and Mental Health) Although, Amendment 2, Question #15 inaccurately lists the provider types measured against 80% and HCA responded "YES" to the question. Can HCA please confirm that #64 is correct, and to disregard #15?	Yes, #64 is correct, and the Bidder should use that list as the correct set of providers that are tested against the 80% capacity rule.
174	General	During the bidders Integrated Care RFP Bidder Conference it was noted that the time and distance standards for MH/CDP was the same in the BHO contracts as the new integrated care contracts. This doesn't seem to be the case. Section 6.11.7.1 of the Draft Integrated Care contract specifies a Urban/non-urban standard of 1 within 25 miles. The BHO contract specifies in section 5.12.1. The Contractor must ensure that when Enrollees must travel to service sites, the drive time to the closest provider of the behavioral health service they are seeking is within a standard of not more than: In Rural Areas, a thirty (30)-minute drive from the primary residence of 5.12.1.1.the Enrollee to the service site. In Large Rural Geographic Areas, a ninety (90)-minute drive from the 5.12.1.2.primary residence of the Enrollee to the service site. In Urban Areas, service sites are accessible by public transportation 5.12.1.3.with the total trip, including transfers, scheduled not to exceed ninety (90) minutes each way. This change from travel time to distance is a significant change for many of the areas in the North Sound region where travel is difficult. Having a provider in a 25 mile radius may still require multiple hours of travel. How can these standards be modified to ensure the existing standards are met?	If the currently contracted providers meet such standards, the standards will not be lessened under IMC because the MCOs are required to attempt to contract with the existing network.
175	General	Please confirm that vendors can place the required restatement of the section numbers and titles within Exhibits C and D, starting our response on the next page, so that the required restatement does not count against the page limits defined for the answers to the questions in the RFP.	This is acceptable. The restatement of sections and questions will not count against the total page limits.
176	General	If an MCO determines an attachment is necessary to answer a question, will the attachment be in addition to any page limit restrictions?	Correct. Attachments will not count against page limits.
177	General	Can HCA please confirm that questions repeated in the answer template will not count against page limits.	Correct. Repeating the question will not count against page limits.
178	General	Could HCA please confirm that electronic network submissions should be titled Exhibit F, not Exhibit E as indicated in the Geocoding Bidders Instructions.	Correct. As described in RFP Section 3, Exhibit F is the Provider Network Submission.

179	General	In consideration of provider and HCA desire to transition BH providers to innovative value based payment methodologies, would the state consider waving the 1st signature requirement, and instead accept LOIs? This would give respondent MCO's more time to work with providers to avoid compensation abrasion and to create incentive contracts that will forward HCA's vision of payment for quality service, over quantity of service	No
180	General	Can HCA host an actuarial bidders' conference where the state actuaries can walk through how the behavioral health rates will be updated and combined with the Apple Health rates? This conference would be helpful for all bidders for a number a reasons (e.g., better understanding of the data limitations mentioned in the Mercer documents and integration savings assumptions assumed by Milliman). We would appreciate a live discussion prior to proposal submission.	HCA will consider this request.
181	General	Regarding the 2019 transition year: A) Please explain the MCOs responsibilities in King and North Sound RSAs during the transition year (e.g., what services will MCOs provide, what capitation will MCOs be paid)? B) Will the behavioral health benefit be added to all of King and North Sound counties, including the behavioral health only members, effective January 1, 2019? C) Please explain what "provide technical assistance" to behavioral health providers during the transition to IMC means on page 9 in section 1.2.1.9?	A) The MCOs will receive 100% of the Medicaid funds during the transition year as a capitated payment just as the MCO would receive in any other integrated managed care region. in King County, subcontractor responsibilities will be determined by agreement between the Bidders and King County's BH-ASO; in North Sound see 3.4.11 for transition responsibilities of the BH-ASO. B) Yes. C) HCA believes this objective is self-explanatory. As the Bidders know, many BHO-contracted providers have never worked with an insurance company. As stated in the objective, HCA is seeking Bidders who will provide TA to these providers so that they are ready and able to obtain authorizations, go through the credentialing process, and operate under MCO billing processes.
182	General	Please describe the value of incremental managed care savings (if any) is going to be assumed in the CY19 and CY20 IMC rates and the sources of information used to determine this adjustment, especially given the data limitations?	Integration savings factors will be region specific and have not yet been set. The actual savings factors by region will be provided as part of the January 2019 and January 2020 rate documentation. The description of the methodology and data sources will be included in the documentation.
183	General	What will the process and timeline be for determining details and implementing risk adjustment to the populations under this contract?	Risk adjustment factors cannot be developed until bidders are selected and the distribution of the regional enrollment to the contracted MCOs in each region is made. We expect to set risk factors at 1.0 initially and will update the factors once the enrollment has stabilized. Our expectation is that the factors would be updated effective July 2019 and July 2020 for the newly integrated regions.
184	General	Please clarify whether the changes to add BH services to the statewide foster care program will be effective on 10/1/18 or 1/1/19.	January 1, 2019.

