

Technical Proposal Question & Answer #3- General RFP questions

Issued on: September 30, 2011

For Request for Proposals RFP-MQD-2011-003

QUEST Managed Care Plans to Cover Eligible Medicaid and Other Eligible Individuals who are not Aged, Blind, or Disabled

Question #	RFP Section #	RFP Page #	Para #	Question	Answer
1	30.200	53	3 rd paragraph	How does DHS intend to verify that applicants meet the solvency standards of HRS 432D-8?	Applicants must turn over a Certificate of Good Standing from the State of Hawaii, Department of Commerce and Consumer Affairs, Insurance Division (Section 80.230.S). This Certificate of Good Standing will only be issued if a health plan meets the solvency standards identified in Chapters 431, 432, or 432D of the Hawaii Revised Statutes (HRS).
2	40.250	125	3 rd paragraph	The health plan shall advise, provide a copy, and obtain approval from the DHS when revising PCP P&Ps. Similar requirements must be met for other P&Ps. If the health plan performs annual review and revisions to meet accreditation requirements and the revisions are not significant or do not materially change the policy and/or process, must the health plan submit and obtain approval for the changes? Is	Any policy and procedure that DHS has to approve initially will require a reapproval if changes are made to it. However, some changes are nominal and do not require a reapproval. Health plans may request a waiver of review but will need to let DHS know the proposed nominal changes (i.e., fixing a typographical error on pg. 3 or changing the P.O. Box on pg. 5). Another option

Question #	RFP Section #	RFP Page #	Para #	Question	Answer
				there a level or threshold of changes that would require notification and P&P submission to the DHS?	is to make the changes in ‘track changes’ and identify the pages DHS needs to review for approval.
3	40.650	156	1 st paragraph	Relating to ‘electronic prior authorization request and approval’, please clarify the DHS’ expectations for this capability. Would the timelines for making a coverage decision differ for an electronic vs a hardcopy or faxed prior authorization request? Is it the DHS’ expectation that this functionality is available on 4/1/12?	No. The timelines would remain the same as identified in Section 50.900. This functionality is expected for April 1, 2012.
4	40.740.1.o	183	1st paragraph	Blood is included in this section relating to Prescription Drugs. We recognize that factors for hemophilia are included in this section but would whole blood be included? Please clarify.	Whole blood is a covered benefit as well.
5	40.740.1.s	186	1 st bullet	Up to 4 face to –face smoking cessation counseling services are covered. Some quit program counselors are unlicensed individuals. Would the following statements be correct? For this benefit, face to face services provided by unlicensed smoking cessation counselors would be recognized if billed under the certified program. Also, individual licensed providers who are recognized by the QUEST program are also eligible to	Yes. These statements are correct.

Question #	RFP Section #	RFP Page #	Para #	Question	Answer
				bill and obtain reimbursement for smoking cessation counseling if acting within the scope of their practice although they may not have specific experience with smoking cessation?	
6	50.100	233	1 st paragraph	Is there a specific time frame on when a member may renew their annual QUEST coverage (30, 60, 90 days prior to their renewal date)? This would help a health plan determine the start of outreach activities.	The Medicaid eligibility review (ER) occurs in the last month of Medicaid eligibility. ER paperwork is mailed at the end of the preceding month of eligibility termination (i.e., mailed the last week of September for and eligibility that ends on October 31). The health plan should use these timelines in developing their outreach processes.
7	50.430	234	3 rd paragraph	Is Mandarin or Cantonese considered the “Chinese (Traditional)” language indicated in 3 rd paragraph?	Both Mandarin and Cantonese are oral languages. The written version of both of these languages is Chinese (traditional).
8	50.460	252	Last paragraph	Can the health plan use a separate addendum to update an existing hard-copy provider directory or does the health have to print a new directory every quarter? The addendum would be included with the hard-copy provider directory when mailed to the member.	The health plan may use an addendum, but it will need to be approved by DHS. Since the provider directory is written material provided to a member, DHS would need to approve the addendum prior to the health plan issuing it (at least the first addendum, as long as the subsequent addendums followed the same methodology).

Question #	RFP Section #	RFP Page #	Para #	Question	Answer
					In reviewing the addendum, DHS would assure that members are easily able to discern who is in the network of the health plan. