

RFP-MQD-2008-006

Issued 11/21/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled
Q&A

Quest. #	Amend. #	# (1 st column on Amendment documents)	Question	Answer
1			In the event a provider chooses not to participate with a MCO, and that provider sees a member on an emergent basis, what is the reimbursement methodology for such visit or admission? Would the health plan pay their lowest contracted rate or 80% of the existing Medicaid fee schedule?	The RFP, at Section 60.220, requires that the health plan 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 FFS program. Whether or not the health plan pays their lowest contracted rate or 80% of the existing Medicaid fee schedule is something the health plan must negotiate with the provider.
2	Q&A Technical Proposal		Would the plan be allowed to contract with a home health agency to assist with completion of the face-to-face assessments – particularly within the first 90 days following commencement of delivery of services – rather than have all such assessments be completed by the service coordinators?	Yes. Health plans would need to follow guidelines outlined in Section 70.500 for the Subcontractor Agreements.
3	Q&A Technical Proposal		If the providers of self directed services are only required to submit time sheets and not claim forms, who is responsible for reimbursement of these services?	The health plan will reimburse the caregiver (provider of self-directed services) for the member. Currently in FFS this service is provided through a contract with Ceridian (a payroll processing company). The health plan can determine how they would like to achieve this objective.
4	Q&A Technical Proposal		Interest is indicated as a variable by quarter. Assuming that configuration can make the monthly updates, what is used to determine if the claim crosses quarters and the interest percentages are different from the time the claim was received and the time the payment is made? Would the entire interest amount be based off the amount in which the claim was paid or prorated?	The interest payment will be based on the amount that is beyond the 30 days due during that quarter. For instance, if the payments for the month of June were delayed beyond 30 days, interest percentage for the quarter ending 9/30 will be used to calculate the amounts.

RFP-MQD-2008-006

Issued 11/21/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

Quest. #	Amend. #	# (1 st column on Amendment documents)	Question	Answer
5			Additionally, the State indicates that the Hawaii Automated Welfare Information System currently holds all information related to cost-sharing. Does the State intend for health plans to utilize this system or have access to it once cost-sharing responsibilities are handed over to the health plan?	No. The DHS will provide the cost sharing responsibility of the member to the health plan in a monthly report. This report will be provided at the end of the month for the next month.
6	Age/Gender Factors	N/A	Do the age/gender factors only apply to the medical portion and potentially the HCBS portion of the rate? We do not understand how the LTC costs could vary based on age/gender unless the factor was calculated using total costs.	The age/gender factors were computed based on total costs for each rate cell. They will be applied to the bid capitation rates, which include all services.
7	Age/Gender Factors	N/A	'What data was used to develop the age/gender factors? Was it HI data, national data or some other data? Did the factors include Medical, RX, LTC and HCBS costs?	Hawaii data was used to compute the age/gender factors, which included all categories of service.
8	Revised Data Book RFP-2008-006	N/A	How is membership impacted by people who move to different islands for services? For example, if a member on Lanai requires LTC services and that member decides to go to a nursing facility in Oahu: 1) Would that member then be considered to be an Oahu or Lanai member? 2) Would we be paid for them using the Oahu rate or the Lanai rate?	Both in the data book and for the future payment of rates, members are assigned to the island of residence. If a LTC placement results in a change of residence, then the payment rates would change.
9	Revised Data Book RFP-2008-006	N/A	We are confused about who was moved into the nursing facility category in the new data book. The notes say it was members on the wait list for the nursing home. If this is the case, are the	See #7 in amendment #6. The data book has been developed to be consistent with how the program will be administered, which

