



## New Hampshire Medicaid Care Management Program

# OFFICIAL RESPONSE TO BIDDERS COST QUESTIONS

## CARE MANAGEMENT RFP # 12-DHHS-CM-01

Nr.	Section	Page	Question	Answer
1			Please provide utilization and cost patterns – detailed claims experience needed for Actuarial and Medical Management analysis and planning (i.e. including PMPMs by category, IP, bed days, ALOS, ER, RX scripts, RX generic/brand mix, RX PMPM; billing patterns, over utilized services)	Please refer to the data book appendices for the requested information. More detailed information regarding prescription drug generic and brand usage is included in the data book addendum. More detailed information regarding inpatient admissions, inpatient length of stay will be provided November 30th, 2011 in an addendum to the data book.
2			Is there any significant out-of-state utilization that should be considered as part of the cost proposal, e.g., utilization in Boston?	Please refer to Appendix D of the data book for the requested information.
3			Can the State provide blinded claims data by provider?	Please refer to Appendix D of the data book for the requested information.
4			Does the State make any other supplemental payments to providers (like Coos County Hospital kick payment) other than DSH/GME? Will the State continue to make these payments? If not, is the State's expectation that we will make these payments? And, if so, will the State consider these additional monies in our capitation rates? And, can the State provide the providers receiving these supplemental payments and the basis for payment?	See RFP addendum #1
5	RFP	101	Please provide more detail on performance guarantees and the withhold program.	This will be specified in the MCO Contract.
6	Cost Proposal Instructions and Data Book	5	If a bidder bids below the range will their rate be brought to the bottom or will they be eliminated from consideration?	A bidder with a bid below the range will not be eliminated from consideration.
7	Cost Proposal Instructions and Data Book	5	Please provide the actuarially sound capitation rate range for each rate cell and population.	DHHS will not provide the actuarially sound capitation rate ranges at this time.
8	Cost Proposal Instructions and Data Book	6	Please detail the benefit package applicable to each rating category.	Benefit package is uniform for Step 1.



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9	Cost Proposal Instructions and Data Book	6	Please provide a detailed mapping of DRG codes, Revenue codes, and CPT-4 codes to the service categories included in Appendix A.	More detail regarding the categorization of hospital inpatient and hospital outpatient services by DRG and revenue code is included in the addendum to the data book. Other service categories are derived from the MMIS service category codes and provider type codes.
10	Cost Proposal Instructions and Data Book	6	Please discuss why Nursing Facility services are not included as a covered service for the populations enrolling in managed care and why the associated claims are excluded from Appendix A.	DHHS will be developing information, guidelines and criteria regarding the specialized services included in Step 2.
11	Cost Proposal Instructions and Data Book	6	Please describe the methodology used to match eligibility and claims for purposes of creating the cost models in Appendix A.	For the eligibility data, a monthly record is created if an individual is eligible for services during that month. The eligibility data is then merged with the claims data based on Medicaid ID number and service month.
12	Cost Proposal Instructions and Data Book	7	Please provide additional details related to the truncation of the first two months of claims and eligibility for beneficiaries (excluding newborns). Was this two months for each calendar year cost model? Was the truncation only for the first two months from an original effective date? How were members with a break in eligibility handled for purposes of this adjustment?	The first two months of eligibility and claims for each individual were excluded in the study period from CY2007 through CY2010. This exclusion is only applied once regardless of breaks in eligibility.
13	Cost Proposal Instructions and Data Book	7	Please provide the fee-for-service pharmacy fee schedule. This may include a MAC schedule as well as other pricing information.	Pricing Algorithm: reimbursed at the lesser of the following: <ul style="list-style-type: none"> <li>a. The AWP, minus a discount of 16% of the AWP, plus the dispensing fee;</li> <li>b. The WAC, plus 0.8% of the WAC, plus the dispensing fee;</li> <li>c. The usual and customary charge to the general public;</li> <li>d. The NHMAC plus the dispensing fee; or</li> <li>e. The FUL plus the dispensing fee</li> </ul> Dispensing fee is \$1.75.
14	Cost Proposal Instructions and Data Book	7	Please clarify the adjustment required to support Coos County providers.	See RFP addendum #1
15	Cost Proposal Instructions and Data Book	11	Will the risk adjustment factors be calculated and applied by rate cell? How will population mix differences be handled when calculating an MCO adjusted risk factor? Please discuss how double-counting of age/gender scores will be avoided using rate cell capitation rates and risk adjustment (that includes an age/gender component).	The detailed risk adjustment process is still under development. The final risk adjustment process will be developed so as to appropriately address age/gender rate cell issues.



