



**State of Oklahoma
Office of Management and Enterprise Services
Central Purchasing Division**

Amendment of Solicitation

Date of Issuance: June 20, 2013

Solicitation No. 8070000558

Requisition No. (Same as Solicitation No.)

Amendment No. 2

Hour and date specified for receipt of offers is changed: No Yes, to: _____ 3.00 PM CST/CDT

Pursuant to OAC 580:16-7-30(d), this document shall serve as official notice of amendment to the Solicitation identified above. Such notice is being provided to all suppliers to which the original solicitation was sent.

Suppliers submitting bids or quotations shall acknowledge receipt of this solicitation amendment prior to the hour and date specified in the solicitation as follows:

- (1) Sign and return a copy of this amendment with the solicitation response being submitted; or,
- (2) If the supplier has already submitted a response, this acknowledgement must be signed and returned prior to the solicitation deadline. All amendment acknowledgements submitted separately shall have the solicitation number and bid opening date printed clearly on the front of the envelope.

ISSUED BY and RETURN TO:

U.S. Postal Delivery:

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Central Purchasing Division
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Beverly Blake
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or

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Beverly.Blake@okhca.org
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Description of Amendment:

a. This is to incorporate the following:

The Request for Proposal for Care Coordination for Medicare/Medicaid Dual Eligible Members is amended in accordance with the attached.

b. All other terms and conditions remain unchanged.

Supplier Company Name (**PRINT**) _____

Date _____

Authorized Representative Name (**PRINT**) _____ Title _____

Authorized Representative Signature _____

RFP REVISIONS

The following change is being made to the **TENTATIVE RFP SCHEDULE**

Program(s) begin operations	January <u>March 1, 2014</u>
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A.1 SCOPE OF WORK, Subsections 3 and 4 are amended as follows:

3. Provide ~~services and~~ care coordination services appropriate for targeted Members; OHCA anticipates that the Contractor will provide care coordination services similar to those that established for OHCA's medical home program (see RFP Library); designed to facilitate CMS's Triple Aim:
 - a. Improving the patient experience of care (including quality and satisfaction).
 - b. Improving the health of populations, and
 - c. Reducing the per capita cost of health care;
4. Use an interdisciplinary care team to develop individual Member ~~action~~ care plans, designed to coordinate the delivery of appropriate health care services; and targeted-Members' health goals to achieve positive health outcomes; and

A.7 PAYMENT STRUCTURE, Subsections 1-3 are amended as follows:

1. Due to the structure of the Centers for Medicare and Medicaid Services (CMS) ~~grant~~ financial alignment demonstration that funds this program, the Contractor shall receive minimal or no reimbursement for care coordination for 18-24 months after its Program begins operating;
2. Compensation for any Contractor who is or who may become a provider of health care services to (non-Medicare-eligible) Medicaid/SoonerCare members will not change. Therefore, if ~~If~~ the Contractor provides SoonerCare-compensable health care services to (non-Medicare-eligible) SoonerCare Members, OHCA shall reimburse Contractor under any active SoonerCare Provider Agreement that the Contractor executes with OHCA;
3. In consideration for the satisfactory performance of ~~the services~~ care coordination under this RFP and only if Contractor achieves all quality thresholds and other measures required by CMS, OHCA shall pay to the Contractor a portion of the savings shown to the Medicare program as determined by CMS;

RFP BIDDER QUESTIONS

1. Cover Page – Please clarify these dates for the procurement as some of them are stated as occurring prior to the release of the RFP
 - a. Discussion Session – listed as June 13
 - b. Submission of Questions – listed as June 17

Answer: Please refer to Amendment 1.

2. Cover Page – Has the response to questions document stated as being released on June 21 been posted on the OHCA procurement website? It does not seem to be available yet.

Answer: Please refer to Amendment 1.

3. Section A.1.3, page 3. Can the Contractor coordinate services among appropriate providers, or must the Contractor be able to provide some or all direct healthcare services to members?