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled
Q&A

Quest. #	Amend. #	# (1 st column on Amendment documents)	Question	Answer
			<p>nursing home costs in this rate cell now understated? That is, if they were not in the nursing home during the experience period, they would have only had medical and potentially HCBS claims; therefore, their presence in the nursing facility rate cell artificially reduces the LTC costs in that cell. This is with the understanding that going forward only members in a nursing home will fall into this category. If there will be members in this rate cell that are not in an LTC facility, please explain who they will be.</p>	<p>is that members who are on a nursing home wait list who reside in an inpatient setting while on that wait list will be considered a nursing home client. The wait list provided by the State is not specifically a list of clients; rather it was a set of inpatient claims that were identified as clients waiting for a nursing home. A data book is being provided that includes only wait list clients during the wait list period to assist bidders in understanding the population.</p>
10	4		<p>In Amendment #4, the State indicates that it wants a listing of membership broken down by type. The State specifically cites TANF, TANF-related and ABD as examples. Given that Medicare will play a prominent role in the delivery of health care for QExA members who are dually eligible, please clarify that the State is asking health plans to also include membership counts in their current Medicare Advantage Plans and/or Special Needs Plans (SNPs). Moreover, the Medicare populations in these SNPs are more similar in their health care needs than the Medicaid TANF population. We recommend that the State consider Medicare Advantage SNP experience as part of the scoring for this section.</p>	<p>See #2 in amendment #6.</p> <p>The table is designed to enable the MQD to contact State Medicaid contacts; this is why Medicare information has not been requested.</p> <p>The State is including Medicare SNP experience as part of the scoring. See Section 80.310. B. on pg. 330 which states that, “The relevance of experience providing services to a large number of Medicaid enrollees....Similarly, Medicare Advantage (including as a special needs plan) experience (not just prescription drug plan experience) with a significant number of beneficiaries (e.g. 15,000 or more) will be considered more relevant than experience with fewer beneficiaries.”</p>

RFP-MQD-2008-006

Issued 11/21/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled
Q&A

Quest. #	Amend. #	# (1 st column on Amendment documents)	Question	Answer
11	4	10	Do "certified professionals" include "certified case managers"?	Yes.
12	4	11	Should this language include that DOH will oversee and pay for case management, HCBS waiver services and ICF-MR facility services and any other long term care for the MR/DD population?	No. The DOH will bill the DHS for case management and HCBS waiver services provided by the DOH. The providers of ICF/MR facility services will bill MQD for services provided.
13	4	11, 36, 37	Given that the DD/MR are considered Non-LOC, is it correct that health plans do not perform level of care determinations for the DD/MR population enrolled in the HCBS waiver and those receiving or entering an ICF-MR facility?	Health plans do not perform level of care determinations for any member in the QExA program. Level of care determinations are made by the DHS or its designee. Yet, health plans are responsible for level of care assessments for QExA members. In the DD/MR population, the initial level of care assessment would be the requirement of the health plan for members with DD/MR who are non ICF/MR LOC and need ICF/MR LOC services. Subsequent assessments would be the responsibility of either the HCBS waiver case manager or provider of the ICF/MR facility.
14	4	292	If a bidder has an HMO license pending with the state of HI, will a copy of the license application satisfy the proof of insurance requirement? Or is it necessary to include the numerous appendices in addition to the application?	Yes. No.
15	4	30	Is the floor and cap for Level 1 Personal Assistance service absolute, meaning that there must be 1200 and no more than 1600? (See MQD's response to question 158- "We have	Yes. As stated in #30 in amendment #4, "The State will provide health plan specific threshold data

RFP-MQD-2008-006

Issued 11/21/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled
Q&A

Quest. #	Amend. #	# (1 st column on Amendment documents)	Question	Answer
			added language to establish a cap on the number of people served receiving personal assistance services Level I. See #30 of Amendment #4."). Since this is a statewide cap, how will it be monitored by the State and what is the process for informing the health plans that enrollment in Level 1 Personal Assistance is closed. Once the cap is reached, will health plans maintain a waiting list?	following Contract Award.” Therefore, the details of the monitoring and the process of informing the health plans of the threshold data will not be shared until after Contract Award. Yes, once the cap is reached, health plans will be able to maintain a waiting list.
16	4	31	In section 40.770, self direction, it states that the member is not obligated to provide health insurance benefits for his/her providers. Are they responsible for workman’s comp if injured on the job? Is the plan?	No. Neither the health plan nor the member is responsible for worker’s compensation for caregivers.
17	4	36	In section 40.820, the new amendment states that the HFA must be completed within 14 days of the event of an ER visit, hospital admission or change in condition. Will the event start when the plan is notified (through claims) or the actual date of the ER or hospital admission? (The plan might not be aware of ER visit or hospital stay until a claim comes in.)	The fourteen days will start when the health plan is notified of the ER visit or hospital admission (either through notification by the hospital (i.e., through hospital staff) or through a claim.
18	4	36	If we determine, through our assessments, that a NF member can transition to HCBS, do we need to seek the State’s approval for this transition? If so, what is the process for approval?	No.
19	4	36 ,37	Is it correct that the timeframes for MR/DD are the 180 day period even though some are receiving HCBS and have a plan of care? Is the same true for those residents in ICF MRs?	Yes to both.