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Nr.	Section	Page	Question	Answer
16	Cost Proposal Instructions and Data Book	11	We appreciate that the capitation paid will be risk adjusted. For purposes of bidding a base rate, what population represents the 1.0?	Cost proposals are to be quoted assuming a risk score of 1.00 for each rate cell, where a 1.00 risk score represents the average acuity of the population included in the data book.
17	Cost Proposal Instructions and Data Book	All Pages	Please provide all appendix information in Microsoft Excel format to allow for health plan manipulation in preparing bid rates.	Excel version is available from DHHS via email.
18	Cost Proposal Instructions and Data Book	All Pages	Please define the units of service provided in the databook.	Will be addressed in addendum #1 to databook.
19	Cost Proposal Instructions and Data Book	All Pages	Please provide additional subcategories to describe the "Mental Health Center" service category. Items such as Clinic versus Rehab Services and mental health versus substance abuse should be differentiated. Also, splits for group and individual counseling and psychotherapy as well as community support programs would be appreciated.	Will be addressed in addendum #1 to databook.
20	Cost Proposal Instructions and Data Book	All Pages	Please provide additional subcategories to describe the "Physician" service category. Items such as office visits, ER services, IP surgery should be differentiated.	Will be addressed in addendum #1 to databook.
21	Cost Proposal Instructions and Data Book	22, 44, 66	Please provide the number and amount of Maternity Kick Payment cases between Vaginal and Cesarean delivery.	Will be addressed in addendum #1 to databook.
22	Cost Proposal Instructions and Data Book	22, 44, 66	Please review the cost per day calculation for the Maternity Kick Payment. Average hospital admission costs of approximately \$1,700 seem unusually low.	The average charge per day for the Maternity Kick Payment is consistent with current FFS payment levels.
23	Cost Proposal Instructions and Data Book	All Pages	Please provide additional subcategories to describe the "Prescription Drugs" service category. The subcategories should include multi-source brand, single-source brand, generic, and specialty.	Will be addressed in addendum #1 to databook.



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Nr.	Section	Page	Question	Answer
24	Cost Proposal Instructions and Data Book	All Pages	There is not a PMPM rate cell for newborn through 1 month; rather there is only the Newborn Kick Payment. Please confirm all costs associated with the 0 to 1 month of life are accounted for in the kick payment.	All costs incurred within the first two calendar months of life are included in the newborn kick payment. As an example, for a baby born any day in July the newborn kick payment includes services incurred in July and August. The first monthly capitation payment for a baby born in July would be made for September enrollment.
25	Cost Proposal Instructions and Data Book	All Pages	Please describe the methodology used to assign claims to the "Emergency Room" service category. Does this include all services on a claim with an ER revenue code? Does it include Urgent Care services? Does it include Radiology and Pathology services provided during the ER visit?	The Emergency Room service category only includes the Emergency Room visit as defined by revenue code 450, 451, 452, 456, and 459.
26	Cost Proposal Instructions and Data Book		What is the purpose of providing bid rates by "broad type of service"? How will this information be used in the evaluation process?	DHHS has not yet determined how this information will be used.
27	RFP	46	Are there any policies defining adequate coverage for out of network services or may the MCO establish their own payment policies for out of network service that leverage a default usual and customary fee schedule?	DHHS does not have policies defining adequate coverage for out of network services
28	RFP	46	What does NH Medicaid pay to non-par providers under its current system? Does the program negotiate with each provider or use a fee schedule.	DHHS currently requires non-participating providers to enroll before payment.
29	Cost Proposal Instructions and Data Book	17	Will the State of NH DHHS issue an addendum with Step II claims by Provider Type for CY2008, CY2009, and CY2010 that is specific to the established 10 Area Agency system in support of those with developmental disabilities (DD) and acquired brain disorders (ABD)? Will this data be available in the same format as the Mental Health Clinics outlined in Appendix D? Will summary reimbursement data be made available for DD/ABD services?	DHHS will be developing information, guidelines and criteria regarding the specialized services included in Step 2.
30	Cost Proposal Instructions and Data Book	3	Does DHHS blend the DD/ABD Step II rates in with the rest of the populations? Are these rates wrapped into the age categories and covered services?	DHHS will be developing information, guidelines and criteria regarding the specialized services included in Step 2.
31	Cost Proposal Instructions and Data Book	2	Under Rate Cell Definitions, it states that the bidder will be required to prepare a cost proposal for each of the 22 rate cells as detailed in Section III of this document." If a proposal is submitted for the support of a portion of the population for the New Hampshire Medicaid Care Management Program, will the state accept a cost proposal that is pertinent only to the impacted rate cells?	A bid that does not provide a cost proposal for all 22 rate cells will not be considered complete and will be disqualified.



