

Questions and Answers
 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

# Assigned	Section	Page #	Para.	Question	Response
139	50.320	173	2, 3	The RFP states: "The health plan shall make all written materials available in alternative formats... The health plan shall make all written materials available in English, Ilocano, Tagalog, Chinese and Korean..." We have historically made our member handbook and other written materials in our new member packet available in the alternate formats and languages. Does this satisfy the requirement?	It is impossible to answer since it is not known whether all materials provided to members are included in the member packet. The health plan is required to conform to all language requirements in the RFP.
140	50.320	174	1	Do all health plan documents including reminder letters or health brochures require translation or is it only pertinent plan information like the member handbook, new member welcome letter and privacy statement?	All member-related documents require translation.
141	50.320	174	1 st paragraph	Please define the types of written materials that must include a language block. Does this include any and all communication that the plan sends to the member (health education offerings, appointment reminders, surveys, newsletters, etc.)	All member-related written materials sent or provided to members must include the language block.
142	50.330	175	1 st paragraph	Are handbooks required to be mailed annually to existing members if there are no content changes from the prior year?	Yes.
143	50.330	177	Sub Bullet 1	A listing of locations where members can access emergency settings are listed in the provider directory. Is this section meant to require health plans to also supply provider names and locations in the member handbook?	Health plans must include, in the member handbook, information on where members may obtain emergency services. The health plan does not need to include the names and locations of all providers in the member handbook.

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144	50.350	180	2	Will health plans be asked to create a separate directory for each island they are contracted for? What is the estimated number of copies that will be requested annually?	No, the health plans will not need to create a separate directory for each island provided they produce one comprehensive directory for distribution. The health plan should plan to produce 100,000 copies for the first year.
145	50.350	180	2 nd paragraph	Is the Plan required to produce copies of the Provider Directory for DHS to distribute to potential enrollees? If yes, will the Plan be reimbursed for the cost of providing these copies?	Yes, the plan is required to produce copies of the provider directory for the DHS to distribute to potential enrollees. No, the plan will not be reimbursed for the cost of providing these copies.
146	50.360	181	1 st and 2 nd paragraphs	"The member ID card must, at a minimum, contain the following..." Listed components include TPL and EPSDT indicators. The second paragraph indicates that a Health Plan does not need to include all the items if providers have access to the information. Could you please provide examples of processes or procedures by which TPL and EPSDT indicators could be accessed that DHS would find acceptable and approve to meet the ID card requirements?	No, the State will not provide examples; the health plan has the burden to demonstrate they have sufficient processes and procedures in place.
147	50.370	182	7	Please provide a list of all holidays observed by the State of Hawaii.	The State observed holidays can be found at the Department of Human Resources Development website at www.hawaii.gov/hrd
148	50.370	183	Last	"A health plan representative shall return messages within thirty minutes of the time the message is left, whether the message is left on the automated system or by the answering service." Does this apply to every call received or just calls that are identified as an emergency?	This applies to all calls.

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149	50.370	183	2 nd	What definition does MQD use for a "blocked call"?	A call that cannot be connected immediately because no circuit is available at the time the call arrives or the telephone system is programmed to block calls from entering the queue when the queue backs up beyond a defined threshold.
150	50.370	183	2 nd	Please clarify "99% of calls are answered by the fourth ring." Is a call that is answered by an automated attendant considered answered?	Yes.
151	50.370	183	2 nd	Please clarify "99% of all calls are answered by the fourth ring". Is the 99% based on total offered calls or actual answered calls?	Total offered calls.
152	50.370	183	1 st paragraph	Is the recording of all hotline calls a requirement, or will plans be able to show monitoring activities in another fashion?	The plan does not need to record all hotline calls but shall record enough hotline calls in order to effectively monitor hotline performance.
153	50.380	184	2	RFP states: "DHS reserves the right to review and prior approve the web site's content information relating to the health plan's information covered under this contract." We post information for providers on our website, which generally have not required MQD review (practice guidelines, provider manual, frequently used forms, provider newsletters). Does this requirement apply to member-targeted materials only?	Generally this requirement applies to member-targeted materials only but reserves the right to review contents of the website as it relates to the QUEST program.

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# Assigned	Section	Page #	Para.	Question	Response
154	50.400	185	Last bullet in section	The health plan is prohibited from: attending educational sessions or presentations without the approval of the DHS. Is there a limit to subject matter? Example: if our Quality Improvement Manager plans to attend an educational session on disease management strategies, does this require MQD approval? If our Medical Director plans to make a presentation at a regional meeting regarding Pay-for-performance or our Customer Service staff plan to attend a seminar on providing good customer servicing, etc., do these require MQD approval?	This relates to attending educational sessions or presentations for the purpose of presenting information on the QUEST program (e.g. health fairs) or for presentations to enrollees.
155	50.430	187	1	RFP states: "All printed materials, advertisements, video presentations and other information prepared by the health plan that pertain to or reference the programs or the health plan's program business shall be reviewed and prior approved by the DHS before use and distribution by the health plan. The health plan shall not advertise, distribute or provide any materials to its members that relate to the programs that have not been previously approved by the DHS." Does the reference in the second sentence to materials to be provided to its members also relate to the first sentence? We frequently deal with program issues in our provider communications that have not required MQD approval in the past. Are we correct in assuming that provider materials are exempt from this requirement for review and approval?	Yes. No, you are not correct in assuming that provider materials are exempt from this requirement for review and approval.
156	50.430	187	1	Are health plan promotion and/or health education materials developed by a health plan considered marketing materials and subject to DHS approval prior to distribution to members?	Yes.

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157	50.520	189	1	Will existing health plans be subject to the readiness reviews described in this section and throughout this RFP since these standards are reviewed on an annual basis by the External Quality Review Organization?	Yes, existing health plans will be subject to the readiness reviews.
158	50.520	191	1,2 bullets	Does the state consider a PBM payment system where clinical care activities are not delegated subject to the delegation requirements listed in both bullets?	Yes.
159	50.520 81.260	189 329	"2" "A"	<p>Section 50.520 regarding Quality Assessment and Performance Improvement Program (QAPI) states that the health plan shall comply with requirements set forth in 42 CFR 438.240, specifically that we submit performance measurement data (HEDIS measures) described in 42 CFR 438.240(c). In the Technical Proposal section 81.260 regarding Systematic Process for Monitoring Quality – QAPI Standard III – Performance Measures Narrative, the RFP states the Offeror shall: "Describe its policies and procedures related to meeting HEDIS performance measures requirements."</p> <p>The requirements detailed in 42CFR 438.240(c) state that annually we must measure and report to the State our performance, using standard measures required by the State. Since the annual submission of HEDIS is a "requirement" we are unclear (beyond signing the contract stating we will meet all requirements), what sort of policy and procedure is expected? Are you looking for a formal P&P describing our internal workflow for actual generation of the report, or more of a "policy statement" that we will submit accurate data on an annual basis? Could you please provide further clarification and guidance on this?</p>	The health plan is required in Section 81.260 to describe its formal process or procedure on how it will go about meeting the requirement.