Answer: The Contractor is required to provide care coordination only, under this RFP, and is not expected to be a provider of direct healthcare services. Direct medical services will be provided by the Members' Medicare or Medicaid / SoonerCare providers. The Contractor is expected to coordinate these services for Members.

Contractor(s) who are qualified may remain or become provider(s) of direct healthcare services; however, those services would not be related to this procurement.

4. Section A.7.2, page 5. Is the Contractor required to have a SoonerCare Provider Agreement?

Answer: No, see answer to question 3 above.

5. Section B.3.1, page 7. Please confirm that submission is via email only with no hardcopy proposal submission.

Answer: Correct, only email submissions will be accepted.

6. Section C.1, page 14. How would a Bidder cite a relevant previous contract with OHCA? In previous value-based procurements, OHCA has determined that a Past Performance Survey would not be provided for a previous vendor interested in a current procurement.

Answer: Past performance information from organizations other than OHCA is to be submitted on Forms 7, 8 and 9. If OHCA determines that a vendor meets the conditions for OHCA to provide past performance information, appropriate documentation of past performance will be incorporated by OHCA.

7. Section C.5, page 17. Is the Contractor required to hold any specific licensure, i.e., facility/provider, HMO, etc.?

Answer: No.

8. Are eligible members currently receiving a health assessment conducted by a healthcare professional? If so:

- a. Will this assessment be made available to the Contractor(s) and in electronic or hardcopy format?

Answer: Since these members are served through Medicare, we are unable to determine if health assessments have been performed. The Care Coordination Contractor is expected to conduct the health assessment for the member as part of the initial enrollment and evaluation process.

- b. Can OHCA provide an example of the assessment form?

Answer: Please see answer to question 8a above.

- c. Is the assessment process conducted by providers or a Contractor, and if the latter, please identify the vendor.

Answer: Please see answers to questions 8a above.

9. Regarding the SoonerCare Silver Concept Submission to CMS. We have several questions:
 - a. Will full dual eligible members who are nursing home residents at the start of the demonstration be enrolled in care coordination?

Answer: Members in Nursing Facilities could be enrolled in the Care Coordination Program through this procurement and receive care coordination services as long as those services do not duplicate any care coordination/case management services the member is currently receiving.

- b. Please clarify the expectations for disease management programming for eligible members

Answer: Contractor(s) will be expected to work with Members to ensure that appropriate measures are taken to maintain optimum management of chronic health conditions including prevention of unnecessary ER visits and hospital admissions due to recurrence of condition. Disease management measures could include: adherence to medication therapies, exercise goals and proper dietary requirements. Care Coordinators employed by the Contractor(s) are expected to assist members with managing chronic conditions to provide maximum health improvement outcomes. The Bidder should use its experience and expertise to propose the most effective program.

- c. Does OHCA expect that the Contractor will have a 24/7 Call Center?

Answer: This is not a requirement; however, the Bidder should use its experience and expertise to propose the most effective program.

- d. Given that 50% of the eligible members have a combination of physical and behavioral comorbidities, please elaborate on OHCA's expectations for interactions with the behavioral health community.

Answer: Contractor(s) will be expected to evaluate Members' behavioral health conditions and assist the member in locating and connecting with available behavioral health resources to ensure the Members receive proper behavioral health services. The Bidder should use its experience and expertise to propose the most effective program.

10. Regarding Section A.7.3 of the RFP:
 - a. What is the percentage of net savings available for sharing the contractor?

Answer: CMS will determine the savings. All savings payments received from CMS will be passed on to the Contractor(s).

- b. Is it correct that if one quality measure or other measure is not achieved then there will be no shared savings to the contractor? What precisely are

the quality thresholds and other measures required by CMS? Will CMS be conducting the 18 month evaluation internally or using a contractor

Answer: The quality requirements and improvement benchmarks will be determined by CMS during the approval of the Memorandum of Understanding (MOU).

11. Since CMS is a party to the contract; does the current RFP include all requirements and terms and conditions or will CMS have additional terms that are not included in the RFP? If CMS terms/conditions are not yet defined and therefore defined after vendor selection, will the vendor have the ability to opt out of the contract if the terms and conditions are not found to be reasonable or acceptable?