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Nr.	Section	Page	Question	Answer
32	Cost Proposal Instructions and Data Book	5 & 6	Page 5 states that "Cost proposals are to be quoted on a per member basis by type of service for a full month of enrollment." How can Step II services be quoted when Step II long term care services are not defined in the "covered services?" The covered services contained in the Databook (page 6) use "claim type, service category information, as well as DRG, revenue codes and CPT-4 codes to summarize the historical fee for services claims for covered services into the categories shown in the databook." Is this available for Step II covered services?	DHHS will be developing information, guidelines and criteria regarding the specialized services included in Step 2.
33	Cost Proposal Instructions and Data Book	12	How will risk adjustment be conducted in year 3 of the contract?	The risk adjustment process for year 3 of the contract has not yet been determined.
34	Cost Proposal Instructions and Data Book		Please confirm the total number of disabled adults (non-dual/non-NF resident) enrolled in December 2010? Total count is 9,229 (2,581+2,516+4132=9,229)? Are any additional dual eligible's, disabled adults enrolled in services and if so, how many in December 2010?	Appendix B shows the most current enrollment information by rate cell.
35	Cost Proposal Instructions and Data Book		Can the state provide a key clearly clarifying definitions for all Aid Code Categories noted in the Databook?	Will be addressed in addendum #1 to databook.
36			Page 6 of the RFP states that "New Hampshire Medicaid spends an average of \$640 per month for each member". Our calculation per member per month cost of the CY 2010 Fee-For-Service claims in Appendix A of the Data Book is \$290.10. This includes the Newborn and Maternity Kick Payments. Why is there such a large discrepancy between these two numbers?	DHHS will be developing information, guidelines and criteria regarding the specialized services included in Step 2.
37	Data Book	-	Please clarify the reinsurance program referenced on the bottom of page 5 of the data book narrative.	If the bidder purchases reinsurance to protect it against potential losses, then both the expected reinsurance premium and reinsurance recoveries should be included in the cost proposal.
38	Data Book	-	Please explain how the risk scores were calculated for the SCHIP population, given the comment about data not being available. Were these scores calculated using CDPS+Rx? How were these scores adjusted for the difference in benefit packages between SCHIP and the Medicaid low income population?	Risk scores were developed using the 3M CRG system. Only members with more than 10 months of eligibility were included. No adjustments were made for benefit package.
39	Data Book	-	Please provide the steps that Milliman will follow to calculate the rate ranges. Also, values or ranges of adjustments (e.g., trends, non-medical load, future program changes) would be helpful.	Milliman is in the process of developing the actuarially sound rate ranges.
40	Data Book	-	Please clarify why no completion factors were given for the maternity/newborn kick payment categories	Will be addressed in addendum #1 to databook.



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Nr.	Section	Page	Question	Answer
41	Data Book	-	The NH Medicaid Annual Report states that an average 132,800 people were covered during SFY10. However the membership provided in the databook Appendix B only shows about an average of 114K members. Is the difference solely due to members who are not eligible for managed care?	Yes.
42	Data Book	-	Please confirm on Appendix F that the line that reads "cv" should say Eligibility Category: Low Income Children and Adults - Age 1-5 Years instead	The line that reads "cv" on Appendix F should say Eligibility Category: Low Income Children and Adults - Age 1-5 Years instead.
43	Data Book	-	Please clarify the "Unknown" categories for the provided Hospice claims in Appendix G. The "unknown" category comprises a large portion of the claims.	Will be addressed in addendum #1 to databook.
44	Data Book	-	Is it possible to get membership data through June 2011? (Hospice claims data is through June 2011 but membership data is through Dec 2010)	No.
45	Data Book	-	The risk scores provided for Healthy Kids Silver and LIFC show fewer average members scored than what the membership actually shows (particularly for Healthy Kids). Please clarify the requirements for a member to be included in the scoring process.	Only those members with more than 10 months of eligibility had risk scores calculated.
46	Data Book	-	Please clarify how rates effective on or after July 1, 2013 will be developed and negotiated with the health plans.	This methodology has not yet been determined.
47	Data Book	-	Please provide information on any large/catastrophic claims that were incurred in the historical data provided (CY 2008 – 2010)	Please refer to Appendix C for this information.
48	Cost Proposal Instructions and Data Book		Please clarify what portion of our Care Management services (care coordination, EPSDT, Utilization Management, etc), if any, can be categorized under the 85%/capitated rates as opposed to the other 15%/admin fee?	Benefit expenses should be accounted for under the capitation amount while administrative expenses that are not typically considered a medical benefit should be classified as administrative expenses.
49	Cost Proposal Instructions and Data Book		Please confirm it is DHHS's intent to have different PMPMs by age group for the MCO Administration line.	The cost proposal template allows MCOs to vary the administrative cost component of their bids by rate cell.
50	Cost Proposal Instructions and Data Book		Page seven of the RFP demonstrates that DHHS would like to achieve \$16M in savings out of the general fund. Can you clarify how the Department anticipates doing that through the rate setting exercise, i.e. negotiating capitated rates which are lower than 2011 PMPM costs? Is the \$16M in savings an annual amount or spread over the 36 month MCO contract life?	No
51	Cost Proposal Instructions and Data Book		What are the assumptions DHHS is making around moving the waiver services into a capitated rate in Step 2. For instance, how does it envision pricing the services and getting CMS approval for the increased cap rate?	DHHS will be developing information, guidelines and criteria regarding the specialized services included in Step 2.