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# Assigned	Section	Page #	Para.	Question	Response
160	50.530	192	4	This section states that approval or member consent is not needed for authorized DHS personnel or personnel contracted by DHS to access behavioral health and substance abuse records. HRS sec. 334-5 does not allow release of behavioral health or substance abuse records without written authorization from the member. Section 70.100, page 270, paragraph 4 states that in the event of a conflict between the language of the contract, and applicable statues and regulations, the latter shall prevail. Please verify that this means health plans would need to obtain written authorization from the member before releasing records to DHS or its designee. If this is not true, please explain why.	Federal regulations require DHS contracts with the QUEST health plans to provide that authorized State personnel shall have the right to audit and inspect any books and records of the entity (and of any subcontractor) that pertain to services performed or determinations of amounts payable under the contract. 42 U.S.C. §1396b(m)(2)(A)(iv). There is no exception relating to records regarding behavioral health or substance abuse services. The State is obliged under Medicaid and HIPAA to keep protected health information confidential. Under those circumstances, we do not believe that HRS sec. 334-5 requires written authorization from the member prior to release of the records. Accordingly, DHS reserves the right to deny coverage or payment for services for which the requisite books and records are not made available as set forth in the RFP.
161	50.550	194	3rd	The RFP states that the health plans shall submit with its proposal, policies and procedures addressing the stated requirements for practice guidelines as well as a list of current practice guidelines, however, in the technical proposal there is not this specific requirement listed. Do the Health plans need to submit all of the above mentioned practice guideline information? If so, where would the State like the documents to be placed within the proposal?	See #21 of Amendment#9.
162	50.600	197	3 rd paragraph	Would Med-QUEST be willing to negotiate types of Utilization Management reports required to evaluate and analyze practitioners practice? These requirements are not applicable to our plan.	No.

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# Assigned	Section	Page #	Para.	Question	Response
163	50.700	199	Bullet 1	Under the current Member Grievance System, if the health plan extends the review time for a standard authorization, the member is notified of their right to file a grievance. This section says the member has the right to file an appeal. Please clarify.	See #22 of Amendment #9.
164	50.700	200	Last	The RFP reads "In the event the health plan fails to make a determination on services authorization request by the date the timeframes expire, the determination shall be considered an approval". Does this apply in circumstances where there is an open QI investigation, or issues of potential fraud & abuse involved, or the service is counter to the PCP plan of care? In these circumstances are additional extensions permitted before the authorization is assumed to be "approved"?	Yes, it does apply in the circumstance requested, as well as in all circumstances. No, additional extensions are not permitted. ,
165	50.700	200	Bullet 1	Under the current Member Grievance System, if the health plan extends the review time for an expedited authorization, the member is notified of their right to file a grievance. This section says the member has the right to file an appeal. Please clarify.	See response for question #163.
166	50.700 50.860	200 218	Last	This section states that if the health plan does not make a determination on service authorization requests by the date the timeframes expire, the determination shall be considered an approval. In Section 50.860 – Notice of Adverse Action, first paragraph on page 218, it states that service authorization decisions not reached within the timeframes specified shall be considered a denial and therefore considered an adverse action. Could you clarify whether authorization decisions not reached within required timeframes are to be considered approvals or denials?	See #23 of amendment #9.

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# Assigned	Section	Page #	Para.	Question	Response
167	50.805	202	2	If health plans are required to notify members of their grievance and appeal resolutions in their primary language, does that notification need to be in writing or can it be done orally? If it must be in writing, will DHS give health plans additional time to translate the information?	Notification needs to be in the member's primary language and shall be in writing. No, DHS will not give health plans additional time to translate the information.
168	50.820	203	3	Is there a specific time frame in which a member must file a grievance? If yes, what is the time frame?	The individual has up to ninety (90) days after the event to file a grievance.
169	50.830	206	2	This section does not require a provider to receive written consent from the member before filing an appeal on their behalf. Balanced Budget Act, 67, Fed. Reg. 41110 (2002), General Requirements (§438.402) states, "A provider, acting on behalf of the enrollee and with the enrollee's written consent, may file an appeal. Has the BBA language been revised?"	See #26 of Amendment #9.
170	50.830	207	Bullet 1	If an appeal is received orally, does the appeal timeframes begin when the member confirms the health plan's write up of the appeal?	The RFP states, "An oral appeal may be submitted in order to establish the appeal submission date..." Thus, the appeal timeframe begins when the oral appeal is submitted to the health plan.
171	50.835	209	4 th paragraph	Is the Health Plan required to notify Med-QUEST's liaison for EVERY expedited appeal?	Yes.

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# Assigned	Section	Page #	Para.	Question	Response
172	50.840	211	2	If the member is not satisfied with the final internal appeal decision, in addition to filing a State Administrative Hearing with DHS, should the member also be informed they can file for a review by the State of Hawaii Insurance Commissioner?	Yes, the member should be informed of their rights to file for a review by the State of Hawaii Insurance Commissioner. In fact, the second paragraph in Section 50.855 states: "The health plan shall inform the member, the member's provider or the member's authorized representative of the process to request an external review by the Insurance Commissioner."
173	50.850	214	1	If the health plan is unable to recover costs of services furnished to a member while the appeal was pending, can the health plan seek reimbursement from DHS?	No.
174	50.855	214	4	After exhausting all internal grievance and appeal procedures, in addition to filing an external review with the State of Hawaii Insurance Commissioner, should the member also be informed they could file a State Administrative Hearing with DHS?	Yes, see Section 50.840.
175	50.860	217	3 rd bullet this page	(Starting on page 215 regarding mailing notices of adverse action to members) – "The health plan shall mail the notice within the following timeframes: For denial of payment at the time of any action affecting the claim". Does this mean that the health plan is expected to send members an EOB for all denied claims? All other bullets address notice of actions taken on authorizations, rather than the claims. Could you clarify?	Yes, the health plans must send an EOB for denied claims. The section applies to adverse action for both claims and authorizations.

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176	50.860	218	1	Here it states that service authorization decisions ot reached within the timeframe specified shall be considered a denial and therefore be considered an adverse action. This conflicts with Section 50.700, page 200, paragraph 1, which states that 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. Please clarify which statement is correct.	See response to question 166.
177	50.910	218	2 nd	"DHS requires ... health plan install DHS approved VPN software..." Please clarify if this refers to the same VPN software that was referenced in Section 31.210?	Yes, it is the same VPN software.
178	50.940	219		Please provide examples of system changes that would require prior approval from DHS.	All system changes that affect the QUEST, QUEST-Net and QUEST-ACE programs and/or the populations enrolled in these programs shall be prior approved by the State.
179	51.100	221	1 st paragraph	Are the publications listed in the Fraud & Abuse section a requirement or just a reference?	These reference documents should be used as a guideline. A good fraud and abuse program would utilize the components in these reference documents.
180	51.100	222	2	Can DHS provide the contact information for the Medicaid Fraud Control Unit of the Attorney General's Office?	http://hawaii.gov/ag/criminal_justice/medicaid/ <u>808-586-1058 for provider fraud</u> <u>807-586-1160 for member fraud</u>
181	51.100	224	1	Under what instances pertaining to Fraud and abuse will DHS impose sanctions on the health plans?	The State may impose sanctions for a variety of infractions, for example, sanctions may be imposed if there is collusion or a pattern of fraudulent behavior that has not been addressed by the health plan.