RFP-MQD-2008-006

Issued 11/21/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled
Q&A

Quest. #	Amend. #	# (1 st column on Amendment documents)	Question	Answer
20	4	36, 37	Is it correct that the category of individuals without a plan of care includes most of the non-LOC individuals?	Yes.
21	4	5	<p>The amendment to Section 21.400 (last bullet) requires large national health plans to obtain or initiate accreditation procedures in states which do not require them to be accredited. For providers of national health plans operating in many states, this requirement is so burdensome and costly that it will discourage or prevent their participation in the competition. The effect of this amendment is to provide an advantage to local health plans or plans operating in one or a small number of states and exclude or disadvantage national health plans in the competition.</p> <p>HRS Chapter 103F does not provide for a small business preference or geographic preference such as this. Please identify the statutory contractor preference or other authority upon which the agency relies to support this restrictive requirement and contractor class exclusion?</p> <p>In addition, the list of disqualifications (the reasons why an applicant will be disqualified and the bid automatically rejected (Section 21.400)) includes a list of egregious, offensive actions/inactions, including noncompliance with</p>	<p>See #1 in amendment #6.</p> <p>This section does not require an applicant or any of its affiliate companies or its parent companies “to obtain or initiate accreditation procedures in states which do not require them to be accredited.” Section 21.400, as amended, requires that the applicant submit proof that the applicant or an affiliate company (as defined in Section 30.200) or its parent company be currently accredited by one of the four specified accrediting bodies in at least one state for at least one product line, or to be in the process of becoming accredited. If an applicant is accredited or has applied for accreditation in more than one state, then the applicant must provider a list of all such accreditations and/or applications, as required by section 80.220. In other words, the applicant must submit proof of at least one completed accreditation or accreditation in process, by either the applicant or one of the applicant’s affiliate companies, or one of its parent companies, to fulfill this requirement.</p>

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled
Q&A

Quest. #	Amend. #	# (1 st column on Amendment documents)	Question	Answer
			<p>applicable laws, lack of financial stability and arrears or defaults on previous contracts. We would like to better understand the rationale for including in the list of disqualifications, rather than as a scored evaluation feature, the requirement that both the applicant and its affiliates be accredited when the regulatory body may not require accreditation. Indeed, in many states there is no requirement for accreditation for either the commercial or Medicaid business and CMS does not require accreditation for Medicare plans by named organizations in Section 21.400 (last bullet).</p> <p>Accordingly, we respectfully request that the last bullet of Section 21.400, including the additional requirements contained in Amendment #4, be deleted.</p>	
22	4	70	<p>Amendment 70 now reads: “<i>A listing, in table format, of contacts for all Medicaid program clients (including those served by an affiliated company, a company with the same parent company as the applicant, and any subcontractors providing direct services), past and present</i>”. Please further define “subcontractor providing direct services.” Can we interpret “providing direct services” to mean “providing covered benefits on a capitated basis”? Using this definition, we would interpret</p>	<p>Yes to the question. The applicant’s interpretation is correct.</p>

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled
Q&A

Quest. #	Amend. #	# (1 st column on Amendment documents)	Question	Answer
			that we would submit State Medicaid client references for a subcontractor providing a vision benefit, or any other service specified in Section 40.700, but we would not submit references for subcontractors who are providing administrative functions (i.e., credentialing, TPL, etc.) for our QExA plan.	
23	4	70	<i>Amendment 70 now reads:</i> “A listing, in table format, of contacts for all Medicaid program clients (including those served by an affiliated company, a company with the same parent company as the applicant, and any subcontractors providing direct services), past and present”. We request that DHS amend this language to read “and any subcontractors providing direct services THAT THE APPLICANT INTENDS TO USE TO SERVE THE QEXA POPULATION ”. This language is consistent with the scope of information required under the Company Narrative section. We request that this change be made for all occurrences of “subcontractors providing direct services” appearing in Section 80.310.	See #2, #3 and #4 in amendment #6.
24	4	71	Amendment 71 now reads: “ <i>Information on (1) whether or not any contract (including those for an affiliate of the company, a company with the same parent company as the applicant), or subcontractor providing direct services) has been terminated or not renewed for non-</i>	The DHS will not amend this.