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Nr.	Section	Page	Question	Answer
52	Cost Proposal Instructions and Data Book		Will DHHS consider giving MCOs credit for creating savings outside of mandatory covered services? Will DHHS consider savings generated from shifting costs from institutionalized long-term care to community-based long-term care (paid for by Medicare)?	No
53	Cost Proposal Instructions and Data Book		With respect to ROI, the savings we achieve are net of rebates. Will we have any role in negotiating rebates or access to the negotiating information that would help us identify other rebate opportunities?	MCOs will not have a role to play in negotiating rebates. The preferred drugs on the PDL provide guidance on drugs with supplemental rebates.
54	Cost Proposal Instructions and Data Book		Appendix A in the data book has breakouts by service and provider type. However, it is not clear whether MD psychiatrist services are included in physician services or under psychology.	Will be addressed in addendum #1 to databook.
55	Cost Proposal Instructions and Data Book		Please confirm that the MCO, or its Pharmacy Benefits Manager will we be responsible for psychotropic drugs.	The MCO will be responsible for all prescription drugs for its members.
56	Cost Proposal Instructions and Data Book		In Appendix C of data book, what does the annual cost of claims column represent?	The annual cost of claims represent the overall PMPM amount for individuals with a specified medical expense amount during a year.
57	Cost Proposal Instructions and Data Book		We've observed that in some areas they have seen some significant reductions in annual PMPMs Have there been many changes in benefits over the 3 year period that caused these reductions? Has DHHS made any changes in provider payments over the 3 year period that caused the reductions? Any changes in 2011 that we should be aware of when creating our pricing models?	Please refer to Appendices H and H1 for this information.
58	Cost Proposal Instructions and Data Book		Actuarial certification is required for the cost proposal and that the cost proposal is actuarially sound, however, is any certification required for the rates negotiated with providers?	An actuarial certification of provider negotiated rates is not required.
59	IV. Data Book Information	9	Can the State provide the average risk scores for each rating cell similar to Table 3 on page 9 of the Cost Proposal and Instructions and Data Book? Can you also confirm that national (CDPS + Rx) weights were used in the average score development and, if not, detail what adjustments were made?	This information is not currently available. The risk scores in Table 3 of page 9 of the data book were calculated by using the CRG risk adjuster by DHHS.



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Nr.	Section	Page	Question	Answer
60	RFP Section 2.1.2	17	Can the State confirm that the emergency room visit limit has not been applied to data book cost models? If the data book has been adjusted, can you provide details of the calculation of the value of this limit? If the adjustment has not be made can the State provide continuance tables for emergency room visits by rate cell?	No adjustments for benefit limits have been applied to the MMIS information in developing Appendix A. DHHS will not be making this data available for this process.
61	Appendix A. - C.	12 +	Can the State provide detailed pharmacy claims on a member-level basis or on NDC utilization data by rate cell?	No
62	II. Rate Cell Definitions	2	Please describe how "member opt outs" work?	To be provided with MCO Contract
63	II. Rate Cell Definitions	2	Will awards be given separately for the 22 rate cells across 11 eligibility categories, or will MCO awards be for all rate cells and categories?	MCO awards will be for all rate cells and categories.
64	II. Rate Cell Definitions	2	Please describe your process for "Auto eligible and assigned newborns"?	To be provided with MCO Contract
65	II. Rate Cell Definitions	3	Will MCOs need to maintain 11 separate rating classes consistent with the Rate Cell definitions, or will they be combined under fewer reporting entities?	To be provided with MCO Contract
66	II. Rate Cell Definitions	3	Please define "Non-NF resident"?	"Non-NF resident" refers to an individual who does not reside in a Nursing Facility.
67	III. Bidding Instructions	5	Please explain what "details by broad type of service" you wish MCOs to present? Will you accept narrative descriptions in a covering memorandum?	Please refer to the Cost Proposal worksheet included in Appendix I for the definitions of type of service for the cost proposal.
68	IV. Data Book Information	6	Will DHHS be computing premiums on a per member per month basis, or per member per day?	DHHS will develop capitation rates on a PMPM basis.
69	IV. Data Book Information	7	Please provide the calculations behind the adjustment to remove two months of claims and eligibility for Medicaid beneficiaries who are not newborns of mothers enrolled in an MCO?	The first two months of eligibility and claims for each individual were excluded in the study period from CY2007 through CY2010. This exclusion is only applied once regardless of breaks in eligibility.
70	IV. Data Book Information	8	What weighting percentages were used for the lag method vs the projection method? What was the annual trend assumed in the projection method portion of this calculation?	Due to the amount of runout, the completion factors were developed using the lag method.
71	IV. Data Book Information	10	Please define your use of the term "Crossover"?	Crossover claims are claims that were submitted to Medicare, adjudicated, and then submitted by Medicare to Medicaid for possible payment.
72	V. Risk Adjustment Process	11	Will an MCO's Adjusted Risk Factor be weighted by the length of time members have been eligible for a risk score? In other words, for members with risk scores, will a member who is in the program for three months have more weight than a member in the program for only one month?	An MCO's average risk score for a time period will reflect the length of enrollment for each member.
73	RFP Section 3, Statement of Work	58	Can the State provide any additional guidelines for non-emergency transportation benefits? For example, is there no benefit if alternate transportation is available or is the benefit limited to specific medical benefits (ie. dialysis), or required to be medically necessary?	Current process is reflected in administrative rules, He-M 500.