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# Assigned	Section	Page #	Para.	Question	Response
182	51.110	224	Abuse Reporting	The HP shall report all cases of suspected child abuse to CPS. If the HP became aware of possible abuse through UM activities such as concurrent or retrospective review of medical records and those records indicate that a referral to CPS was made by facility personnel, is the requirement for the HP to report waived in this instance since CPS was already notified?	No, the requirement is not waived.
183	51.110	224	Abuse Reporting	The RFP reads "the health plan shall report all cases of suspected child abuse to CPS and APS". We have on many occasions tried to report cases to CPS, and we have been told that this is 3 rd hand information that they are unable to act on. Have you discussed the plans' required reporting to CPS and APS with those agencies, and received assurance that they are willing to take the report? Is there a formal referral process or format you could provide to the Plans that would facilitate Plans reporting instances of suspected abuse to CPS and APS?	See #29 of Amendment #9. The requirement for health care professionals to report a suspected case of abuse or neglect is a State law requirement. Health plans awarded a contract will be provided with information on the referral process to CPS and APS.
184	51.220	225	Bullet 8 & 9	Must the person directly in charge of member and provider services be at a Director level? Is it acceptable to have a supervisor who is in charge of these areas who reports to a manager?	The person in charge of these services must be at the Director level. It is not acceptable to have a supervisor who reports to a manager.
185	51.220	226	Last sentence	Is the submission of a staffing plan to DHS within 30 days of contract award waived for returning plans?	No, returning plans will not be waived from this requirement.

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# Assigned	Section	Page #	Para.	Question	Response
186	51.300 – 52.200	227 - 245	Reporting Requirements	In these sections, DHS identifies new and existing reports required for this QUEST contract. Many subsections end with a statement that the health plan shall report in the format specified by the DHS. Could you please address the following questions in relation to the reporting requirements: a. Will the reports listed in these sections be included in the yearly QUEST Memos on the Annual Reporting and Monitoring Activities calendar? b. For reports that are not described in detail, when will the DHS provide the requirements and formats for the various reports so that Plans are able to devote adequate resources to develop and implement the reports in a timely manner?	a. MQD will continue issuing Memos on the Annual Reporting and Monitoring Activities calendar. The Format and frequency is under review. b. MQD will share report formats in sufficient time for Health Plans to develop and implement the reports.
187	51.310	227	1 & 2 nd	The RFP reads "the health plan shall comply with all additional requests from the DHS, or its designee, for additional data, information and reports". Can you provide an example of what additional requests might be or identify the scope of the reports that may be requested? Are all reports provided considered confidential, or are they available to the public? "All" is a very broad term and Plans may not be able to accommodate because of privacy agreements we are bound to i.e., rebate structures with manufacturers, board meeting minutes, software programs etc. Are documents of this nature excluded from this requirement?	MQD may have additional requests for data, information and other reports based upon unique circumstances or changes in the law in order to manage and monitor health plans. Reports that plans consider confidential should be noted on the submission to MQD and MQD will consider the request on a case-by-case basis.

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# Assigned	Section	Page #	Para.	Question	Response
188	51.410	227	2 nd	Is the provider network adequacy and capacity reporting requirement the same as the provider directory (50.350, p. 180) reporting requirement? Is there only one provider network reporting requirement that will be used to determine adequacy and capacity, and enable DHS to provide members with a provider directory? Where can the file layout for the requirement be found? Is the PMR file layout from the Hawaii Health Plan Manual going to be used for the submission of the data? If so, when will the Health Plan Manual be updated?	No, the provider network adequacy and capacity report is not the same as the provider directory. The network adequacy and capacity report is the one that the State will use to determine network adequacy; the provider directory is not a report--it is a directory that will be provided to members. Formats for the Network Adequacy and Capacity Report are being reviewed.
189	51.410	228	Bullet 5 – 11	Will the Health Plan Manual be updated to include these data elements? When can health plans expect to be notified of the specific file format for these additional fields?	The Health Plan Manual will be updated. MedQUEST will notify Health Plans of report formats upon contract execution.
190	51.460	232	Provider Complaints report, 1 st bullet	The HP shall submit a quarterly report that includes the number of calls from providers, the percentage of calls abandoned and the average wait time for each month in the reporting quarter. Our customer service department handles both member and provider calls and there is no mechanism to route calls to member only or provider only lines. If a caller is unable to get through right away, all calls are held in the same queue until the next available Customer Service representative becomes available. Aggregate statistics for all calls are captured. Can these aggregate statistics for call abandonment and average wait times be used as a proxy measure of call responsiveness to provider calls given that all calls are treated equally?	See #30 of amendment #9.

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191	51.460	232	3 rd bullet on page	This bullet requests a quarterly report of delays in claim payment. The 1 st bullet within this section requests provider call volume while the remaining bullets request specific information regarding claim payment. Should the 1 st bullet regarding provider call volume be its own quarterly report separate from the quarterly claim report?	See response to question 190.
192	51.460	232	2 nd bullet from bottom of page	Plans are required to submit quarterly reports showing percentage of claims processed at 14, 30, 60, and 90 days after date of service for each month of the reporting quarter. Since the plans generally allow 120 days for claims to be submitted, should the report be percentage of claims processed at 14, 30, 60, and 90 days after receipt? This would be a better gauge of plan performance. If requiring the analysis from date of service, could you provide the rationale?	The bullet as identified will remain and tied to date of service. MedQUEST is interested in provider payment issues and processing time from a management perspective.
193	51.460	233	Bullet on top of page	On this bullet, item (3) Provider not eligible on date of service.... What does this denial reason mean? What is provider not eligible for?	It means that the provider was prohibited from providing services on that date for that service, for example, the provider is listed on the excluded provider list.
194	51.720	236	Bullet 1	The categories listed under this bullet lists actions that are elsewhere defined as an appeal. What constitutes a grievance and an appeal in this section?	See #32 of Amendment #9 .

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195	51.720	236	Entire section	RFP states: "The health plan shall submit a quarterly <i>Report of Grievances a Provider Has Filed on Behalf of Members.</i> " As a returning plan following the BBA requirements, we have not been separately logging grievances filed on behalf of a member separately from other member grievances, as they ultimately get treated in the same way once we receive documentation that the member has given consent for the provider (or any other representative for that matter) to file on his or her behalf. Since details of these grievances will be included in the "regular" quarterly grievance report, would you consider removing this report, which is duplication of effort? If this report is not removed, please note the following discrepancy. The report is for grievances filed on behalf of a member, but some of the categories (denial of authorization or denial of payment) are by definition "appeals" and you are not requesting a quarterly report of appeals filed on behalf of members. What it appears you are looking for is a report of provider complaints, grievances and appeals (filed by the provider himself or herself, not necessarily on behalf of the member). If that is what you are looking for, could you revise the wording that this is a Provider Grievance system report?	See response to question 194.
196	51.720	236	2	Will DHS provide a format and content requirements to report grievances a provider files on behalf of a member?	See response to question #194.

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197	51.740	238	1 st bullet	This section is regarding Member Grievance reports. The first bullet asks for the number of "complaints". By definition, members have inquiries, grievances, and appeals (there is no "complaint" category). Should the wording be revised to be: "the number of grievances and appeals by type"?	See #31 and #34 of amendment #9.
198	51.740	238	2 nd and 3 rd bullets	This section is regarding Member Grievance reports. These bullets request that we report "type of assistance provided" and "administrative disposition of the case". Could you clarify and/or provide examples? The other bullets seem to describe this is a quarterly "summary" report not a case-by-case report. What categories of "assistance provided" and "administrative disposition" are acceptable, to summarize quarterly data?	See response to question 197.
199	51.810	238	1	The RFP states: "The health plan shall submit on a semi-annual basis, a Prior Authorization Requests that have been Denied or Deferred Report." Where is the specified record layout for this report?	The DHS will provide the sample lay-out to offerors awarded contracts.
200	51.810	239	Second bullet at top of page	What is acceptable for "justification" from a provider? Can the state supply a list?	At a minimum, the service/medication must be medically necessary and appropriate to diagnose and/or treat the person's medical condition. A list will not be provided.
201	51.810	239	Third bullet at the top of page	What is acceptable for "justification" for the health plans denial or deferral of an authorization request?	Clinical criteria and/or utilization criteria that the plan used in the denial or deferral of the authorization request.

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202	51.820	239-240	1 st sentence	Will all "(4) reports two (2) times per year" cover the same reporting period? Could you please provide an example of the reporting period for each of the 4 reports?	All four (4) reports need to be submitted twice a year. The reporting period will cover 6-month increments and will be due twice a year.
203	51.820	239-240	1st (A/B)	<p>A. Please clarify what will be required for the Health Plan to provide to meet section A and B as it relates to "criteria that is used/developed to evaluate their appropriate, safe and effective use, and the outcomes/results of the evaluations."</p> <p>B. Please elaborate on what cost parameter (e.g., AWP, U&C, etc) will be used for the "top 50" high cost drugs? Could you elaborate on the utilization parameter (e.g., number of prescriptions, days supply, etc) that will be used for the "top 50" highly utilized and non-formulary drugs?</p> <p>C. Non-formulary drugs within the "top 50" will have clinical criteria to determine coverage. Is it the clinical criteria that the State is requesting? Also, is the State looking for number of approvals/denials as the output for "outcomes/results of the evaluations?" If not, could you elaborate on the exact data element(s) you are requiring for outcomes/results?</p> <p>D. Please define charges and allowances for each drug in section B. What aspect of the drug costs is the State requiring? Many PBMs have proprietary arrangements with manufacturers and Health Plans regarding the charges and allowances associated with drug products. Will the amount the HP actually pays be sufficient information to base this report on?</p>	<p>A. The DHS requires that QUEST plans review the listing. If the listing contains medications that its clinical staff feel might be overutilized or inappropriately utilized, the DHS expects that the plan develop criteria to correct or improve the utilization and measure the effectiveness of the implementation of the criteria. This includes all prior authorization criteria developed.</p> <p>B. The costs are what the plan's costs are. These costs must be submitted per named drug. The utilization is the actual utilization of the drug and includes drug name and number of paid claims.</p> <p>C. See above paragraph.</p> <p>D. Actual costs will be acceptable.</p>

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204	51.820	239-240	3 (C)	Does MQD have a specific definition for "high users of controlled substances" that all plans are expected to use? Could you elaborate on what you would be looking for under "2) the results of the CC/CM services provided?"	The DHS does not have any definition of high users. However, the DHS requires the criteria used by the plan to identify high users. Under "the results of the CC/CM services provided," the DHS is looking for the utilization of controlled drugs before and after implementation of CC/CM for a specific member.
205	51.830	240	"A"	Please clarify what is meant by the phrase "compared to the health plan's specialty". Is there a word missing from this sentence (as in "B", which reads "compared to the health plan's specialty norm."). Or do you mean that Plans should compare PCP providers against aggregate PCPs who are in the same discipline/specialty?	This means the specialty of the PCP; for example: pediatrics, internal medicine, family medicine, etc.

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# Assigned	Section	Page #	Para.	Question	Response
206	51.830	241	Subpart C.	By QI Investigations for Delay in Treatment, do you mean grievances that a health plan receives that pertain to delays members experience in receiving treatment? If not, please clarify.	<p>See #38 of amendment #9.</p> <p>This is the rate of QI investigations conducted by the health plan in a 12 month period that were related to a delay in treatment by a PCP who has more than 100 members in their panel.</p> <p>Denominator: The number of all QI investigations conducted in a 12 month period for PCPs with 100 or more assigned health plan members.</p> <p>Numerator: The number of QI investigations conducted in the same 12 month period for the reason of a delay in treatment by a PCP with 100 or more members. If the rate is 20% or more, the expectation is for the health plan to research and determine the probable root cause of the reported rate. For example, a high percentage may be an indication of an inadequate PCP network in a high demand geographic region that results in underutilization of preventive care services.</p> <p>Note: Whether the investigation substantiates that a QI issue exists is not relevant in determining the numerator or denominator.</p>

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# Assigned	Section	Page #	Para.	Question	Response
207	51.830	241	"C"	As part of reporting over and underutilization of services, there is a request that we report "QI Investigations for Delay in Treatment: Listings of PCPs that have twenty percent (20%) or more of QI referrals experiencing delays in treatment." Unless there is a suspected adverse clinical result of a report of a delay in treatment, reports to us of this nature may actually be processed through our grievance/appeals process or our Compliance reporting (provider out of compliance with accessibility standards) processes and not our QI referral process. Given that we will be providing other reports of access and availability, and PCP visit rates, would you consider removing this report, as it duplication of effort for reporting same/similar information in other reports?	No. See #38 of amendment #9.
208	51.830	241	"E"	As part of over and underutilization of services, there is a request that we report "Selected Specialty Visit Rates". There is great variation in member geographic concentrations and availability of some kinds of specialists on certain islands or certain areas of Oahu. A specialty provider who is providing more or less services to health plan members may be more a function of how many other specialists in the area are providing the same services to our members, or the geographic concentration of our members. It is unclear what meaningful information you would get from this report, and/or what actions you would expect us to take in regard to the results of this report. Could you provide clarification regarding what you are looking for, and how you would evaluate?	No. See #40 of amendment #9.

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# Assigned	Section	Page #	Para.	Question	Response
209	51.830	241	"F"	Could you please define "utilization variance"?	The threshold identified by the QUEST plan's medical director that triggers further investigation and the basis for his/her selection of the threshold. See #41 of amendment #9.
210	51.900	242	Entire section	RFP states: "The health plan shall submit a Fraud and Abuse Report...." What is the frequency of this report? Would this report include all alleged fraud and abuse cases investigated (including those found not to be substantiated), or only those where reasonable suspicion of fraud or abuse was confirmed?	See #43 of Amendment #9.
211	52.110	242	2	The QUEST Financial Reporting Guide referenced in this section as Appendix S is not fully included in the RFP; only the disclosure forms are included. Has DHS updated or revised the current Financial Reporting Guide that was issued in August 1997 and amended in March 1998?	The complete financial reporting guide is included in Appendix AA under amendment #8 dated 7/21/06.
212	52.110	242	1 st	The QUEST Financial Reporting Guide references Appendix S. Although Appendix S-1 is titled "Financial Reporting Guide Forms", it is not a reporting guide but the forms for the annual disclosure reporting. Could you please verify that your reference to Appendix S is correct and if not, provide the correct reference?	See response to question #211.
213	52.140	245	1	When will the first quarterly encounter data/financial summary reconciliation be due and for what period? Should it be submitted along with the quarterly financial statements?	The first quarterly encounter data/financial summary reconciliation will be due with the quarterly filing of the financial statements. With the services beginning February 1, 2007 the first set of financial statements are due May 15, 2007.

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# Assigned	Section	Page #	Para.	Question	Response
214	52.200	245	1 st	Reference to Section 52.300 is incorrect. Should the reference be 52.400?	See #44 of Amendment #9.
215	52.210	246	1st bullet	When will the Health Plan Manual be revised to agree to the requirements in the RFP? Per RFP: 80% of the encounter data shall be received by the DHS no more than 120 days from date of service. Per Health Plan Manual (Section 4.5.1): 80% of encounters within 120 days of the end of the month in which the services were rendered.	The health plan manual will be revised to reflect the encounter data received by DHS prior to enrollment of members.
216	52.210	246	1 st bullet	One of the timeliness of encounter data requirements is that 80% are to be received by DHS no more than 120 days from the date that services were rendered. Is the number of days associated with the 120 day encounter submission requirement based on a CMS requirement that DHS is held accountable to and if so could you please provide a reference? Due to provider pressure, Med-QUEST had worked with the plans in the past to adopt a community standard of allowing 120 days from date of service for the claims submission deadline. Plans then have 30 days to finalize clean, paper claims. Given these parameters, could this requirement be changed to be that 80% are to be received by DHS no more than 180 days from the date that services were rendered, to better reflect the previously agreed upon provider submission timeline (and accounting for the plans' claims processing time)?	No to both questions. The DHS is holding the health plans to these requirements because encounter data is critical to the understanding and operations of the program. CMS has been placing more emphasis and pressure on the timeliness, accuracy and completeness of the encounter data.
217	52.210	247	2	Does failure by DHS to respond within 60 days mean the decision will be in favor of the health plan? If not, what recourse does a health plan have if the decision is not timely?	Yes, failure to respond within 60 days means the decision will be in favor of the health plan.

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# Assigned	Section	Page #	Para.	Question	Response
218	52.210	247	Last	"The health plan shall continue reporting encounter data twice a month..." Should this be once a month so that it agrees to Section 52.200?	See # 45 of Amendment #9.
219	52.210	247	1 st	Please provide a description of the "accuracy and completeness edits" that are described in this paragraph? Will there be an opportunity for Plans to review and comment on these?	The description of the encounter edits can be found in the Health Plan Manual. All encounter data must conform to the data elements specifications defined in the Health Plan Manual.
220	52.300	248	1	If a health plan is unable to collect medical records for reasons beyond their control, will the health plan still be fined \$200.00 per day? If yes, is there a cut off point?	The health plan is responsible to obtain medical records as requested by the DHS or its designee. Penalties will be assessed until the records are received.
221	52.400	248	2	Is there a specific certification form or specific certification language that must be completed for each reporting submission that requires plan certification?	No, there is no specific form, but each certification must include all language required in Section 52.400.
222	52.400	249	Last	Does a provider's signature in box 31 of the CMS 1500 form meet this certification requirement?	No.
223	52.500	249	2	Upon completion of reviews by DHS or its designee, is there a specific timeframe health plans can expect a report of its findings?	No, there is not specific timeframe.
224	60.100	251	1 st -2 nd paragraph	The only compensation to the plan will be the monthly capitation payment. Payment will be made for members enrolled for the entire month. Will pro-rata payment be made for members enrolled for partial months, as indicated at 60.200?	Yes. See Section 90.200
225	60.110	251	3	Under what conditions will DHS enact retroactive enrollments and disenrollments?	DSH will enact retroactive enrollments for newborns who will be enrolled in the mother's plan effective the date of birth. See Section 30.520.

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# Assigned	Section	Page #	Para.	Question	Response
226	60.110	251	1	Can a payment date be set for the monthly capitation so plans know when to expect payment?	Yes.
227	60.200	252	2 nd paragraph	Risk factor adjustment is mentioned. Will the risk factors be age, sex, and program category? Will there also be an annual, retroactive risk adjustment?	Rate cells will vary by age, sex, and program category. DHS may consider risk adjustment in future years. There will be no annual retroactive risk adjustment.
228	60.210	239	1	For the following programs -- QUEST, QUEST-Net, QUEST-ACE, General Assistance, Medicaid FFS -- could you please provide definitions of each of these populations and explain how it would be determined that a member of one group could qualify for and move into another group?	Section 30.300 describes the populations enrolled in the programs covered by this RFP. A member moves to another group when their eligibility changes.
229	60.300	254	1	Is the health plan responsible for costs associated with securing an NCQA Certified Compliance Auditor to validate HEDIS measurements selected as part of the incentives for health plan performance program?	No. The DHS will secure the NCQA Compliance Audit through its EQRO.
230	60.310	256	1	Will DHS require the diabetes measures to be audited by a NCQA Certified Compliance Auditor? If yes, is the health plan responsible for costs associated with the audit? Please provide the rationale for requiring additional validation using encounter data and DHS's enrollment?	The database measure will be audited by a NCQA Certified Compliance Auditor. DHS will secure and pay for the audit. The DHS does not wish to provide incentive payments based on data that has not been properly certified.
231	60.320	257	3	If a NCQA Certified Compliance Auditor audits the health plan, please provide the rationale for additional validation using encounter data and DHS's enrollment?	See response to question 230

