

## Answers to Inquiry Number 23997

1. Current health needs assessment requirements are stated in the last bullet of Section 4.4C.3.
  - Choice counseling must also assist potential enrollees in choosing the MCP that best meets their health care needs; it includes:
    - o Existing health care provider relationships;
    - o Special health care needs;
    - o The managed care panel that contains primary care provider(s) and/or specialist(s) to meet potential enrollees health care needs;
    - o Scheduled surgeries, treatments, or pregnancies; and,
    - o Additional benefits that an MCP might provide such as transportation, annual eye exams for adults, gift certificates for obtaining prenatal care, etc.
2. The hours stated refer to this RFP only.
3. No. Re-enrollments are generally the result of a loss of eligibility and regaining eligibility within 60 days. Once consumers regain eligibility, the States system (MITS) will automatically re-enroll the consumer in the same MCP. If the consumer regains eligibility after 60 days, MITS will re-issue an enrollment notice requiring the consumer to select an MCP. It then becomes the Hotline's responsibility to enroll the consumer following normal enrollment procedures delineated in 4.4,C.
4. This information is obtained from the callers to assist in managed care selection and inform MCPs of existing health care needs. This information would subsequently be placed on the consumer contact record (CCR) to the MCP's as shown in Appendix B, Managed Care CCR Format. The information in Appendix A is obtained from the consumer when the consumer requests a just cause or managed care exception (refer to Appendices O and P and 4.4.,J and K.
5. November is Ohio's single annual time period for open enrollment. MITS generates an open enrollment notice 60 days prior to the open enrollment month (i.e., August) as federally required to inform consumers of the upcoming open enrollment month. Consumers must wait until November's open enrollment to make any managed care change requests.
6. This should reference 4.4.,C.3.
7. No. Face-to-face outreach activity is not part of this RFP.
8. Yes, the call volume provided in Appendix M includes the outbound reminder calls to avoid auto assignment.

9. Appendix B., Managed Care CCR Format, is used to provider all managed care consumer contact data to MITS and the managed care plans. At this time, this file is only for managed care data. There are plans to also transfer all non-managed care related data to MITS, but it is unknown when this will be implemented. Appendix E, Hotline MCP Enrollment to MITS, provides all managed care reenrollment data to MITS.
10. The 4th bullet under 4.4,E.4 refers to the managed care consumer contact record (CCR) referenced in Appendix B. This is the managed care contact data sent daily to the MCPs (and ODJFS). Appendix H., Premium File Layouts, is related to the last bullet under 4.4,E.4 which describes the files of premium data exchanged between CRIS-E and the vendor.
11.
  - a. Yes
  - b. A template of the invoice will be added as an Appendix, as well as list of invoices messages that must be added to individual invoices based on the payment status. Please note, the ODJFS logo, which, must be printed on each invoice, does not appear on the invoice.
12. A template of the premium letter will be added as an Appendix. However, currently the letter is not used.
13. There is not a required format. However, the vendor must submit reconciliation, non-postable, and refund reports every Tuesday and Thursday.
  - Reconciliation reports must include a summary of the amount received for each day prior the report and detail of the amount received for each case.
  - Refund reports must include the case, category, and sequence number, the date the payment was received and a copy of the payment (check or money order) to be refunded.
  - Non-postables must include a copy of the payment received (check or money order).
14. The items to be mailed by the vendor are listed in Appendix N. There is not a comprehensive list of all ODJFS mailings, however, the Hotline is listed on all Medicaid related CRISE notices, applications, and publications.
15. The vendor must have the ability to assist callers complete their application, for example populating demographic data into the application. On average, 19 applications per month are partially completed by the call center before mailing to the caller.
16.
  - a. The pathway code refers to the process ODJFS uses to determine which MCP best fits a consumer's health care utilization pattern. It takes into account such things as prior provider and managed care utilization history. If this history matches an MCP or MCP provider panel then the consumer is assigned to that MCP. The vendor is NOT responsible in

making this determination. The assignment utilization file contains all managed care eligible individuals not currently enrolled in an MCP and has the recommended MCP the consumer is to be assigned to. The pathway code is to be included on the CCR and a further explanation of the pathway codes are in Appendix C, Assignment Code Table, within the Managed Care CCR Format (Appendix B of the RFP).

- b. Item E – This is called discretionary assignments. ODJFS provides a Word document to the Hotline of all MCPs currently able to receive an assignment within the applicable region and county. ODJFS develops this list based on MCP membership thresholds and MCP provider panel capacities. The Hotline then assigns consumers to MCPs permitted to accept discretionary assignments in a round robin manner. The discretionary assignment algorithm is only for those consumers not existing on the AUF. Discretionary assignments represent approximately 50% of all assignments.
  - c. Item G should reference 4.4.E.4.bullet 5 and Appendix E, Hotline MCP Enrollment to MITS.
  - d. Item H should reference 4.4.E.4. bullet 4 and Appendix B, Managed Care CCR Format.
17. Auto disenrollments and re-enrollments are processed by the State.
18. The premium file only includes consumers who are required to play a premium. The premium file contains that data that the vendor uses to build their premium collection system and account records. The premium file does not tell the vendor who needs a refund.
19. That is a typo, the actual number is 1,501.
20. The increase was due to “pharmacy carve-out”. Medicaid fee-for-service began managed care plans lost their contract with ODJFS and subsequently all of their members had to change plans.
21. Approximately 900 per month.