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Nr.	Section	Page	Question	Answer
74	IV. Data Book Information	6-7	Capitation payments assume payments are pro-rated based on days eligible during the month. Are member months in the data book similarly calculated, including only a partial member month for members without a full month of eligibility?	Member month counts were calculated from eligibility data files extracted from New Hampshire's MMIS system. Each day a beneficiary is eligible for Medicaid coverage is counted and months of eligibility are determined by dividing the total number of eligible days by 30.42.
75	Cost Proposal Template		Should care management services (e.g., case management, disease management) be classified as medical expenses or administration in the bid?	Benefit expenses should be accounted for under the capitation amount while administrative expenses that are not typically considered a medical benefit should be classified as administrative expenses.
76	III. Bidding Instructions	5	The RFP references that bids should be net of reinsurance. Is there a state reinsurance program? If so, can you provide the details? Was this accounted for in the data book?	New Hampshire does not have a state reinsurance program.
77	IV. Data Book Information	10	Cost proposal instructions indicate that Table 4 (pg 10) includes TPL collections not already captured in the MMIS system. Can the State provide total TPL collection percentages including those that are captured in MMIS?	All TPL recoveries (except accident and trauma) are included in Table 4 and are not included in Appendix A.
78	IV. Data Book Information	6-7	Can the State provide the pharmacy copay amounts? Does the State have any information regarding collection rates of pharmacy copays?	Brand drugs and compounds \$2.00, generic drugs \$1.00. The state does not have information on copayment collection.
79	IV. Data Book Information	7 Appendices	We are not aware of any geographic risk adjustments applied to rates. Is this correct?	DHHS will pay statewide capitation rates.
80	V. Risk Adjustment Process	11	Is the risk factor developed by the CDPS + Rx system the MCO Adjusted Risk Factor? Is it normalized to 1.0 for the entire population? Given that the factors are applied to varying base rates, will the end result be a revenue neutral exercise for the State? If so, how will this be done? Are there any modifications to standard risk scores in the system?	The detailed risk adjustment process is still under development. The risk adjustment process will use CDPS+Rx and will be revenue neutral to DHHS across the MCO and FFS populations. Cost proposals are to be quoted assuming a risk score of 1.00 for each rate cell, where a 1.00 risk score represents the average acuity of the population included in the data book.
81	V. Risk Adjustment Process	11 - 12	Are SED/SMI (severely emotionally disturbed/severely mentally ill) members part of this program?	Yes
82	V. Risk Adjustment Process	11 - 12	Will the risk factors be normalized for each eligibility category and the age/gender categories within them?	The detailed risk adjustment process is still under development. The final risk adjustment process will be developed so as to appropriately address age/gender rate cell issues.
83	V. Risk Adjustment Process	11 - 12	Does the MCO capitation rate calculation include any adjustment factor for the county/state region in which the member lives?	DHHS will pay statewide capitation rates.
84	V. Risk Adjustment Process	11 - 12	Is the Base Capitation Rate in the risk adjustment process to be calculated on a daily rate or a monthly rate?	The capitation rates will be developed on a per member per month basis.



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85			Will the Data book be available in an Excel format?	Excel files are available from DHHS via email.
86		7	Please explain why 2 months of claims and eligibility data were removed rather than 1 month. Does DHHS' eligibility evaluation process take more than 1 month?	DHHS eligibility data does not retain information that can be used to directly identify retroactive enrollment periods. Retroactive eligibility periods can extend for several months, so using a one month exclusion would understate the retroactive enrollment period.
87		Databook	The monthly enrollment seems to vary significantly from one month to the next. Often there will be a decrease one month and an increase close to the decrease the next. Is there an explanation for this oscillation in enrollment?	Appendix B shows the most current enrollment information.
88		Databook	There appears to be some errors in the Claim Probability Distributions. The CY2010 data for Low Income Children and Adults shows \$5,000 in Average Annual Claim Costs for 8 member months when the cost corridor is >\$549,999.99. There is a similar issue in the CPD for CY2009 Severely Disabled Children \$553,295.00 average claim within the \$500,000-\$549,999.99 cost corridor). Another is in the CY2009 & CY2010 Disabled Adults CPDs: there are 12 member months but no claims in CY2009 and 22 member months but no claims in CY2010 in the >\$549,999.99 cost corridor.	Some errors in the Claims Probability Distributions have been corrected. Please refer to the data book addendum for the revised CPDs.
89		Databook	Would you please provide the formula for the "Annual Cost of Claims"? We cannot re-produce the values from the data given.	The annual cost of claims is calculated as the total cost, times the frequency, times twelve, divided by the member months. The number of individuals in each cost corridor is not shown. With this information you would be able to recreate the annual cost of claims.
90		Databook	Appendix E contains completion factors for each rating group except the newborn and maternity kick claims. Were these omitted in error? If not, which eligibility group's completion factors should be used to complete the newborn and maternity kick claims?	Will be addressed in addendum #1 to databook.
91		N/A	If the bidding entity has other business, does the financial reporting, including the audit, need to segregate the financial results from this contract?	In regards to the proposal refer to Section 6.8 of the RFP. Reporting requirements to be provided with MCO Contract
92		Databook	A new "Diabetic Supply Program" was added in February 2011. Could DHHS please provide a detailed description of this program? Define impact on cost.	NH Medicaid contracted with Magellan Health Services, its PBA, to manage a NH Medicaid diabetic supplies program through the point of sale at pharmacies. For this initiative, Magellan Medicaid Administration has retained two companies – Abbott Diabetes Care, Inc. and Roche Diagnostics Corporation – to be preferred providers of blood glucose monitors and strips effective January 3, 2011. This program applies to all NH Medicaid recipients without other insurance or Medicare coverage. New monitors, if needed, were also supplied. The NH Medicaid program has to date billed \$513,959 and collected \$305,157 in rebates for the diabetic supply program.
93		Databook	Are the Maternity and Newborn Kick claims included in the Claims Probability Distributions? If yes, how?	The Maternity and Newborn Kicker claims are not included in the Claims Probability Distributions.



