

Technical Proposal Question & Answer- #2

Issued on: October 4, 2013

For Request for Proposals RFP-MQD-2014-005

QUEST Integration (QI) Managed Care to Cover Eligible Medicaid and Other Eligible Individuals

Question #	RFP Section #	RFP Page #	Para #	Question	Answer
1	30.900	103	1	Members are able to receive LTSS through completion of the 1147/1148 process. Please clarify when it would be necessary to complete the ADRC process for these members? Is there still a need to complete the 1147/1148 and ADRC for members who are already SHCN? If yes, how will we be able to tell (from the 834) that a member is already deemed disabled?	Health plans shall complete the ADRC process for all members that require LTSS. Individuals who require LTSS need to go through a second eligibility determination process for long-term care. The eligibility worker needs an approved ADRC, approved 1147, and an 1148 to complete the long-term care eligibility determination.
2	31.200	107	Last	Are attachments to policy memorandums also considered memorandums? For example, if a new reporting template with instructions or requirements different from the RFP is attached to a memo; are those instructions considered equivalent to a contract amendment?	Policy memoranda are not contract amendments. However, health plans shall comply with all requirements of the policy memorandum as described in Section 31.200. In the example provided, health plans would use the new reporting template, even if different from the RFP.
3	40.220	117-118	First paragraph, tenth bullet item	Section 40.220 requires that at a minimum, the network shall include the following medical care providers: Licensed dietitians.	Licensed dietitians are not a required provider for proposal submission in Section 80.315.2. Therefore, neither executed contracts nor letters of intent are required

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			in section.	Will a Letter of Agreement/Intent be acceptable for this new provider type until more guidelines about benefits and rates are released?	for proposal submission for this provider type.
4	40.250	126	1 <sup>st</sup> full paragraph	<p>The RFP requires that the health plan maintain a PCP-to-member ratio of 'less than or equal to 1 to 300'.</p> <p>Is this a ratio that is being applied at the health plan level or is this a limit that should be applied down to the individual PCP that would limit any individual PCP to no more than 300 assigned members?</p>	<p>The RFP requires that "The health plan shall monitor the number of members that are assigned to <u>each</u> PCP..." and "The health plan may <u>not</u> restrict their members from choosing <u>a PCP who reaches</u> the 1:300 ratio."</p> <p>This ratio is applied at the individual PCP level.</p>
5	40.920.2	244	2	Will DHS "grandfather" current non-NFLOC members who are receiving the listed HCBS services if they do not meet the "at risk" criteria?	The current QExA health plans determine which members, who do not meet NFLOC, are eligible for chore services. DHS expects that individuals eligible for chore services are those for whom the services help prevent decline to NF LOC or reduce more costly services utilization. DHS anticipates that the health plans will continue to provide such services. DHS will allow health plans to provide HCBS to any members that are receiving "at risk" services and continue to need them.
6	50.250	275	1 <sup>st</sup> Paragraph	The RFP states that the health plan is responsible for submitting form 1179 if/when health plan has access to first	If a newborn has already been enrolled into their mother's health plan, then the health plan does not need to submit a DHS 1179 to

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				<p>name of newborn or within 30 days of birth, whichever is sooner. Or submit first name as BB or BG at 30 days and then an additional form 1179 upon receipt of child's first name.</p> <p>According to Application Simplification Workgroup notes dated 9/26/2011, it was determined that the health plan would only submit the 1179 after the 31<sup>st</sup> day from DOB if the newborn had not been enrolled into the mother's health plan. (Attached are the meeting notes. See page 2, 7<sup>th</sup> bullet)</p> <p>Please clarify.</p>	<p>add the newborn.</p> <p>However, if the newborn is not added to the mother's health plan when they receive the babies name (or within 30 days of birth), then the health plan shall submit the DHS 1179 to add the newborn.</p>
7	50.455	290	1 <sup>st</sup> Paragraph	<p>The RFP states that 'The VOS shall include a summary of claim(s) or explanation of benefits for the month prior to mailing' and that the services should at least be forty-five (45) days after the claim was submitted.</p> <p>Please clarify which criteria should be followed for service identification.</p> <p>If the health plan follows the month prior to mailing criteria, should the services be</p>	<ol style="list-style-type: none"> <li>1. Health plans shall review healthcare service claims submitted the month prior. Of all claims submitted, health plans shall randomly select 25% of the members.</li> <li>2. The VOS should be selected based upon claim submission (or receipt) date, not service date.</li> <li>3. Health plans can choose if they want to only include paid claims or all claims.</li> </ol>