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# Assigned	Section	Page #	Para.	Question	Response
232	60.330	258	3	Will DHS require the Follow-up Visits After Hospitalization for Mental Health Diagnosis measures to be audited by a NCQA Certified Compliance Auditor? If yes, is the health plan responsible for costs associated with the audit? Please provide the rationale for requiring additional validation using encounter data and DHS's enrollment?	Yes. See response to question 230.
233	60.410	259	1 st paragraph	Second sentence states that plans may use a discounted Medicaid fee-for-service reimbursement methodology. Will DHS publish an updated Medicaid fee-for-service schedule to use to assist in structuring provider reimbursement if a plan wants to use this methodology? Does DHS plan to increase or decrease provider reimbursement fee schedules within the next year? If so, could you please provide as much detail as possible regarding what is planned?	Yes, DHS will publish an updated schedule. Any increases and/or decreases in provider reimbursement are still being considered.
234	60.410	260	2	If a plan is not able to pay an out-of-network provider who delivers an emergency service any more than an individual in the Medicaid fee-for-service program, what is to prevent the provider from not accepting the payment as payment in full from the health plan and from balance billing the member?	Providers may not bill the member but must accept the plan's payment as payment in full. It is illegal for providers to balance bill members; also see Section 40.220.
235	60.410	260	3	If the health plan has documented 3 unsuccessful attempts to contract with a provider and the health plan reimburses the provider at the Medicaid fee-for-service rates less 10%, what is to prevent the provider from not accepting the payment as payment in full from the health plan and from balance billing the member?	See response to question #234.

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# Assigned	Section	Page #	Para.	Question	Response
236	60.410	260	2 & 3	If a health plan is required to compare their out-of-network payments to the Medicaid fee-for-service rates, will DHS be providing these rates to the health plans?	Yes.
237	60.410	260	4 & 5	Could you elaborate (beyond the definition on page 31), on what constitutes an "emergency service" and include specific examples?	No. The definition contained in the RFP is the federal definition and speaks for itself.
238	60.410	260	2	RFP states: "The health plan shall not pay out-of-network providers who deliver emergency services more than they would have been paid if the emergency services had been provided to an individual in the Medicaid fee-for-service program." Will MQD be providing us with both professional and facility fee schedules and payment methodologies ("reso text") for the FFS program, to assist us in implementing this provision?	Yes.
239	60.410	260	3	RFP states: "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%). Will MQD be providing us with both professional and facility fee schedules and payment methodologies ("reso text") for the FFS program to assist us in implementing this provision?"	Yes.

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# Assigned	Section	Page #	Para.	Question	Response
240	60.410	260	4 & 5	What legal authority supports the requirement that plans pay out of network providers who deliver emergency services no more than the Medicaid FFS program rates or 10% less than Medicaid FFS rates if the provider refuses to contract after three document attempts by the health plan? This provision seems unenforceable without legal requirements. We will need to be able to provide this reference to providers if they disagree with the payments made under these provisions.	See #46 of amendment #9.
241	60.410	260	4 & 5	If providers refuse to accept the Medicaid rates, what recourse do plans have?	The plans are responsible for developing and maintaining an adequate network. It is the plan's responsibility to assure that their members receive the care that is determined medically necessary.
242	60.410	260	5	What constitutes an attempt to contract with a provider?	See response to question 240.
243	60.410	260	4	Are we correct in assuming that the claims processing parameters provided in the paragraph are superseded by the Hawaii State statute regarding "clean claims" (Prompt Payment Act)?	The language in the contract is consistent with the Hawaii State statute regarding clean claims.
244	60.420	263	1	RFP states: "If the health plan later determines that a member has been billed for health plan-covered services, the plan shall refund the member directly." Current contract wording is that the health plan may refund the member directly. Do the health plans still have an option to work with the provider to refund the member and submit a claim? This allows plans to submit accurate encounter data, by processing the claim from the provider.	No. The plan must refund the member directly.

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# Assigned	Section	Page #	Para.	Question	Response
245	60.440	264	2	How will the new health plan know what old health plan the member was enrolled in and the PCP the member was assigned to in that plan? Is the new health plan's participating provider fee considered payment in full?	During operational readiness, each plan will be required to submit information necessary to implement this provision.
246	60.440	264	2	At what rate is the plan required to pay for this one-time visit? Are other services to be covered besides the PCP visit?	The plan will be required to pay for the one-time visit at whatever rate they would pay a network provider for the service rendered.
247	60.440	264	Entire section	RFP states: "The health plan shall coordinate with other health plans and the State to provide a one-time payment to a PCP for one visit for a member who was auto-assigned to a new health plan during the positive enrollment period who receives services from the PCP to which they were assigned under the old health plan, provided that the PCP is not in the network of the new health plan." Could you clarify how this would work? Are you requiring the health plan that is not receiving the monthly capitation from the State to pay for the PCP visit? What about specialty or facility services that were prior approved by the old health plan for specialty or facility providers not in the new health plan's network. Who needs to pay for those? Which plan is making the payment and why?	In the unlikely event that a member seeks services from a provider who is not in the assigned plan's network, the plan in which the member is enrolled when the service is rendered will be expected to pay for the service. Prior approved services will be honored for either 45 days after enrollment or until the new PCP makes a determination that the prior approved service is or is not medically necessary according to the clinical criteria of the plan.

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# Assigned	Section	Page #	Para.	Question	Response
248	60.510	265	First	For TPL, the RFP states that "Reimbursement from the third party shall be sought unless the health plan determines that recovery would not be cost effective." Does the DHS have any guidelines on a dollar amount threshold that it would consider to be the minimal amount that a health plan would be required/expected to pursue for TPL payment or is the health plan's analysis and determination acceptable?	Plans should follow federal guidelines regarding the cost-effectiveness of pursuing TPL. The state's rate ranges have already been adjusted for expected TPL collections.
249	60.530	266	4 th bullet	"Provide copies of bills....." Does the term 'bills' refer to claim forms?	See #47 of amendment #9.
250	60.620	267	3	The reporting period for Catastrophic Care has been July 1 through June 30. Will the reporting year change for existing health plans since this contract begins February 1, 2007? If yes, how will current health plans who are awarded a contract report Catastrophic Care for July 1, 2006 through January 31, 2007?	The reporting year for catastrophic care will not change and will remain as July 1 to June 30. The plan that has the recipient from July 1-Jan 31 will notify and file reinsurance amount with Cyrca Health. Should the medical expenses exceed the thresholds, the original plan will receive a reinsurance payment. Should the recipient change plans as of Feb 1, the new plan will be notified by Cyrca Health and the new plan will file any additional expenses with Cyrca Health. Any additional reinsurance expenses filed by the new plan will be reimbursed to the new plan.
251	60.630	268	4 th paragraph	Plans are to utilize a listing of diagnostic codes to refer cases to the catastrophic reinsurer. Will DHS include the list of diagnostic codes in the RFP?	Each of the successful bidders will receive a list of procedure and diagnostic codes from the catastrophic reinsurer.