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94		Databook	Could DHHS provide a detailed description of the service limits imposed on nursing home and waiver recipients?	DHHS will be developing information, guidelines and criteria regarding the specialized services included in Step 2.
95		35	If pharmacy claims are paid through a different claims platform than medical claims, describe how third-party liability information is coordinated and shared. Is DHHS looking for other health insurance only (basically COB info)?	MCO's are expected to coordinate their own TPL activities for their members
96			Appendix H of the cost proposal notes that chiropractic benefits were eliminated as of January 2010. Please provide the historical chiropractic costs from 2008 through 2010 by rate cell (or confirmation that chiropractic costs were not included in the historical data book summaries).	The chiropractic costs were not included in the data book.
97			Podiatry services are subject to a 12 visit limit per fiscal year effective July 2010. Has DHHS determined the estimated impact of this benefit change? Alternatively, can DHHS provide a historical distribution of podiatry visits so that we can estimate the impact of the benefit change on podiatry utilization?	DHHS will not be making this data available for this process.
98			Pharmacy costs are based on Wholesale Acquisition Cost (WAC) as of December 2010. What was the aggregate impact of the pricing methodology change on prescription drug unit costs?	DHHS will not be making this data available for this process.
99			The 18 visit limit on physician services was removed effective October 2011. Can DHHS provide a historical distribution of physician services so that we can estimate the impact of this benefit change on physician utilization?	DHHS will not be making this data available for this process.
100			Emergency room department (ED) visits are subject to a 4 visit limit per fiscal year and other outpatient services are subject to an 8 visit limit per fiscal year effective January 2012. Can DHHS provide a historical distribution of ED and other hospital outpatient services so we can estimate the impact of these benefit changes on hospital outpatient utilization?	DHHS will not be making this data available for this process.
101			What were the effective dates of the SFY 2008 reimbursement rate changes listed?	All changes occurred prior to CY2008
102			There are several service categories for which the SFY 2008 reimbursement rate changes impact some, but not all, procedure codes within the category. What was the overall impact of the rate changes on each service category since these rate increases were later rolled back effective April 2010?  a. Wheelchair van services (six codes increased by 2%) b. Adult medical daycare (two codes increased by 2%) c. Physician services (18 codes increased by varying percentages) d. Medical support / equipment (various codes with different rate change percentages)	DHHS will not be making this data available for this process.
103			Inpatient DRG rates for SFY 2009 were decreased by 10% for five groups. What was the overall impact of these rate changes on total hospital inpatient costs (i.e., what percentage did these five groups represent of total hospital inpatient costs)?	DHHS will not be making this data available for this process.
104			The FQHC / RHC encounter rate changes effective April 2009 vary from 1.6% (\$156.16 vs. \$158.66) to 6.5% (\$72.18 vs. \$76.84). What was the aggregate impact of these rate changes on FQHC / RHC costs?	DHHS will not be making this data available for this process.



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Nr.	Section	Page	Question	Answer
105			There are many significant reimbursement rate changes effective in SFY 2010 listed in Appendix H. What was the aggregate impact of each of these changes for each of the service categories shown in Appendix A? For example: a. Diagnostic lab set to 60% of Medicare b. Physician / professional services set to 80% of Medicare c. Set surgical assistance to 20% of physician rates and disallowed for some codes d. Suspension of inpatient outlier payments e. Shift from cost-based to fee schedule based reimbursement for outpatient hospitals for imaging, therapies, and physician services f. Reduced rates for various mental health center services	DHHS will not be making this data available for this process.
106	Databook(IV Data Book Information)	Page 7	Per pg 34 of the RFP, DHHS will be responsible for collecting pharmacy rebates, "In accordance with changes to rebate collection processes in the Patient Protection and Affordable Care Act (PPACA), DHHS will be responsible for collecting OBRA 90 rebates from drug manufacturers on MCO pharmacy claims. The MCO shall provide all necessary pharmacy encounter data to the State to support the rebate billing process." Please verify that the MCOs will not be collecting the rebate.	DHHS will collect OBRA rebates on MCO pharmacy claims.
107			In addition, please verify all MCOs will have the same pharmacy formulary. Thus, there will be no difference in the rebate amounts DHHS collects due to different formularies.	Same
108			Since the MCOs will not be responsible for collecting the pharmacy rebates, there is no need for the MCO rate bids to reflect pharmacy bids. Correct? If not correct, please explain why?	To the extent that MCOs are able to negotiate supplemental rebates in addition to the rebates that DHHS will collect, MCOs should reflect these supplemental rebates in their cost proposals.
109	Databook(IV Data Book Information)	Pg 7	Milliman estimated the impact of the retroactive exposure. Please provide the methodology and the data used.	We excluded the first two months of eligibility and claims for each individual in the study period from CY2007 through CY2010. This exclusion is only applied once regardless of breaks in eligibility.
110	Databook(IV Data Book Information)	Pg 10	What does "IP Crossover" refer to in Table 4? What does "Not Matched To TCN" refer to in Table 4? Why is this information broken out separately on Table 4?	"Not matched to TCN" are for recoveries not linked to a specific claim ID. Crossover claims are claims that were submitted to Medicare, adjudicated, and then submitted by Medicare to Medicaid for possible payment.
111	Databook	Appendix B	Please provide a recent snap shot of the number of members or current membership by rate cell.	DHHS will not be making this data available for this process.
112	Databook	Appendix B & G	Exhibit G provides hospice claims data through June 2011. However, Appendix B only includes membership counts through Dec 2010. Please provide monthly membership counts by rate cell (as presented in Appendix B) for January 2011 to June 2011. What time period was the Hospice claims paid through? Please provide appropriate completion factors for the Hospice data.	DHHS will not be making this data available for this process.
113	Databook	Appendix B	Please provide projections of SFY12 and SFY13 Medicaid eligible membership by rate cell. If this is not available, please provide the projected membership by Medicaid eligibility category.	DHHS will not be making this data available for this process.