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				<p>selected based on service dates during the prior month or paid dates during the prior month?</p> <p>If the health plan follows the ‘at least forty-five days after the claim was submitted’ criteria, should the services be selected based on claim receipt date?</p> <p>Should the health plan only report paid claims in the VOS document?</p>	
8	50.490	295	Last	For clarification please provide more details in regards to the definition of an EOB (Explanation of Benefits). Is there a model template that can be provided?	An explanation of benefits (EOB) is information provided to the member that explains what healthcare services were paid (or denied) on their behalf. DHS does not have a model template for an EOB.
9	50.490	295	Last	Please provide what fields are required for the prior authorization requirement on the member portal.	The DHS will address this type of question with health plans that have been awarded contracts during readiness review.
10	50.490	295	Last	How far back do we need to provide historical prior authorization data?	Health plans shall maintain any open prior authorizations. Health plans may propose how long they want to maintain denied prior authorizations during readiness review.
11	50.490	296	First	Besides address changes, what additional demographic changes should members be able to request on the member portal?	Health plans may include change in telephone number as well.

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12	51.410	362	Table	Can DHS provide the vision and/or division of labor for having two separate Administrators for the LTSS and non-LTSS members?	<p>The Administrator of LTSS members would be responsible for assuring that all LTSS requirements are met to include but not limited to Section 40.800, 40.900, and Appendix L. Because LTSS are not traditional healthcare services, DHS is requiring that health plans provide leadership with subject matter expertise to meet the unique requirements of individuals receiving these services.</p> <p>The Administrator of non-LTSS is responsible for managing members in the health plan who are receiving more traditional healthcare services.</p>
13	60.400	427	2	What format and frequency does the state want us to report the TPL recoveries we are not pursuing due to non-cost-effectiveness.	In a written format determined by the health plan as frequently as this situation occurs.
14	60.400	427	2	Does the state want us to report TPL recoveries that are not recovered for reasons other than it was not cost effective?	Yes.
15	80.315.2	481	Table	<p>The heading for the last column on the right has 'Accepting new QUEST Integration members (Y/N)?'.</p> <p>The column heading in the table for</p>	DHS will maintain both tables as the RFP was issued. In addition, see answer to question #22.

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				<p>section 80.513.4, page 486, has a column heading of ‘Accepting new QUEST Integration members without any limitations’.</p> <p>Should the column headings have the same description in both tables?</p>	
16	80.315.2	481	Table	<p>Can an applicant add more columns to the table for easier presentation?</p> <p>Additional columns are <b>bolded</b>.</p> <p>Table headings would be ‘Provider Type’, ‘<b>Specialty</b>’, ‘Island/County (for Oahu include the City)’, ‘<b>Affiliated clinic if applicable</b>’, ‘Provider Name (Last name, First name, Middle Initial)’, ‘Accepting new QUEST Integration members (Y/N)?’</p>	No. Please only use the tables that DHS has identified in the RFP.
17	80.315.2	482	1	<p>The RFP states that ‘The applicant shall list each provider once’.</p> <p>For consistency of provider counts between the provider lists and the count of providers in the Provider Maps in section 80.315.4, should the applicant follow the same guidance that was provided in section 80.315.4 which is to</p>	Yes.