Answer: The quality thresholds or other measures have not yet been determined by CMS. Contractor(s) will be permitted to opt out if they are determined by the Contractor to be unreasonable.

12. In regard to the SoonerCare Silver Concept Paper, it is noted that 7.5% of the dual eligible population is American Indian while on OHCA website, the American Indian percent of total Medicaid is 16%. Can you verify the accuracy of the much lower rate American Indians in the dual eligible population?

Answer: In the SoonerCare Silver Concept Paper, the total enrollment for Dual Eligible SoonerCare Members includes ‘American Indian’ at 7.5% which is comprised of those who self-reported as ‘American Indian Only’. The ‘Multiple Races’ group includes those who self-reported as ‘Multiple Race American Indian’.

The American Indian percent of total Medicaid of 16% from the Fast Facts on OHCA’s website is for (both) ‘American Indian Only’ plus ‘Multiple Race American Indian’. The percent of ‘American Indian Only’ is 11%. A recent review of the June 2012 Fast Facts for this population indicated similar results for each category, 15.1% and 11.8%, respectively.

Therefore, when using the June 2011 data, the 7.5% Dual Eligible ‘American Indian’ should be compared to the 11.8% SoonerCare ‘American Indian Only’ rather than the category which includes (both) ‘American Indian Only’ plus ‘Multiple Race American Indian’ and is reported as 15.1%.

13. In regard to the SoonerCare Silver Concept Paper, are both practice facilitation as well as nurse care management expected components of the SoonerCare Silver intervention? Or only the later?

Answer: As identified in A.1 of the RFP, Care Coordination which is appropriate for targeted Members is required. Practice facilitation is not required. The Bidder should review the RFP Objectives and use its experience and expertise to propose the most effective program.

14. In regard to the SoonerCare Silver Concept Paper, how many dually eligible clients receive services through SoonerCare Care Management (SCCM)?

Answer: Currently the OHCA does not have a program that provides services to dually eligible Members.

15. In regard to the SoonerCare Silver Concept Paper, will both the Health Homes Model and Systems of Care Program be available for dually eligible clients?

Answer: The Bidder should use its experience and expertise to propose the most effective program. Health Homes and Systems of Care Programs have not been implemented at this time.

16. How frequently will claims data be provided to the Contractor? Will claims be full Medicaid and Medicare claims inclusive of Part D? What is the delay time between claim submission and availability to the contractor? If a concurrent control group is being used for evaluating impact, how often will their claims be provided to allow for impact determination? Will the vendor have access to the claim sets used in the cost-savings analysis for concurrent conduction of the assessment, including basement determinations/trends and final outcome?

Answer: Claims that have been received by OHCA will be sent weekly. Claim receipt dates from Medicare are not yet available. Assuming the MOU with CMS allows, claims are expected to be full Medicaid and Medicare, inclusive of Part D. The delay between claim submission and availability to Contractor(s) is expected to be up to one week from receipt of claim by OHCA, unless the claim is suspended awaiting additional documentation. OHCA does not anticipate the use of a concurrent control group. Also, please refer to the System Requirements in Section A.4 of the RFP and in the Bidder's Library.

17. The concept paper indicates that OHCA will oversee quality evaluation measures and cost savings; while the RFP p6 indicates that CMS will calculate savings. Are both OHCA and CMS using identical measurement approaches?

Answer: The most recent guidance received from CMS indicates that CMS will establish and oversee the quality evaluation and savings calculations for the states. See also answer to question 21.

- a. The concept paper indicates research is underway to explore methods to overcome upfront care coordination investments until the state is eligible for retrospective payment from Medicare. Has research produced additional methods for upfront payment? If the State does not receive CMS funds for any reason outside cost savings calculation reasons, does the State have a contingency payment plan aligned?

