

Amendment #9
Issued on: July 26, 2006

Request for Proposal RFP-MQD-2007-002
QUEST Managed Care Plans to Cover Medicaid and Other Eligible Individuals Who Are Not Aged, Blind, or Disabled

#	RFP Section #	RFP Language	Amendment
1	30.200	<p>Reads:</p> <p>Adverse Action (may also be referred to as an action)</p>	<p>Amend to read:</p> <p>Action (may also be referred to as an adverse action)</p>
2	30.200	<p>Definition for Grievance reads:</p> <p>An expression of dissatisfaction from a member, member's representative, provider on behalf of a member, or a provider that the health plan must address.</p>	<p>Definition of Grievance shall be amended to read:</p> <p>An expression of dissatisfaction from a member, member's representative, provider on behalf of a member about any matter other than an action.</p>
3	30.320	<p>1st sentence in the 3rd paragraph in this section reads:</p> <p>Adults enrolled in QUEST-Net with incomes exceeding 100% will pay a premium.</p>	<p>1st sentence in the 3rd paragraph in this section is amended to read:</p> <p>Adults enrolled in QUEST-Net with incomes exceeding 100% of the FPL will pay a premium.</p>
4	30.570	<p>1st paragraph in the Section reads:</p> <p>The DHS will implement enrollment caps as follows:</p> <p>Islands with 3 or more plans - 50% of Island enrollment Islands with 2 or fewer plans – No cap</p>	<p>1st paragraph in the Section is amended to read:</p> <p>The DHS will implement enrollment caps as follows:</p> <p>Islands with 3 or more plans - 65% of Island enrollment Islands with 2 or fewer plans – No cap</p>
5	30.780	<p>3rd sentence in the Section reads:</p> <p>Individuals that are determined to be disabled will be disenrolled from the health plan no later than the first day of the second month from the month in which the ADRC approved the individual.</p>	<p>3rd sentence in the Section is amended to read:</p> <p>Individuals that are determined to be disabled will be disenrolled from the health plan no later than the first day of the second month following the month in which the individual or health plans files the request.</p>

6	40.210	<p>2nd to last sentence in the 1st paragraph on p. 90 reads:</p> <p>The health plan shall report provider application denials or termination to the DHS where individuals were on the exclusions list.</p>	<p>2nd to last sentence in the 1st paragraph on p. 90 is amended to read:</p> <p>The health plan shall report provider application denials or termination to the DHS where individuals were on the exclusions list as they occur. The health plan shall utilize the format provided by the DHS.</p>
7	40.295	<p>Paragraph with bullets on p. 108 reads:</p> <p>The health plan shall submit to the DHS all finalized and executed contracts thirty (30) days after the date of contract award. The health plan shall submit to the DHS all finalized and executed contracts that have not been previously submitted at the following times:</p> <ul style="list-style-type: none"> • Sixty (60) days after the date of contract award; • Ninety (90) days after the date of contract award; and • One hundred twenty (120) days after the date of contract award. 	<p>Paragraph with bullets on p. 108 is amended to read as follows:</p> <p>The health plan shall submit to the DHS:</p> <ul style="list-style-type: none"> • All finalized and executed contracts thirty (30) days after the date of contract award; • All finalized and executed contracts that have not been previously submitted sixty (60) days after the date of contract award; • All finalized and executed contracts that have not been previously submitted ninety (90) days after the date of contract award; and • All finalized and executed contracts that have not been previously submitted one hundred twenty (120) days after the date of contract award.