RFP-MQD-2008-006

Issued 11/21/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled
Q&A

Quest. #	Amend. #	# (1 st column on Amendment documents)	Question	Answer
			<i>performance or poor performance ...</i> We would request that DHS amend this language to read “Information on (1) whether or not any STATE MEDICAID contract...” This suggested change aligns the required information with the scope of what is requested by 80.310A and 80.310B.	
25	4	72 & 73	DHS has expanded the requirement for the EQRO and EPSDT submissions to apply to the applicant, and “ affiliated company or a company with the same parent company as the applicant ”. Because we anticipate that our submission will be sizable, we would like to include a one page cover page to our EQRO/EPSDT submission to make it easier for DHS to review. On this cover page, we will indicate all our State Medicaid contracts, what we are submitting by State contract and context regarding our State customer’s reporting requirements if needed. Will DHS permit this?	Yes. Also see #5 in amendment #6.
26	4	85	Regarding the revised Appendix L-26- According to the State's definition of "key personnel"; (i.e. Chief Executive Officer, Medical Director, Financial Officers, Consultants, Accountants, Attorneys, etc.) what is the State's definition of a "Consultant"?	The "Consultant" listed under this section refers to any consultant that will represent the company in any capacity by either meeting with or correspondence with the state.

RFP-MQD-2008-006

Issued 11/21/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled
Q&A

Quest. #	Amend. #	# (1 st column on Amendment documents)	Question	Answer
27	4	L-1	The SPO-H-200 form L-1 in Amendment #4 is version dated 09/04 and yet the same form on the State Procurement website (which we were referred to during the session following the distribution of the original RFP) is version dated 09/06. Which one should we complete?	Use the version dated 09/06. For a fillable version of this form, go to the SPO website listed below and search for SPO-H-200 form in the search box. Choose the form listed which will bring you to a fillable form to complete. www.spo.hawaii.gov/
28	4	L-20	On the Financial Planning Form page L-20 it appears that the “No _____” answer has been eliminated in Amendment #4 for both d) and e). Can we add these back in on our forms we submit?	See # 6 in amendment #6.
29	4	L-32	The original Appendix L had duplicate forms numbered L-32 and L-33, both of which referred to an Appendix Z that was not included in the original appendix. Amendment #4 L-32 has been changed to refer to the form in Appendix L. We assume that this is form L-34. Is this correct? Also, can DHS clarify the purpose of form L-24 which still refers to a form in Appendix Z, but would otherwise seem to be a duplicate of form L-32? Can we disregard form L-24 and just complete form L-32?	See # 6 in amendment #6.
30	4	Page L-1 (Proposal Letter)	"It is also understood that failure to enter into the contract upon award shall result in forfeiture of the surety bond." Will you please clarify which surety bond is being referenced in this	See # 6 in amendment #6. There is no surety bond requirement for submitting the proposal.

RFP-MQD-2008-006

Issued 11/21/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled
Q&A

Quest. #	Amend. #	# (1 st column on Amendment documents)	Question	Answer
			Statement? §71.500 identifies the performance bond requirements for the health plan, but it doesn't appear that the performance bond needs to be in place until the execution of the contract. Thus, we would like to understand if there is a separate surety bond requirement for submitting the proposal.	
31	5		For employed physicians such as those at Queens Medical Center, can the single LOI be used to meet various specialty access requirements? Similarly, in the event we sign an LOI with a large hospital system with facilities on multiple islands, is that single LOI sufficient for meeting the hospital requirements on the outer islands?	No. Yes. The single LOI is sufficient for meeting the requirement of one hospital for each island represented.
32	5		In Amendment #5, the State provides additional clarification on the requirements for collecting spend-down. Currently, the State's Eligibility Worker (EW) authorizes eligibility for the member. Please describe what type of interactions, if any, will health plans have with these EWs.	The health plans will not have direct interaction with the Eligibility Workers. The information regarding a member's cost sharing obligation will be transmitted to the plan.
33	5	2	Should the definition of cost-sharing delete reference to premiums since there are no premiums under QExA?	No. At this time, there is no premium in the QExA program. Yet, the DHS' definition of cost sharing includes premium, therefore, premium will remain in the QExA RFP.
34	5	2	Is the example provided using the actual MNIL for the aged and disabled? Is the MNIL for the aged and disabled, 100% of the federal poverty level?	Yes. No. The MNIL is equal to the TANF payment standard (50% of the 2006 FPL).