Answer: If funding is not received from CMS for Implementation, there is no contingency payment plan. Therefore, Contractor must have the funds to implement and operate the program for 18-24 months without expecting a payment for implementation. OHCA has applied for implementation funds, but has not yet received approval.

- b. Retrospective payment from savings from Medicare are noted; is the state or CMS also anticipating sharing in Medicaid savings (from both reductions in state expenditures and in reductions from federal government Medicaid matching amounts)? If not, why not? If net savings hypothetically arise from reductions in avoidable Medicaid expenditures and not from Medicare, would no savings be available for sharing despite reductions in both state and Federal outlays?

Answer: No shared savings from the State Medicaid expenditures is being considered at this time. CMS has indicated that the Federal share of Medicaid expenditures for the dually eligible populations will be considered in the overall savings calculations. See also answer to question 21.

18. The concept paper indicated contracting with vendor is a risk based contract with payment based on Medicare savings. Are fees then considered 100% at risk until Medicare, but not Medicaid, savings are established?

Answer: Yes

19. Are fees the same for all clients who do not opt out? Are fees adjusted by the risk stratification level of the clients? Are fees adjusted for the participation level of the clients?

Answer: CMS will be calculating the shared savings model on money saved, not fees. The calculations will be based on the expenses paid for the members served prior to the implementation of the SoonerCare Silver care coordination program vs. the expenses paid for the members served during the demonstration program.

- a. Will the State consider paying a fixed monthly amount during the first 18 to 24 months?

Answer: No

- b. Will the State consider alternative payment methods such as PMPM? If so, what payment methods will the State consider?

Answer: No

20. Are there any concurrent or new programs occurring within these populations that would positively or negatively impact any potential savings calculations?

Answer: OHCA is not aware of any such changes.

21. Assuming a control group, what precautions are in place to prevent any changes to interventions to the control group that would impact results? If intervention occurs, what is the planned baseline or control adjustment methodology?

Answer: Savings calculations will be determined by CMS. OHCA's most recent guidance from CMS is that savings will be based on the past expenditures for the population being served and not measured against a control group for this demonstration. In discussions, CMS has suggested that they will use a baseline comprised of federal dollars spent for services for the targeted population (from both Medicaid and Medicare) for a designated time period prior to the start of the

care coordination services. It has also been suggested that a pre-determined threshold (such as the 2% which has been used in similar demonstrations) will be set by CMS during the approval of the MOU to allow for random fluctuation of spending and that savings over the threshold will be attributed to the demonstration program. Guidance received from CMS also indicates that following the initial savings calculations, only a portion (such as 60% for example) of the half of the savings expected to be allocated to OHCA for distribution to Contractor(s) will be made and that the remaining portion (such as 40% for example) will be retained until CMS has determined that quality thresholds and other measures have been met.

22. Assuming multiple vendors are selected, are there any technologies or platforms that will be used across vendors or with whom the vendors need to connect to?

Answer: At this time, it is assumed all vendors will be expected to connect to OHCA and/or Medicare only.

23. Does the State have any planned coverage changes post-baseline (trend) measurement, or any phased coverage changes during the measurement period(s)? Is yes, what is the methodology to compensate for that impact on savings calculations?

Answer: There are no planned coverage changes anticipated by the Oklahoma's Medicaid Program during the measurement periods.

24. Does Oklahoma Medicaid recognize any CPT billing codes for care coordination activities?

Answer: No CPT billing codes will be used for the care coordination services provided through this contract.

25. Will OHCA allow the vendor to expand their Care Coordination program after the first 18-24 months of the contract based on results for the initial members engaged?

Answer: OHCA may allow a Contractor to expand if there are eligible members not receiving care coordination services from another vendor or program after the first 18-24 months and the Contractor wishing to expand meets CMS required quality measurements.

26. In regard to Section A.2, will OHCA provide the vendor with risk scores and other data from the state's predictive modeling software (MEDai) for engaged Members? How frequently will data be received?

Answer: OHCA will have to modify its Medicaid Management Information System to generate reports for this member population, so the data may not be available on the "go live" date. After the initial data is sent, reports are expected to be sent on a monthly basis.