8	40.315	<p>Last sentence in the 1st paragraph reads:</p> <p>The health plan shall make an effort to notify the member prior to the health service being provided that it is not a covered benefit or that they are exceeding the coverage limits.</p>	<p>Last sentence in the 1st paragraph is amended to read:</p> <p>If aware, the health plan shall make an effort to notify the member prior to the health service being provided that it is not a covered benefit or that they are exceeding the coverage limits.</p>
9	40.360	<p>1st sentence of the 1st complete paragraph on p. 133 reads:</p> <p>The health plan is not responsible for covering ITOPs or related services performed for family planning purposes.</p>	<p>1st sentence of the 1st complete paragraph on p. 133 is amended to read:</p> <p>The health plan is not responsible for covering any ITOPs or any other related services performed for family planning purposes.</p>
10	40.800	<p>The last paragraph on p. 151 (also the 1st paragraph on p. 152) reads:</p> <p>The health plan shall be responsible for all behavioral health services provided to children that meet the criteria for SEBD. When the individual requests the health plan to provide the services as opposed to DOE or DOH, in these circumstances, the health plan shall follow the procedures in Section 30.770. The DHS will reimburse the health plan for these services.</p>	<p>The last paragraph on p. 151 (also the 1st paragraph on p. 152) is amended to read:</p> <p>The health plan shall be responsible for all behavioral health services provided to children that meet the criteria for SEBD. When the individual requests the health plan to provide the services as opposed to DOE or DOH, in these circumstances, the health plan shall follow the procedures in QUEST Memo ADM - 0106 . The DHS will reimburse the health plan for these services.</p>

11	40.900	<p>The 1st paragraph on p. 155 reads:</p> <p>The health plan may require prior authorization for non-emergency off-island and out-of-state services.</p>	<p>The 1st paragraph on p. 155 is amended to read:</p> <p>The health plan may require prior authorization for non-emergency off-island services.</p>
12	40.900	<p>The 1st sentence in the 2nd paragraph on p. 155 reads:</p> <p>The health plan shall be responsible for the transportation costs to return the individual, and their attendant if applicable, to the island of residence upon discharge from an out-of-state or off-island facility when services were approved by the health plan.</p>	<p>The 1st sentence in the 2nd paragraph on p. 155 is amended to read:</p> <p>The health plan shall be responsible for the transportation costs to return the individual, and their attendant if applicable, to the island of residence upon discharge from an off-island facility when services were approved by the health plan or from an out-of-state or off-island facility when the services were emergency or post-stabilization services.</p>
13	41.140	<p>Section reads:</p> <p>The health plan shall provide for all re-evaluations of disability for the general assistance program for TANF recipients and Medicaid (evaluations submitted to the ADRC) except that the DHS is responsible for the following:</p> <ul style="list-style-type: none"> • The initial disability determination for all public financial assistance programs; and • The re-evaluations of disability (determinations of continued mental or physical impairment) for the financial assistance program entitled General Assistance, except for TANF recipients. <p>The health plan shall utilize the panel of providers provided by the DHS for all evaluations for mental disability.</p>	<p>Section is amended to read:</p> <p>The health plan shall provide for all re-evaluations of disability (determinations of continued mental or physical impairment) for the public assistance program for TANF recipients and Medicaid (evaluations submitted to the ADRC). The DHS is responsible for the initial disability determination for all public financial assistance programs and the re-evaluations of disability for the financial assistance program entitled General Assistance.</p> <p>The health plan shall utilize the panel of providers provided by the DHS for all evaluations for mental disability.</p>

14	50.100	<p>The 2nd sentence in the 2nd paragraph on p. 161 reads:</p> <p>Upon receipt of enrollment information from the DHS, the health plan shall issue a new member enrollment packet within ten (10) days of enrollment by DHS.</p>	<p>The 2nd sentence in the 2nd paragraph on p. 161 is amended to read:</p> <p>The health plan shall issue a new member enrollment packet within ten (10) days of receiving the notification of enrollment from DHS.</p>
15	51.100		<p>Delete the last bullet, which reads:</p> <p>Membership card(s) to the enrolled members with information as described in Section 50.360.</p>
16	50.100	<p>The last sentence in the section on p. 162 reads:</p> <p>The information shall be provided to all new members within ten (10) days of enrollment.</p>	<p>The last sentence in the section on p. 162 shall be deleted.</p>
17	50.110	<p>The last paragraph in this section (on p. 162) reads:</p> <p>The new health plan shall be responsible for professional fees and outpatient prescription drugs from the date of enrollment into the health plan.</p>	<p>The last paragraph in this section (on p. 162) shall be amended to read:</p> <p>The health plan (or the State in the event the member has been transferred to fee-for-service) into which the hospitalized member has been enrolled shall be responsible for professional fees and outpatient prescription drugs from the date of enrollment into the health plan.</p>