185	General	Please clarify which rates the bidders should “accept” given the 7/1/18-12/31/19 rates in the most current Mercer attachment (quoted in this RFP section) are draft and have not yet been combined with the Apple Health rates. Additionally, funding for other services (e.g., wrap around) have not been included in these rates. Can the draft combined rate ranges be provided?	At the time of the release of the RFP the Behavioral Health rates were in the process of being updated. The integrated rates for January 2019 will be finalized by October 1, 2018, and will be provided to bidders. Once final, the rate documentation will be provided to potential bidders. The final funding allocation by region for the wrap-around contracts will also be provided.
186	General	Given that the BHSO and IMC rates are not final, will winning Bidders have an opportunity to forgo executing the final contract if it is discovered post award that material assumptions underlying their proposals are different and we are not able to negotiate mutually agreeable final rates and terms with HCA?	Final rates for each region will be available by October 1, 2018. If the final rates are not acceptable to bidders, they will not be forced to execute contracts.
187	General	Regarding the Southwest RSA: A) Please provide the BH rates within the Mercer BH rate ranges that the MCOs are paid (as part of the overall capitation rate) - please separate rates by the various time periods. B) Please provide the combined physical and behavioral health rates that the MCOs are paid - by the various time periods.	Rates for each region are set separately. The current rates for SWWA would not provide insight into the rates being developed for the regions included in this RFP.
188	General	Please confirm that the withhold will also apply to the behavioral health portion of the integrated rate.	The withhold is applied to the entire integrated premium amount.
189	General	Regarding the BH Wraparound Coverage: A) Please explain how the wraparound coverage works today compared to how it will work in the IMC contracts. B) Please provide the amount of funding (by year) and detail for the BH Wraparound coverage. C) What happens to the BH Wraparound coverage when the funding runs out? D) Please confirm that the MCOs do not have risk with the Wraparound coverage.	A) Today, BHOs have contracts with DSHS that are funded by non-Medicaid funding sources. Those funding sources support a variety of non-Medicaid costs, many of which are outlined in the Sample MCO Wraparound Contract and the ASO Contract. The BHO contracts these funds out to their provider network in accordance with DSHS contract requirements. B) The details for the "Wraparound coverage" can be found in the Sample Wraparound Contract that is attached to the RFP. HCA's current intent is to divide the state-only funds with a 65/35 split between the ASO and MCOs, with the ASO in each region receiving 65% of the state-funds allocation. The 35% of state-funds will be contracted to MCOs proportional to their regional enrollment. There may be some additional proviso funds that are available to MCOs. HCA will provide each MCO a budget in association with the Wraparound Contract. C) When the funding runs out there is no additional funding until the next fiscal year. MCOs are expected to monitor expenditures so that funds are available for critical non-Medicaid costs over the fiscal year. D) Correct.

190	General	Please confirm that the pass throughs (SNAF, PAP) for the current Apple Health coverage will be the same for IMC coverage.	There is no expectation that there will be any change to SNAF and PAP in the integrated regions.
191	General	Can HCA confirm that a font size 11, with tables as low as font size 9, are acceptable?	Correct. There is no font size limit.
192	General	Will HCA make the Attachments and Exhibits listed on page 11 of the IMC contract available?	All exhibits can be found on our external website here.
193	General	In consideration of provider and HCA desire to transition BH providers to innovative value based payment methodologies, would the state consider waving the 1st signature requirement, and instead accept LOIs? This would give respondent MCO's more time to work with providers to avoid compensation abrasion and to create incentive contracts that will forward HCA's vision of payment for quality service, over quantity of service	LOIs will not be accepted in lieu of signed contracts.