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				list up to 1 location per island when a provider has multiple offices? (e.g. If a provider practices on Oahu and Maui then to list both locations)	
18	80.315.2	483	2	<p>For clarification on the presentation of a clinic within the provider list, the RFP states ‘For clinics serving in the capacity of a PCP, list the clinic and under the clinic name, identify each specific provider (e.g., physician, nurse practitioner, etc.).’</p> <p>If a clinic has 5 PCPs, the provider list would contain 6 records (1 record for the clinic and 5 records for the individual PCPs). Is this correct?</p>	Yes.
19	80.315.3	486	Last Paragraph	<p>Which of the following is acceptable to meet the RFP electronic provider list requirement?</p> <ul style="list-style-type: none"> <li>• Submit a single Excel file all providers, all providers listed in a single tab</li> <li>• Submit a separate Excel file for each provider type</li> <li>• Submit a single Excel file with each provider type presented separately within a worksheet tab of the file</li> </ul>	The RFP does not provide specific guidance on the format of the Excel file; however, providing DHS with a single Excel file with each provider type presented separately within a worksheet tab of the file would be our preference.
20	80.315.4	484	Last Paragraph	Which of the following is acceptable to meet the RFP electronic provider list	The RFP does not provide specific guidance on the format of the Excel file; however,

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				<p>requirement?</p> <ul style="list-style-type: none"> <li>•Submit a single Excel file containing all providers, all providers listed in a single tab</li> <li>•Submit a separate Excel file for each provider type</li> <li>•Submit a single Excel file with each provider type presented separately within a worksheet tab of the file</li> </ul>	<p>providing DHS with a single Excel file with each provider type presented separately within a worksheet tab of the file would be our preference. Also, section 80.315.4 does not have a requirement of submission of an electronic file of providers. This requirement is only found in Sections 80.315.2 and 80.315.3.</p>
21	80.315.4	486	Bottom of page	<p>The RFP states that ‘The applicant shall submit a separate map of each of the provider-types listed above....’</p> <p>Should the applicant consolidate/group all the LTSS provider types together (adult day care facilities through specialized medical equipment and supply providers) and then plot all of those providers on the LTSS map without any distinction by provider type?</p>	<p>Yes.</p>
22	80.315.4	487	2	<p>The RFP notes that an applicant is to submit a geo access map for all contracted providers and one for contracted providers who are accepting new QUEST Integration members “without any limitations”. Please provide clarification on the criteria</p>	<p>DHS defines that “without any limitations” is a provider that will accept any new patient. Health plans should use the same criteria for “without any limitations” to the “Y/N indicator” for accepting new patients. Health plans shall not include age or gender specific providers (i.e., pediatricians,</p>

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				<p>for determining ‘without any limitations’.</p> <p>Which limitations should an applicant take into consideration for excluding providers or is this just a ‘Y/N’ indicator for reporting whether the provider is accepting new patients?</p> <p>If it is more than just ‘Y/N’ for accepting new patients, can the health plan assume that these limitations do not include age (pediatrician) or gender (OB/GYN)?</p>	<p>OB/GYN, geriatrician, etc.) in the “without any limitations” column.</p>
23	80.320.4.C	491	Top of page 491, section “C”.	<p>In question 80.320.4.C the RFP requires that the "applicant shall provide a description of their processes (supported by statistics from its largest Medicaid contract)..." Is it the State's intent that applicants submit EPSDT supporting data from their largest plan in Hawaii (QUEST or QExA) or from any state in which the organization has a Medicaid contract?</p>	<p>Applicants should provide Hawaii specific data (if they have this information) in responding to questions in the proposal since this is a State of Hawaii contract. However, if an applicant has information outside of the State of Hawaii that would support their proposal, they should include this. Please note that the evaluation criteria for this question (see Section 100.530) is specific to implementation of Hawaii’s EPSDT plan.</p>
24	Appendix D	D-24	Question number nine	<p>Please confirm that the State is only looking for Hawaii-based information?</p>	<p>No. The request is not limited to Hawaii-based information.</p>