18	50.140	<p>This section reads:</p> <p>The health plan shall notify the DHS within twenty-four (24) hours of receiving notification of the birth of a newborn to one of its members.</p>	<p>The section is amended to read:</p> <p>The health plan shall notify the DHS within twenty-four (24) hours of receiving notification of the birth of a newborn to one of its members. If the notification to the health plan is on a weekend or on a day preceding a holiday, notification on the next business day following the weekend will be accepted.</p>
19	50.220	<p>2nd sentence in the 2nd paragraph on p. 167 reads:</p> <p>The member's disenrollment will become effective no later than the first day of the second month from the month in which the ADRC's determination was made.</p>	<p>2nd sentence in the 2nd paragraph on p. 167 reads:</p> <p>The member's disenrollment will become effective no later than the first day of the second month in which the individual or health plan files the request.</p>
20	50.230	<p>1st sentence in the 1st paragraph reads:</p> <p>If the health plan identifies a member it believes would meet the disability criteria, it shall refer the member for an evaluation by the ADRC as outlined in QUEST Memo ENR9702.</p>	<p>1st sentence in the 1st paragraph is amended to read as follows:</p> <p>If the health plan identifies a member it believes would meet the disability criteria, it shall submit a referral to the ADRC for evaluation.</p>

21	50.550	<p>Second paragraph reads:</p> <p>The health plan shall submit with its proposal, policies and procedures addressing the stated requirements, a list of all current practice guidelines as well as the practice guidelines adopted specifically for asthma, diabetes, and pregnancy/high risk pregnancy.</p>	<p>Second paragraph is amended to read as follows:</p> <p>The health plan shall submit its policies and procedures addressing the stated requirements, a list of all current practice guidelines as well as the practice guidelines adopted specifically for asthma, diabetes, and pregnancy/high risk pregnancy within thirty (30) calendar days of contract award.</p>
22	50.700	<p>Third sentence in the 1st bullet for the fourth paragraph reads:</p> <p>... If the health plan extends the timeframe, it shall give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to appeal if he or she disagrees with that decision.</p>	<p>Third sentence in the 1st bullet of the fourth paragraph is amended to read as follows:</p> <p>If the health plan extends the timeframe, it shall give the member written notice of the reason for the decision to extend the timeframe and inform the member of their right to file a grievance if he or she disagrees with that decision.</p>
23	50.700	<p>Last paragraph reads:</p> <p>In the event the health plan fails to make a determination on service authorization requests by the date the timeframes expire, the determination shall be considered an approval.</p>	<p>Last paragraph shall be deleted.</p>

24	50.820	<p>1st and 2nd sentences in the section read:</p> <p>A member or a member's representative (on behalf of a member with written consent) may file a grievance orally or in writing. A grievance may be filed about any matter other than an adverse action, as defined in Section 30.200...</p>	<p>1st and 2nd sentences in the section are amended to read:</p> <p>A member or a member's representative (on behalf of a member with written consent) may file a grievance orally or in writing. A grievance may be filed about any matter other than an action, as defined in Section 30.200...</p>
25	50.830	<p>1st paragraph in the section reads:</p> <p>An appeal may be filed when the health plan issues a notice of adverse action to a health plan member.</p>	<p>1st paragraph in the section is amended to read:</p> <p>An appeal may be filed when the health plan issues a notice of action to a health plan member.</p>
26	50.830	<p>2nd paragraph in the section reads:</p> <p>A member, provider, or authorized representative (on behalf of the member with the member's written consent) may file an appeal within thirty (30) calendar days of the notice of adverse action.</p>	<p>2nd paragraph in the section is amended to read as follows:</p> <p>A member, or a provider or authorized representative on behalf of the member with the member's written consent, may file an appeal within thirty (30) calendar days of the notice of action.</p>
27	50.860	<p>Section reads:</p> <p>The health plan shall give the member and the referring provider a written notice of any adverse action within the timeframes specified below. The notice to the member or provider shall include the following information:</p> <ul style="list-style-type: none"> • The adverse action the health plan has taken or intends to take; • The reasons for the adverse action; • The member's or provider's right to an appeal with the health plan; • The member's or provider's right to request an appeal; • Procedures for filing an appeal with the health plan; • The circumstances under which 	<p>Section is amended to read:</p> <p>The health plan shall give the member and the referring provider a written notice of any action within the timeframes specified below. The notice to the member or provider shall include the following information:</p> <ul style="list-style-type: none"> • The action the health plan has taken or intends to take; • The reasons for the action; • The member's or provider's right to an appeal with the health plan; • The member's or provider's right to request an appeal; • Procedures for filing an appeal with the health plan; • The circumstances under which