27. Section A.5 specifies a weekly Risk Report will be required during the Implementation Period. The overall schedule of activities on page 1 of the RFP

indicates the contract will be awarded on November 7, 2013 and program operations will begin January 1, 2014. Should we assume the Implementation Period is the interval between contract award and the beginning of program operations?

Answer: Yes, the Implementation Period is the interval between contract award and the beginning of program operations. Please note that this period is being lengthened with this Amendment as the date to begin Program Operations is being delayed until March 1, 2014. Some activities which traditionally occur during an implementation period may occur during the Clarification Phase of the procurement method described in the RFP.

28. In regard to the payment structure in Section A.7, we assume the calculation of savings generated by the vendor's Care Coordination program will be performed annually, with the first calculation done 18-24 months after the start of the program. Is this correct? Will subsequent savings calculations be performed every 12 months, with the second calculation (and vendor payment) occurring 12 months after the initial payment?

Answer: The initial evaluation and savings calculation will be determined by CMS and are expected to be included in the final MOU between CMS and OHCA. Indications are that the initial evaluation is expected to begin shortly after the first 12 months of operation. Payments may not be made for 18-24 months depending upon how long it takes CMS to complete the evaluation and savings calculation. Indications are that subsequent evaluations and savings calculations are expected to be performed annually.

29. In regard to the payment structure in Section A.7, we understand funding for this program will come from savings generated by the vendor's Care Coordination program. We have several questions about this funding model:

a. What proportion of the savings will be provided to the vendor?

Answer: Please see the response to Question 10a.

b. Will the amount of savings be calculated by OHCA, CMS, the vendor, or some other party?

Answer: CMS is responsible for the savings calculation. They will determine whether to use in-house staff or to contract it out to a vendor.

c. What analytic model will be used to calculate savings?

Answer: CMS has not provided that information. The final savings calculation requirements will be specified during the approval of the state's MOU.

d. Will the vendor have an opportunity to review and comment on the results of the savings analysis?

Answer: CMS will make that determination.

30. In regard to Section B.7 and the Value Added Form (Form-6), since the financial model does not include state funding to pay for vendor operations, we are not

clear about the purpose of the Value Added Plan. Under this funding arrangement, the vendor will be responsible for developing (and funding) any additional enhancements or value added benefits. Given this situation, will the vendor still need to complete Form 6? If Form 6 is not required, will OHCA change the evaluation weights listed in Section C.1 of the RFP?

Answer: Value Added Plans are not included in the project budget and OHCA assumes that additional reimbursement is required for any value added option. The Bidders may provide value added options along with a price to implement and/or operate them. If OHCA chooses to accept value added options, it would obtain additional funding. Even if no value added options are accepted, OHCA considers the Value Added Plan an important indicator of the Bidder's expertise and understanding of the RFP objectives.

Bidders may also use the value added plan to propose changing or eliminating RFP requirements that would lower the project cost and/or improve project outcomes. If removing a requirement would lower costs, Bidders may show an estimated project cost reduction for their value added plan, but this would not affect their reimbursement. If removing a requirement would improve outcomes, Bidders should propose this in the Value Added Plan and show how it would improve outcomes; in this case, the cost impact could be none.

Innovative and expert features of the Bidder's project plan that are within scope and do not require additional reimbursement should be discussed in the Project Capability Plan.

31. Section D.2 of the RFP indicates the contract will begin January 1, 2014. However, the overall list of activities on page 1 of the RFP says the contract will be awarded on November 7, 2013 with the beginning of program operations on January 1, 2014. Which is correct? If the contract doesn't begin until January 1st, and the beginning of program operations also begins January 1st, when is the Implementation Period?

Answer: Implementation begins at Contract Award. Also, please see Answer to Question 27.

32. In regard to Form-11, please clarify your reference to A.9.4 in the RFP. We do not see that section in the RFP.

Answer: Please refer to Amendment 1 which you can find at:

< www.okhca.org/rfp >