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# Assigned	Section	Page #	Para.	Question	Response
252	70.100	270	3	The RFP states that the health plan shall comply with all applicable laws, ordinances, codes, rules and regulations of the federal, state and local governments, as well as any contract requirements. Hawaii State law requires that all health plans be accredited by a nationally recognized accrediting body (e.g. NCQA, URAC, etc.). Does this requirement apply for all QUEST bidders? If accreditation is not required during the bidding process, by when should accreditation be achieved?	Health plans must be accredited by a nationally recognized entity within 5 years of establishing business in Hawaii.
253	70.100	270	3	This question is in reference to compliance with applicable laws, in particular, the open formulary for psychotropic medications. As a result of the recently enacted law requiring QUEST plans to have an open formulary for psychotropic drugs, we anticipate that there will be substantial increased financial costs. How will the requirements of this mandate be factored into the proposed capitation rate and will the bidders be able to see and discuss the assumptions with the actuaries?	Each plan must make their own assumptions regarding these changes. Should your bid rates fall below the actuarially sound rate range, then discussions of this and other assumptions will take place between the actuaries.
254	70.100	270	3	This question is again in reference to compliance with applicable laws, in particular, the expanded benefits for specific behavioral health conditions resulting from the Mental Health Parity law. How will the requirements of this mandate be factored into the proposed capitation rate and will the bidders be able to see and discuss the assumptions with the actuaries?	Each plan must make their own assumptions regarding these changes. Should your bid rates fall below the actuarially sound rate range, then discussions of this and other assumptions will take place between the actuaries.

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# Assigned	Section	Page #	Para.	Question	Response
255	70.100	270	3	This question is in reference to compliance with QUEST contract requirements and memos, in particular, relating to the new ADRC processes which in effect will result in a health plan covering ADRC-appropriate members for longer periods of time. How will these changes in processes as developed by MQD be factored into the proposed capitation rate and will the bidders be able to see and discuss the assumptions with the actuaries?	Each plan must make their own assumptions regarding these changes. Should your bid rates fall below the actuarially sound rate range, then discussions of this and other assumptions will take place between the actuaries.
256	70.100	270	2 nd paragraph	Will the State be providing Plans with a template for acknowledgement of receipt and intention to implement each memorandum?	We assume your intent was to ask how auto assignments will be distributed in the event of a first-place tie in the scoring. In this case the auto assignments would be re-distributed equally to these two plans.
257	70.200	273	3	The contract effective date is September 12, 2006. Does this new contract impact the current health plan contract extended through December 31, 2006?	The health plan is responsible to obtain medical records as requested by the DHS or its designee. Penalties will be assessed until the records are received.
258	70.410	276	1	The DHS will conduct on-site readiness reviews, and the health plan shall submit a plan for implementation of the program and shall provide progress/performance reports every 2 weeks beginning 2 weeks after notification of contract award. Will this be waived for returning plans?	No, this will not be waived for returning plans.
259	70.500	277	1 st bullet	Regarding subcontractor agreements, the RFP states: "The health plan obtains the prior written consent of the State." For returning plans currently using subcontractors where the relationship will continue for the new contracting period, is the requirement for written consent from MQD waived?	No, this requirement is not waived.

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# Assigned	Section	Page #	Para.	Question	Response
260	71.200	285	Last	"..Health plan shall implement, as directed by MQD, a secure electronic mail (email) encryption solution..." What is the MQD-recommended email encryption solution? If not already named, when will the specification of the recommended email encryption solution(s) be made available to the health plans?	See #48 of Amendment #9.
261	71.320	286	Last	The RFP indicates that penalties or sanctions may be imposed for untimely data for reports. Plans want to comply with the State requirements but there may be instance where an extension is needed? Can sanctions and penalties be waived on a case-by-case basis if adequate justification is provided for the delay?	The State may, at its discretion, waive sanctions and penalties on a case-by-case basis. The State alone will determine if justification is adequate to waive sanctions and/or penalties.
262	71.320	287	1	Is there a specific timeframe in which DHS will notify a health plan of sanctions?	The timeframe will be determined on a case-by-case basis.
263	71.320	288	2	What due process and appeal rights are afforded the Plan if the Plan disagrees with any damages, sanctions and/or financial penalties which the State imposes? Section 52.210 (page 247, 2 nd paragraph) addresses how to file a written challenge to a financial penalty but this is specific to encounter data.	The health plan may appeal damages, sanctions, and/or financial penalties to DHS as described in Section 52.210
264	72.400	302	2 nd paragraph	There is no Section 60.140 as noted in this section	See # 49 of Amendment #9.

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# Assigned	Section	Page #	Para.	Question	Response
265	72.400	302-303	2 nd	In the paragraph that begins with "(i) in light of the federal rules intended to encourage contracting between health plans and FQHCs and RHCs...", could you please provide the specific Federal law or regulation that authorizes DHS to require this covenant? If the Plan is unable, for whatever reason, to comply with this covenant, what are the consequences?	The covenant required by section 72.400, and the attestations referred to in the covenant, carry out the long standing federal policy that procurement transactions provide, to the maximum extent practical, open and free competition, and meets the state's obligation, as the recipient of federal funds, to be alert to organizational conflicts of interest as well as noncompetitive practices among contractors that may restrict or eliminate competition or otherwise restrain trade. See 42 C.F.R. §434.6(a)(1) and 45 C.F.R. §74.43. The requirement also furthers the goal of choice among health plans for program recipients. See 42 C.F.R. §438.52(a). If an offer is submitted by an offeror who is subject to the requirement of a covenant, fails for any reason to provide for such covenant, the State reserves the right to take any appropriate action up to and including refusing a contract with that offeror.
266	80.200	306	n/a	Is a proposal bond required (as distinct from a performance bond)?	No, a proposal bond is not required for this RFP.
267	80.300	311	"A"	The RFP states: The offeror shall provide: A listing of contacts for all state Medicaid program clients (including those served by an affiliated company), past and present. Could you please clarify if this requirement means that the offeror should list all other Medicaid program clients from other states and does not include the State of Hawaii (DHS/MQD)?	"All Medicaid program clients" means all clients including the State of Hawaii.

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# Assigned	Section	Page #	Para.	Question	Response
268	80.420	313	2	Offerors may include in their provider listing both providers who have a signed contract as well as those who have a signed letter of intent. A copy of the letter of intent is to be included with the offeror's proposal. Is it the DHS' expectation that the signed provider contracts for providers that appear on the offeror's list will be specific to the QUEST contract and materially describes the requirements listed in Section 40.295 Provider Contracts (page 104-108) of the RFP? If evidence of a QUEST provider contract is an amendment to an existing contract, does DHS expect a specifically signed amendment which materially describes the requirements found in Section 40.295? Similarly, should the letter of intent specifically list those same required provisions? If this assumption is not correct, specifically what will be required and by when will it be required?	Yes, DHS does expect a specifically signed amendment. No, the LOI does not need all provisions..
269	80.420	313	Attachment : Required Providers	The RFP states the plan must use the form provided in Appendix V to report the plan's provider listing. We are unable to locate Appendix V from among the appendices. Could you please provide the form?	Appendix V (Provider Network Matrix) is included in the file "RFP-2007-002 Appendices O-V" which is located on the RFPs for Health and Human Services web-site.