		<p>an expedited resolution is available and how to request it; and</p> <ul style="list-style-type: none"> • The member’s right to have benefits continue pending resolution of an appeal, how to request that the benefits be continued, and the circumstances under which a member may be required to pay the costs of these services. <p>The notice of adverse action to the member shall be written pursuant to the requirements in Section 50.320 of this RFP.</p>	<p>an expedited resolution is available and how to request it; and</p> <ul style="list-style-type: none"> • The member’s right to have benefits continue pending resolution of an appeal, how to request that the benefits be continued, and the circumstances under which a member may be required to pay the costs of these services. <p>The notice of action to the member shall be written pursuant to the requirements in Section 50.320 of this RFP.</p>
28	50.860	<p>Last paragraph in the section reads:</p> <p>Service authorization decisions not reached within the timeframes specified above shall be considered a denial and therefore considered an adverse action.</p>	<p>Last paragraph in the section is amended to read:</p> <p>Service authorization decisions not reached within the timeframes specified above shall be considered a denial and therefore considered an action.</p>

29	51.110	<p>Section reads:</p> <p>The health plan shall report all cases of suspected child abuse to the Child Protective Services Section of the DHS, and all suspected dependent adult abuse to the Adult Protective Services Section of the DHS as required by state and federal statutes.</p>	<p>Section is amended to read:</p> <p>The health plan shall report all cases of suspected child abuse to the Child Protective Services Section of the DHS, and all suspected dependent adult abuse to the Adult Protective Services Section of the DHS as required by state and federal statutes. The health plan shall ensure that its network providers report all cases of suspected child abuse to the Child Protective Services Section of the DHS, and all suspected dependent adult abuse to the Adult Protective Services Section of the DHS as required by state and federal statutes.</p>
30	51.460	<p>The 1st sub-bullet under the 4th bullet in the list reads:</p> <p>The number of calls from providers received for each month in the reporting quarter; percentage of calls abandoned for each month in the reporting quarter; and average wait time for each month in the reporting quarter;</p>	<p>The 1st sub-bullet under the 4th bullet in the list shall be deleted.</p>
31	51.710	<p>Section 51.710 <u>Member Grievance and Appeals Report</u> reads:</p> <p>The health plan shall submit to the DHS a <i>Member Grievance and Appeals Report</i> on a quarterly basis. Reports shall be submitted November 30 for the quarter July-September, February 28 for the quarter October-December, May 31 for the quarter January-March, and August 31 for the quarter April-June. Reports shall meet the formatting and content requirements outlined in Section 50.805, and shall be submitted in the format provided by the DHS.</p>	<p>Section 51.710 <u>Member Grievance and Appeals Report</u> shall be amended to read:</p> <p>The health plan shall submit to the DHS a <i>Member Grievance and Appeals Report</i> on a quarterly basis. Reports shall be submitted November 30 for the quarter July-September, February 28 for the quarter October-December, May 31 for the quarter January-March, and August 31 for the quarter April-June. Reports shall meet the formatting and content requirements outlined in Section 50.805, and shall be submitted in</p>

			<p>the format provided by the DHS. At a minimum the reports shall include:</p> <ul style="list-style-type: none"> • The number of grievances and appeals by type; • Type of assistance provided; • Administrative disposition of the case; • Overturn rates; • Percentage of grievances and appeals that did not meet timeliness requirements; • Ratio of grievances and appeals per 1,000 members; and • Listing of unresolved appeals originally filed in previous quarters.
32	51.720		Delete entire section
33	51.730		Delete entire section
34	51.740		Delete entire section

