AMENDMENT / Questions AND Answers
RFP #1597-DDES-SM
For the Delivery of Managed Long-Term Care in Selected Service Areas
June 25, 2007

Please note several questions have resulted in amendments to sections of the RFP. These amendments are noted in the answers to the questions and are part of the RFP by reference.

Question 1: I believe the RFP has an error in Section 2.1.3 when it references s.46.285(6) of the Wisconsin Statutes. Should it be s.46.284(6)?

Answer: The reference should be s.46.284(6).

Question 2: On page three of the RFP, under who may submit a proposal, second bullet from the bottom, it states "a group of counties acting cooperatively under s.66.030 Wisconsin Statutes." CCCW's agreement is a 66.0301. Please let me know if this poses a problem.

Answer: Having an agreement under s.66.0301 does not pose a problem. For Page 3, Section 1.4.2 Second Bullet - The referenced Wisconsin Statute should be 66.0301 *not* 66.030 and is amended by reference.

Question 3: RFP Section 2.3.3.5 Business Plan. How many years should this plan include? There are references to a 3-year business plan and this section talks about financial stability within two years of initial contract award.

Answer: The business plan needs to be a three-year plan (36 months). This is referenced in the Readiness Template (Appendix 1 of the RFP).

Question 4: Regarding the business plan, if the first year is a ramp-up year, does that count?

Answer: Yes. That year would be part of the 36-month business plan.

Question 5: According to Section 1.4.2, it would appear that Community Care Inc., which is a 501(c)3, must be regulated by OCI in order to bid. If that is correct, then the bid must be submitted under its HMO, CCHP. Community Care does not meet the other permitted definitions as a county or county created entity, or an Indian tribe. This seems to be further reinforced by Section 2.3.3.4 which states that "Any organization other than a county or group of counties acting jointly will also be required to be licensed as an HMO or other insurance entity by the Office of the Commissioner of Insurance."

Answer: An entity was left off the list of who may apply in Section 1.4.2 and was discussed at the Vendor's conference held on June 15, 2007. The following two sections are amended to correct this:
Pages 3 and 4, Section 1.4.2 of the RFP is amended by this document to include "a privately held managed care organization" as an entity who may apply. Page Section 2.3.3.4 is also amended

to read … “the organization ‘may’ also be required to be licensed as an HMO or other insurance” as opposed to “‘will’ also be required”.

Question 6: If you don’t yet have an HMO license, where do you need to be in the process on July 13, 2007?

Answer: Since an HMO license is not necessary for providing Family Care, this answer assumes you are proposing a program other than Family Care.

For Section 2.3.3.4 Solvency and risk, additional language is added by reference to and through this amendment:
The Department will accept a proposal if we have evidence that you have applied for an HMO license. Proposers who do not yet have their HMO license should submit a copy of the license application with their proposal. However, if your proposal results in a letter saying the Department intends to contract with your organization, we will not begin the certification process until you have received an HMO license.

Question 7: Can the health plan operate under an indemnity license or is an HMO license required?

Answer: An HMO license is required if you are offering a program that includes acute and primary healthcare services, such as Family Care Partnership or Family Care Plus.

Question 8: Section 2.3: Have the capacity to carry out an enrollment plan developed jointly with DHFS that will result, within 24 months from the effective date of the contract in the MCO being able to enroll, with no waiting, all persons who are eligible and choose to enroll.
What is the definition of the 24-month period? If we stagger the start times is the 24 months from each start date or does it mean 24 months in total?

Answer: It depends on how the start times are staged. If the start times are staggered county by county, we consider the 24-month period to start when enrollment in a particular county starts.

Question 9: Page 18, Section 2.4.1: Provide evidence that any aging and disability resource centers (ADRCs) within the proposed service area have been informed of the proposer’s intent to respond to this RFP.
If there is currently no aging and disability resource center in the proposed service area or part of the service area, provide evidence that there is an organization ready and willing to apply to the Department to become an aging and disability resource center. What constitutes as evidence that there is an ADRC and/or organization ready and willing to apply?

***Answer*:** A signed statement from the agency or agencies that plan to apply.

Question 10: Will the enrollment process be done by the ADRCs?