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# Assigned	Section	Page #	Para.	Question	Response
270	81.300	331	"B"	The RFP instructions states that "The offeror will provide a narrative describing the...: B) UMP policies and procedures and a description of the mechanisms" to address QAPI Standard X. This section is allotted a maximum of 20 pages. The QAPI Standard X for UM alone has extensive requirements and multiple P&Ps address the QAPI standard. In order to ensure that our response to this question adequately and accurately describes our UM program, please clarify what you mean by "describe the UMP policies and procedures." Is the requirement that we list the applicable P&Ps and provide a narrative description of what each one pertains to or are you requiring that the UM P&Ps be submitted? If you are not requiring the P&Ps in the submission, can we provide them as supporting documentation and not have them counted against the section page limit?	The requirement is that the applicable P&Ps be listed and that a narrative description be provided within the 20 page limit. Actual P&Ps provided as supporting documentation will not be reviewed.
271	81.500	332	3 rd bullet	Does MQD want a copy of our disaster planning and recovery operations policies and procedures manual as support for meeting this requirement?	No. This tool will be available, however, after contracts are awarded.
272	81.500	332	C (under 81.500)	Clarify when a copy of the Disaster Planning and Recovery Operations Manual is due. Section 81.500 says to submit with the proposal. Section 50.950 says to provide within thirty (30) days of contract award.	Section 81.500 requires "A description of its disaster planning and recovery operations policies and procedures." The actual documentation describing its disaster planning and recovery operations is due within 30 days of contract award.
273	81.800	335	Bullet A	What is meant by 'encounter data reports'? Does this refer to the new report in Appendix B?	Appendix B is an example of an encounter data report.

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# Assigned	Section	Page #	Para.	Question	Response
274	81.910 40.295	335 104-108	Attachments: Provider Contracts	Offerors are required to include a copy of the following provider contracts: PCP; Specialist; Hospital; and a sub-capitation contract (if to be used by the plan). In Section 40.295 on Provider Contracts (page 104-108), the RFP lists the required elements of written provider contracts. Is it the intent of Section 81.910 that offerors will submit contracts that materially meet the requirements listed in Section 40.295 with the understanding that these contracts provide the minimum standards that were used by the offeror in procuring their provider network?	Yes, offerors are to submit contracts that materially meet all requirements listed in Section 40.295.
275	100	338		Will MQD provide potential bidders with the scoring tool that will be used to score submitted proposals?	No. This tool will be available, however, after contracts are awarded.
276	100.100	338	Bullet 3	Will DHS provide plans a rate range?	No, rate ranges will not be provided.
277	100.200	338	1	Can the plans be provided with details on who are the members of the bid evaluation committee for each area of review (mandatory/qualifications)?	No, details on the bid evaluation committee(s) will not be provided.
278	100.400	340	1	If a submitted proposal does not meet the minimum standards, when would the plan expect to get back their bid submission (as described in this section)?	The proposals will be returned following contract award.

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# Assigned	Section	Page #	Para.	Question	Response
279	100.600	343	Table	One of the goals of the QUEST demonstration project is to provide choice for beneficiaries. The RFP proposes limits to the number of winning plans on each island. In prior years, when there were more plans, the maximum number of plans established by DHS to be selected for certain Neighbor Islands was greater than the current RFP. Increasing the maximum number of plans would potentially encourage competition on these islands and allow beneficiaries greater choice. Could you please provide the reason for limiting the number of plans on the Neighbor Islands to the levels established in the RFP? Would DHS consider increasing the limit?	The State has established limits on the number of plans in order to ensure financial stability for those plans. The DHS will not consider increasing the limit.
280	Appendix B	B1		Should the reconciliation include encounters that have been pended and identified on the .241 Encounter Input Detail Report?	Yes, the reconciliation should include encounters that have been pended.
281	Appendix H	H1 – H2		Will DHS provide monthly reporting (or some other appropriate reporting time period) of the results of auto-assignment to a plan?	No.
282	Appendix H	H-1, H-2	Entire section	The auto-assignment algorithm is used to calculate an "auto assignment rate" for each plan. Is this applied on a daily basis (the percentages are applied to all recipients eligible for auto assignment each day)? If not, how is the total number of auto-assigned recipients onto which the percentages are applied determined, and over what time period?	The "auto assignment rate" is applied on a daily basis and is applied to all recipients eligible for auto assignment each day.
283	Appendix H	H-1-H-2		If there is a tie in the total number of points, how will the points in the service area be distributed?	We assume your intent was to ask how auto assignments will be distributed in the event of a first-place tie in the scoring. In this case the auto assignments would be re-distributed equally to these two plans.

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# Assigned	Section	Page #	Para.	Question	Response
284	Appendix J	J-6	n/a	Heading should be APPENDIX J	See # 52 of Amendment #9.
285	Appendix K	K-26	# 27	If health plans are required to make provisions to provide results of its identification and assessment of members with SHCN's to another health plan, how will a health plan do so and still comply with HIPAA? If it will be through a member release, can this section be amended to add with a signed release from the member?	See response to question #22.
286	Appendix K Standard VIII- Continuity of Care # 33	K-28	1st Identification of additional groups of children	Are there any exclusions or exceptions for medications such as vitamins or fluoride?	The DHS is addressing drugs used for the treatment of behavioral health/medical condition and not medications taken on an as needed basis for infections or for prevention of dental caries.
287	Appendix K Standard VIII- Continuity of Care #20	K-25	1st Interfacing and Integrating	Whom does the state expect the Health plans case mgmt system to interface with? Please explain "provider agencies"	The DHS means both contracted and non-contracted agencies that provide services to the member. Thus, services provided by the public sector such as the Department of Health need to be included in a member's plan of care.

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# Assigned	Section	Page #	Para.	Question	Response
288	Appendix K Standard VIII- Continuity of Care #24	K-25	5th Identificatio n of individuals with special health care needs	A reference is made to an attachment of the states of Hawaii Quality Strategy; is the referenced attachment (A-5) available to view?	This can be made available.
289	Appendix K Standard VIII- Continuity of Care #24	K-25	5th Identificatio n of individuals with special health care needs	Does the state have indicator codes on the enrollment file for adults or children who have been previously identified as SHCN member?	No.
290	Appendix L	J-6 & J-7		Please review pages J-6 and J-7. Heading indicates that this is Appendix L (Continued) but has page numbers of J-6 and J-7.	See # 52 of Amendment #9.
291	Appendix P	n/a	n/a	Is the EPSDT guideline form outdated?	No.
292	Appendix T	T-1	Risk Share	Because of potential substantial year to year variation in gains and losses common for health plans, would the State consider applying the risk share program to the entire length of the contract rather than on a year by year basis? This approach would help to "smooth" year by year performance.	Yes, the state will amend the RFP to reflect a risk share over the entire length of this contract.
293	Appendix V	V	V-1 Columns 7, 8, and 9	How is the information found in columns 7, 8, and 9 obtainable?	The provider listed in the 2nd column should provide this information.