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Nr.	Section	Page	Question	Answer
114	Databook(III Bidding Instructions)	Pg 5)	Pg 5 states that "Pricing proposals are effective for year one of the program (July 1, 2012 – June 30, 2013)". If this is the case, how will the SFY14 rates be determined?	The methodology to develop the SFY14 capitation rates has not yet been determined.
115	Databook	Appendix A	There appears to be a significant decrease in the average cost per service reimbursement for Inpatient psychiatric and outpatient radiology from CY09 to CY10 in the Appendix A exhibits. Please clarify the reason for these decreases.	Please refer to Appendix H and H1.
116	Databook(IV Data Book Information)	Pg 7	Please provide the prescription drug copayments by eligibility category and the effective dates for 2008, 2009, and 2010. Please provide any projected changes to these copayments for SFY13 and SFY14.	Brand drugs and compounds \$2.00, generic drugs \$1.00. The state does not have information on copayment collection. No changes are planned for FFS.
117	Databook(IV Data Book Information)	Pg 7	Please provide any copayments (besides prescription drug) by eligibility category and the effective dates for 2008, 2009, 2010. Please provide any projected changes to these copayments for SFY2013 and SFY14.	There are no-copays outside of pharmacy.
118			Please provide the impact on underlying util/1000, average cost per service, and PMPM of each Databook service category for each rate cells in Appendix A for 2008, 2009 and 2010 for each of the items listed in Appendix H.	DHHS will not be making this data available for this process.
119			Please provide the detailed utilization, unit cost and PMPM cost adjustments used in developing the rate ranges submitted to CMS.	This information is not currently available. Milliman is in the process of developing the actuarially sound rate ranges.
120			Examples (this is not an all-inclusive list) of benefit changes that do not have underlying data clearly communicated include: <ol style="list-style-type: none"> <li>1. January 2010: eliminated the chiropractic benefit. However, the amount and the service category that the 2008 and 2009 chiropractic benefit costs are included in Appendix A are not disclosed.</li> <li>2. February 2011: Added diabetic Supply program: There is no information on how much this will add to the PMPM cost or which service category that it will contribute to.</li> <li>3. ER visits limited to 4 per year starting in July 2012. There is no information on how much this will impact the utilization rate, average unit cost or PMPM cost or which service category that it will contribute to (Hospital Outpatient Emergency Room and which Professional service categories?).</li> </ol>	<p>The chiropractic costs were not included in the data book.</p> <p>DHHS will not be making this data available for this process.</p> <p>DHHS will not be making this data available for this process.</p>
121	Databook	Appendix H	The changes in the Medicaid cost reimbursements described in Appendix H are important, but of little value without the impact on underlying util/1000, average cost per service, and PMPM of each Data book service category for each rate cells in Appendix A.	DHHS will not be making this data available for this process.
122			Please provide the underlying util/1000, average cost per service, and PMPM of each Data book service category for each rate cells in Appendix A for 2008, 2009 and 2010 for each of the items listed in Appendix H.	DHHS will not be making this data available for this process.
123			Please provide the detailed average unit cost and PMPM cost adjustments used in developing the rate ranges submitted to CMS.	This information is not currently available. Milliman is in the process of developing the actuarially sound rate ranges.