RFP-MQD-2008-006

Issued 11/21/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled
Q&A

Quest. #	Amend. #	# (1 st column on Amendment documents)	Question	Answer
35	5	7	Is it correct that once an individual goes through the post-eligibility treatment of income process that they now have a long term care share of cost but not a "spend-down?"	Yes. Spenddown is used to determine eligibility. The level of cost sharing of the medical payment for the eligible individual is used in post-eligibility.
36	5	9	Please confirm that the intent of #9 in Amendment 5 is as follows: Two solo practitioners with offices in the same building can count as two LOI's. A group practice consisting of seven practitioners will count as one LOI. If this is correct, what is the state's objective in imposing this amendment?	Yes. Amendment #5 is provided as a clarification in the RFP.
37	5	9	If practitioners in a group practice independently sign LOI's, can they be submitted separately, with each counting toward the LOI requirement?	Yes, as long as the practitioners have the authority to sign the LOI (i.e., a business license identifying themselves as the provider) and are considered as separate providers in the Medicaid system (i.e., have separate Medicaid Provider Identification Numbers), if applicable.
38	5	9	Please confirm that clinic providers, such as Kauai Medical Clinic and Bay Clinic will count as one LOI each.	Yes.
39	5	9	Our interpretation of the wording in 80.315.2 "If a provider has multiple site that offer identical specialties. Only one site would be counted." lead us to believe that if a provider has a site that offers multiple services, we could count the provider multiple times (i.e. If an organization owns a Hospital and a Care Management group on the same Island, both can be counted). Can you validate this is still correct given the recent amendment?	Yes. If a provider has multiple services in their business (as described in your example), each service can be counted for one LOI.

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled
Q&A

Quest. #	Amend. #	# (1 st column on Amendment documents)	Question	Answer
40	5	9	Our interpretation of the wording in 80.315.2 "...Only one site will count...If a provider has specialties on multiple islands, the same LOI can be counted for all islands represented" lead us to believe that we could count an LOI multiple times for a given provider group if the group had service sites on multiple islands, but count only once if the provider group offering one service has multiple sites on the same geographical area/island. (i.e. if a home health agency has locations in Hilo, Kona, and Oahu, we would count the HHA 3 times). Can you validate this is still correct given the recent amendment?	Yes. If a provider has service sites on several islands, the LOI can be counted for the number of islands the provider serves (as described in your example).
41	5	9	Section 80.315.2, table: Please confirm the 1st paragraph for the specialists also be amended accordingly with the 2nd paragraph to read: ...applicant must have LOIs from 3 Specialists in each of the categories listed (the other 8 may be from any category).	No. This amendment does not refer to the table. Also, #12 in amendment #5 that does refer to the table, is discussing the second paragraph. The first paragraph in 80.315.2, table referring to specialists remains intact.
42	5	9	Please clarify how a health plan would submit LOIs signed by one entity representing both PCPs and Specialists within their IPA. How would the health plan reflect both categories of providers using the one signed LOI and would that LOI be counted as 2 LOIs?	If one LOI met the category needs for both PCP and specialist, it would be counted as 2 LOIs.
43	5	9	Please provide additional clarification on how this guidance would be applied to providers within a community health center or a hospital related provider group.	The example provided would be applied to providers within a community health center or hospital related provider group.

RFP-MQD-2008-006

Issued 11/21/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled
Q&A

Quest. #	Amend. #	# (1 st column on Amendment documents)	Question	Answer
44	5	9	If a provider group has 3 of the required PCP categories i.e. Family Practice, Pediatrician and OB/GYN, and signs one LOI do you only recognize 1 of the categories as met or all 3? If one, which one?	This example would meet the specialist category requirements for one LOI. The specific category would be the choice of the health plan.
45	5	9	If an SNF provider has 4 free standing facilities, 3 in various locations on one island and 1 on another island and signs one LOI do you only recognize 1 SNF facility or all 4? If one, which one?	This example would meet the requirement of Nursing Facilities for two islands.
46	5	9	On Section 80.315.2 on amendment #5, the insertion of the new paragraph reads: When a health plan is submitting an LOI for a group practice, the health plan may complete one (1) form and attach a spreadsheet containing the names of all providers in the group practice. Does this mean that all specialists are counted separately or only as (1) provider. It then continues to say: A group practice LOI shall count as only one (1) submitted LOI.	Item #9 in amendment #5 states that “A group practice LOI shall count as only one (1) submitted LOI.” Therefore, in the example you provided, if all specialists are in one group practice, the group practice LOI would count as one LOI.