35	51.830	<p>The 1st sentence in the section reads:</p> <p>The health plan shall submit a <i>Report of Over-and Under Utilization of Services</i>, consisting of the following six (6) reports, on September 30 and March 31:</p>	<p>The 1st sentence in the section shall be amended to read:</p> <p>The health plan shall submit a <i>Report of Over-and Under Utilization of Services</i>, consisting of the following six (6) measures.</p> <p>All measures, with the exception of item "C. QI Investigations for Delay in Treatment" shall be measured twice per year with reports due on September 30 (for the period January to June), and March 31 (for the period July to December). Item "C." shall be measured on an annual basis (for the period January to December) and shall be due on March 31.</p>
36	51.830	<p>The 1st sentence in item "A." in the section reads:</p> <p>A. PCP Visit Rates: Listings of PCPs that are at the top three percent (3%) and bottom three percent (3%) in utilization compared to the health plan's specialty.</p>	<p>The 1st sentence in item "A." in the section shall be amended to read:</p> <p>A. PCP Visit Rates: The percent of PCPs that are at the top three percent (3%) and bottom three percent (3%) in utilization compared to the health plan's specialty.</p>
37	51.830	<p>The 1st sentence in item "B." in the section reads:</p> <p>B. Approved Authorization/1000 Member Months: Listings of PCP that are at the top three percent (3%) and bottom three percent (3%) in utilization compared to the health plan's specialty.</p>	<p>The 1st sentence in item "B." in the section shall be amended to read:</p> <p>B. Approved Authorizations/1000 Member Months: Percent of PCP that are at the top three percent (3%) and bottom three percent (3%) in utilization compared to the health plan's specialty.</p>
38	51.830	<p>The item "C." in the section reads:</p> <p>C. QI Investigations for Delay in Treatment: Listing of PCPs that have twenty percent (20%) or more of QI referrals experiencing delays in treatment.</p>	<p>The item "C." in the section shall be amended to read:</p> <p>C. QI Investigations for Delay in Treatment: The measure to be reported is the rate (20% or more) of QI investigations conducted by the health plan in a 12 month period relating to a delay in treatment by a PCP with more than 100 members.</p>

39	51.830	<p>The item "D." in the section reads:</p> <p>D. Listings of hospitals and other providers delegated for concurrent review that have one hundred fifty percent (150%) or higher of services that exceed the health plan average and of those that have twenty-five percent (25%) or less than recommended services provided by clinical decision criteria adopted by the health plan e.g. Milliman or InterQual guidelines."</p>	<p>The item "D." in the section shall be amended to read:</p> <p>D. The over-utilization measure to be reported is the percent of hospitals and other providers delegated to perform concurrent reviews that have one hundred fifty percent (150%) or higher of service utilization exceeding the health plan average.</p> <p>The under-utilization measure shall reflect the percent of hospitals and other providers delegated to perform concurrent reviews that have utilization of twenty-five percent (25%) or less of the recommended services in the clinical decision criteria adopted by the health plan e.g. Milliman or InterQual guidelines.</p>
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40	51.830	<p>The item "E." in the section reads:</p> <p>E. Selected Specialty Visit Rates: Listings of the top and bottom three percent (3%) compared to the health plan's specialty norm of individual providers within the specialty of cardiology, general surgery and orthopedics that have fifty (50) or more approved prior authorizations in a six (6) month period.</p>	<p>The item "E." in the section shall be amended to read:</p> <p>E. Selected Specialty Visit Rates: The percent of individual providers within the specialties of cardiology, general surgery and orthopedics with fifty (50) or more approved prior authorizations in a six (6) month period that are at the top and bottom three percent (3%) in utilization compared to the health plan's specialty norm.</p>
41	51.830	<p>The item "F." in the section reads:</p> <p>F. Selected Chronic Conditions: Listings of the follow-up utilization variance per clinic practice guidelines or disease management guidelines adopted by the health plan and follow-up utilization variance per clinical practice guidelines. For each measure, the health plan shall identify the threshold designated by the health plan's Medical Director that triggers further investigation for over and/or under utilization.</p>	<p>The item "F." in the section shall be amended to read:</p> <p>F. Selected Chronic Conditions: The follow-up utilization variance per clinical practice guidelines or disease management guidelines adopted by the health plan for two (2) relevant chronic conditions selected by the health plan.</p>
42	51.830		<p>The section shall be amended by adding a last paragraph that shall read:</p> <p>For each measure, the health plan shall identify the threshold designated by the health plan's Medical Director that triggers further investigation for over- and/or under-utilization.</p>
43	51.900	<p>First paragraph of the section reads:</p> <p>The health plan shall submit a Fraud and Abuse Report that shall include, at a minimum, the following:</p>	<p>First paragraph of the section is amended to read:</p> <p>The health plan shall submit a quarterly Fraud and Abuse Report that shall include, at a minimum, the following information on all alleged fraud and abuse cases:</p>