Answer: On an ongoing basis, the ADRCs will be the entry point into the long-term care system, and they will coordinate the Medicaid eligibility determination and enrollment with

income maintenance units. However, people who are current participants in home and community-based waivers may enroll directly into the new managed care program without contacting the ADRC. For these individuals it will be allowable for current county waiver staff to explain their options to them, and obtain their signature on an enrollment form.

Question 11: Are the health plans able to assist with enrollment if an applicant makes contact with them?

Answer: No. The enrollment process must be kept separate from the care management process. Potential enrollees that make contact with a health plan should be referred to the ADRC.

Question 12: What is the timeframe for enrollment from the time an applicant makes their wishes/intent known

Answer: For individuals who are not currently Medicaid recipients, it is expected that the ADRC and income maintenance will complete the eligibility process, including selection of an enrollment date, within 30 days of the application being filed. For individuals who are already participating in the Medicaid program, it is expected the process would be completed in less than 30 days, but no specific timeframes have been promulgated.

Question 13: Page 13, Section 2.3.1.2 5th bullet: Your organization's willingness to enter into an MOU or other written agreement with the resource centers in the service area to serve individuals who are functionally eligible and at imminent risk of harm, hospitalization or institutionalization without the services of the MCO but whose financial eligibility is pending.

We are concerned with the risk factor associated with pending financial eligibility. Does the Department have any suggestions how we can manage this risk?

Answer: The actual language that appears in the MCO/CMO contract states that: The CMO shall have an MOU with the resource center "**that describes the circumstances"** in which the CMO will provide services to an individual who is functionally eligible but whose financial eligibility is pending. It is assumed the MCO would manage their risk by setting the parameters of when they are willing to serve people prior to a final determination of financial eligibility in those circumstances described in the MOU. In some cases, there will be a very high degree of probability someone will be financially eligible. In other circumstances, it will be less certain.

Question 14: Page 21, Section 3.4.3: Proposers must also submit 8 paper copies of: 1) Completed response to Section 2, 2) Copies of any attachments (see Section 3.4.4) used to provide supporting information. Label attachments at the top of the first page using the following naming convention: "MLTC – [name of organization in Section 2.1] – Attachment [section or subsection number to which the attachment is applicable]. Required forms (see Section 3.7.4).

The required forms are mandatory via paper copy submission. Are they supposed to be included in the electronic submission?

Answer: Yes, the forms should be included in the electronic submission. However, the electronic copy of the DOA 3261 does not need to be signed when submitted electronically. The paper copy absolutely requires a signature.

Question 15: Page 23, Section 3.7: The State of Wisconsin reserves the right to incorporate standard State contract provisions into any future contract negotiated from any proposal submitted responding to this RFP who meets the qualifications to move on to Phase II of this RFP [Standard Terms and Conditions (DOA-3054) and Supplemental Standard Terms and Conditions for Procurements for Services (DOA-3681)]. Failure of the successful proposer to accept these obligations in a contractual agreement may result in cancellation of the award.

Could you provide clarification or examples of the contract provisions the State may consider for future contracts?

Answer: The administrative rules require that the standard terms and conditions apply to every contract unless amended or deleted by the parties. Other than as otherwise specified in this RFP the Department intends that the standard terms will apply. During final contract negotiations any appropriate amendments will be considered. The Standard Terms and Conditions and Supplemental Standard Terms and Conditions are posted along with the RFP main document and other attachments at VendorNet.

Question 16: Page 22, Section 3.4.8: It is the intention of the State to maintain an open and public process in the submission, review and approval of awards. All material submitted by proposers will be made available for public inspection……. No proposal submitted to the State may be marked as confidential, and any materials so marked, by being included in the proposal, will be considered public information.

It is our understanding the RFP process for Kenosha/Racine counties provided the flexibility of submitting certain proprietary materials in a confidential manner. Due to the statement contained in this section that all information submitted is considered public, can you clarify the confidentiality aspect of this RFP?