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Nr.	Section	Page	Question	Answer
124			<p>Examples (this is not an all-inclusive list) of reimbursement changes that do not have underlying data clearly communicated include:</p> <ol style="list-style-type: none"> <li>1. Hearing Aid Increases as of 10/1/08 from \$0 to \$1275.00. There is no line item for Hearing Aids and the change in reimbursement level seems to indicate a new benefit was added. What service category is this adjustment included in?</li> <li>2. On page 3, high-level descriptions of Inpatient and Outpatient hospital changes are listed, but no percentage change impacts for the average cost per service or PMPM is provided. Please provide the detailed impacts.</li> </ol>	<p>Hearing aids are included in the DME service category.</p> <p>DHHS will not be making this data available for this process.</p>
125	Databook	Appendix A	Please provide an electronic data file in a text-delimited or other standard format (not pdf) for the detailed claims data and membership information that was used to develop Appendixes A and B.	DHHS will not supply detailed claims and eligibility data.
126	Databook	Appendix A	What type of claims are in the Inpatient other category (and the outpatient other category)? Please provide a high-level description (e.g. SNF, Nursing Care) and specify the coding process (e.g. specific DRGs, Rev codes with descriptions).	More detail regarding the categorization of hospital inpatient and hospital outpatient services by DRG and revenue code is included in the addendum to the data book.
127	Databook	Appendix A	Please provide a breakout of Physician claims by PCP and Specialist by rate cell for 2008, 2009 and 2010.	Will be addressed in addendum #1 to databook.
128	Databook	Appendix A	Please provide a breakout of pharmacy claims and utilization by brand and generic drugs by rate cell for 2008, 2009, 2010.	Will be addressed in addendum #1 to databook.
129			Describe how "opt-outs" work	To be provided with MCO Contract
130			The Cost Proposal states that the Cost Proposal Template must be used. Does it need to be in Excel or can it be PDF?	The cost proposal template must be provided in Excel.
131			Can we provide a letter of intent from providers rather than a contract?	A signed letter of intent is sufficient for inclusion in the proposal.
132			Who developed the removal of the 2 months of data (the exclusion) to account for retroactive eligibility? Was this Milliman or the state?	Milliman suggested the two month exclusion as an assumption since retroactive eligibility periods are not identifiable in DHHS eligibility data.
133			Does Table 4 p. 10 TPL include accident and trauma or does it exclude it?	Table 4 is exclusive of accident and trauma recoveries.
134			Please describe what is included in the inpatient and outpatient hospital "other" rows in Appendix A?	More detail regarding the categorization of hospital inpatient and hospital outpatient services by DRG and revenue code is included in the addendum to the data book.
135			Describe the units used in Appendix A – are they cases, visits, procedures, or ....?	Will be addressed in addendum #1 to databook.
136			Question on risk adjustment with respect to rate cells in the buckets underneath the 2-11 months and the 1-5 year old low income children – how will you make sure you don't double count?	The detailed risk adjustment process is still under development. The final risk adjustment process will be developed so as to appropriately address age/gender rate cell issues.
137			Please provide a more detailed description of the American Academy of Pediatrics fluoride and oral exam benefit.	Will be addressed in addendum #1 to databook.



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Nr.	Section	Page	Question	Answer
138			For CY '10 through FY '13, please describe aggregate impact of the benefit and reimbursement changes that have taken place or are expected to take place by rate cell and Category of Service.	DHHS will not be making this data available for this process.
139			Will Milliman be doing the actuarial certification that goes to CMS?	Yes
140			Can you provide the rate ranges?	DHHS will not provide the actuarially sound capitation rate ranges at this time.
141			On p. 100, the Maternity Kick Payment says all maternity services are included, including prenatal care. However, the databook and (today's) presentation states that prenatal care is excluded. Please clarify what the "ruling language" is here.	Prenatal care is excluded from the maternity kick payment.
142			Page 5 of the databook states that the pricing proposal is effective for Year 1 (FY '13). How will the FY '14 rates be set?	The methodology to develop the SFY14 capitation rates has not yet been determined.
143			With regard to risk adjustment, typically rates are identical and you adjust from a common base rate. Sounds like different MCOs will have different rates. How will you take that into account together with the multiplicative aspects of that process?	An MCO's risk adjustment factors will be applied to that MCO's final capitation rates.
144			Can you provide a recent snapshot of members by rate cell? You have provided through 2010 but not data from 2011 – we're just asking for an update/more current experience.	DHHS will not be making this data available for this process.
145			Can you provide – for prescription drugs – detail by brand, generic, and psychotropic by rate cell?	Please refer to the data book addendum for more detailed categorization of prescription drug services.
146			Risk adjustment is typically cost-neutral to the state in that it is used to apportion capitation revenue between the MCOs. Could you reiterate your prior statement about FFS being included and how that would affect the overall funding?	The detailed risk adjustment process is still under development. The risk adjustment process will use CDPS+Rx and will be revenue neutral to DHHS across the MCO and FFS populations. Cost proposals are to be quoted assuming a risk score of 1.00 for each rate cell, where a 1.00 risk score represents the average acuity of the population included in the data book.
147			If an MCO submits a proposal where the blended rate is below Milliman's lower bound of the rate range, how will Milliman assess if the MCO's rate is truly viable?	Milliman will compare cost proposals to the actuarially sound rate range and review the actuarial certification and memorandum.
148			Confirm that all out-of-state services are included in the databook.	All covered services are in the data book, whether provided by New Hampshire providers or out-of-state providers.
149			Can you provide us with the methodology you used to come up with the rate range that you will send to CMS?	This information is not currently available. Milliman is in the process of developing the actuarially sound rate ranges.
150			If a MCO submits a [cost] proposal with a rate range below Milliman's range, how will Milliman assess if the rate is truly viable?	Milliman will compare cost proposals to the actuarially sound rate range and review the actuarial certification and memorandum.



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Nr.	Section	Page	Question	Answer
151			The databook information is gross of rebates but the Cost Proposal instructions say net of rebates.	To the extent that MCOs are able to negotiate supplemental rebates in addition to the rebates that DHHS will collect, MCOs should reflect these supplemental rebates in their cost proposals.
152			However, we understand that the state will collect all rebates.	DHHS will collect OBRA rebates on MCO pharmacy claims. To the extent that MCOs are able to negotiate supplemental rebates in addition to the rebates that DHHS will collect, MCOs should reflect these supplemental rebates in their cost proposals.
153			How has the state worked with Milliman to ensure that all supplemental payments made outside of the claims system are included in the databook?	DHHS and Milliman reviewed all claims data and non-system payments to develop the data book.