44	52.200	<p>2nd sentence in the section reads:</p> <p>Encounters shall be certified and submitted by the health plans as required in 42 CFR 438.606 and specified in Section 52.300.</p>	<p>2nd sentence in the section is amended to read:</p> <p>Encounters shall be certified and submitted by the health plans as required in 42 CFR 438.606 and specified in Section 52.400</p>
45	52.210	<p>The last paragraph in the section reads:</p> <p>The health plan shall continue reporting encounter data twice a month beyond the term of the contract as processing and reporting of the data is likely to continue due to lags in time in filing source documents by subcontractors and providers.</p>	<p>The last paragraph in the section shall be amended to read:</p> <p>The health plan shall continue reporting encounter data once per month beyond the term of the contract as processing and reporting of the data is likely to continue due to lags in time in filing source documents by subcontractors and providers.</p>
46	60.410	<p>Fifth paragraph reads:</p> <p>If the service is not available from an in-network provider and the health plan has three (3) documented attempts to contract with a provider, the health plan is not required to pay this out-of-network provider more than Medicaid fee-for-service rates for the applicable service less ten percent (10%).</p>	<p>Fifth paragraph is amended to read:</p> <p>If the service is not available from an in-network provider the health plan is not required to pay an out-of-network provider more than Medicaid fee-for-service rates.</p>
47	60.530	<p>The 4th bullet in the list (on p. 262) reads:</p> <p>Provide copies of bills with similar response time as the above;</p>	<p>The 4th bullet in the list (on p. 262) is amended to read:</p> <p>Provide copies of claim forms with similar response time as the above;</p>
48	71.200	<p>Last paragraph, section 71.200 reads:</p> <p>The health plan shall implement, as directed by MQD, a secure electronic mail (email) encryption solution to ensure confidentiality, integrity, and authenticity of email communications.</p>	<p>The last paragraph, section 71.200 is amended to read:</p> <p>The health plan shall implement a secure electronic mail (email) encryption solution to ensure confidentiality, integrity, and authenticity of email communications.</p>
49	72.400	Section 60.140	Section reference is amended to read:

			Section 60.410
50	80.210		<p>Insert:</p> <ul style="list-style-type: none"> L. A statement of independent price determination as described in Section 21.600.
51	81.140	<p>Section reads:</p> <p>The offeror shall describe how it will educate members about:</p> <p>A. Their rights and responsibilities;</p> <p>B. The benefits provided and protocols and processes for obtaining care;</p> <p>C. The role of PCPs;</p> <p>D. How to obtain care;</p> <p>E. What to do in an emergent or urgent medical situation;</p> <p>F. How to request a grievance or appeal;</p> <p>G. How to report suspected fraud and abuse; and</p> <p>H. The importance of good health and the use of preventive care, including a description of the specific activities it will undertake.</p> <p>The offeror shall describe how it will ensure that all written materials meet the language requirements detailed in Section 50.320 and which reference material will be used to ensure that the 6th (6.9 or below) grade reading level requirement is met.</p>	<p>Section is amended to read:</p> <p>A. The offeror shall describe how it will educate members about:</p> <ol style="list-style-type: none"> 1. Their rights and responsibilities; 2. The benefits provided and protocols and processes for obtaining care; 3. The role of PCPs; 4. How to obtain care; 5. What to do in an emergent or urgent medical situation; 6. How to request a grievance or appeal; 7. How to report suspected fraud and abuse; and 8. The importance of good health and the use of preventive care, including a description of the specific activities it will undertake. <p>B. The offeror shall describe how it will ensure that all written materials meet the language requirements detailed in Section 50.320 and which reference material will be used to ensure that the 6th (6.9 or below) grade reading level requirement is met.</p>
52	Appendix J	<p>Page J-6 has following heading:</p> <p>Appendix L (continued)</p>	<p>Heading is amended to read as follows:</p> <p>Appendix J (continued)</p>
53	Appendix O	<p># 16. reads:</p> <p>Smoking cessation classes (medication for</p>	<p>Delete #16.</p>

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