Answer: In the Standard Terms and Conditions Attachment to this RFP which is posted on VendorNet, it states in Section 27.2 that the bidder/proposer may request Form (DOA-3027) Designation of Confidential and Proprietary Information if the form is not included in the RFP/RFB. However this RFP is being amended to include the DOA-3027 Form and is being posted on VendorNet simultaneously with this document. If you plan to submit the form designating parts of your proposal as confidential or proprietary, please read the Standard Terms and Conditions section form for an understanding of the requirements.

Question 17: Does the Medicare risk-based contract for Part A, Part B and Part D benefits that needs to be in place by 1/1/08 for the Family Care Partnership benefit need to be a Special Needs Plan Institutional Plan or subset to be considered for a DHFS contract in 2008 or is any Medicare Advantage plan that includes Part D allowed?

Answer: In regards to Section 2.2.4 of the RFP, your question addressed institutional-based special needs plans (SNPs.) The current Partnership Plans have been redesignated as sub-setted dual eligible SNPs. They are no longer designated as institutional SNPs.

Your SNP must be designated with the appropriate subset for the target population that you propose to serve. CMS makes the determination on your subset based on your application. To operate a Partnership Plan, you must work with CMS, Division of Special Needs Plans, to secure the appropriate sub-setted dual-eligible SNP designation.

Question 18: Regarding the risk-based contract for Part A, Part B and Part D benefits, does the subset need to be institutional?

Answer: In Section 2.2.4, the RFP does not contain a specific requirement for the subset because CMS regulates Medicare special needs plans. Following the proposers' conference call, the Department had a conversation with CMS during which they emphasized that you do need to work with CMS to establish the appropriate subset. However, the Department is currently reviewing all of its contracts for its managed long-term care programs, including the Partnership Program. Part of this contract review work will involve a determination of the degree to which the Department will define the parameters for a SNP contracting with the Medicaid program. A fundamental policy objective of the Department in that contract review work is to contract with SNPs that specialize in the provision of services to dually-eligible persons at an institutional level of care.

Question 19: Can you tell me what program we need to use for the electronic submission of the RFP? Is PDF okay? Also, it appears you would like the attachments saved separately. In other words, they cannot be part of the same PDF file (assuming PDF is okay.) Am I correct?

Answer: PDF is the preferred program for all text documents that you submit. Clearly labeled attachments may be submitted with the text documents. However, documents involving financial material, such as the three-year business plan, should be submitted in Excel format.

Question 20: Under Section 3.4.4 the RFP states that attachments may not exceed 25 pages in total. Does this mean 25 pages per attachment, or all attachments may not exceed 25 pages?

Answer: All attachments combined may not exceed 25 pages.

Question 21: Will there be data books regarding historical utilization for the target groups for at least 2 years? If so, how can they be obtained?

Answer: Under Section 2.3.3.5 of the RFP we have stated that information on service utilization by the current waiver population for state fiscal years 2003-2005 is available upon request. To request a data set of this information, please contact Tom Lawless at (608) 261-7810 or LawleTM@dhfs.state.wi.us

Question 22: So far we have not located any information (rates) for the majority of the counties listed in the RFP. Please provide rates and cost date for the expansion counties (or point us to where that data is located).

Answer: Rates will be calculated for the expansion counties in the fall of 2007. Please refer to Section 2.3.3.5 for information on obtaining cost data.

Question 23: Are the MCOs paid a separate rate for Family Care Plus plan, or do they receive the Family Care Program plan capitation rate plus a managed Medicaid medical capitation rate? If we are paid via the managed Medicaid medical capitation rate, into which rate category will this population fall?

Answer: The Family Care Program rate will represent the long-term care component of the Family Care Plus rate. An acute care component will be added to the long-term care component of the rate to determine the Family Care Plus rate.

Question 24: How will DHFS decide on which plans will serve a county if there are multiple applicants for that county? For example, will the preference for enrollments of 1500 or more be considered when allocating counties? A plan that has a limited service area may need to have other plans excluded from that service area if it is to reach the minimum enrollment threshold.

Answer: The Department will score the proposals according to criteria contained in the RFP (Section 3.5). As stated in the RFP, the Department must ensure that each organization with which it contracts has a sufficient number of enrollees to allow for successful operation as a managed long-term care organization.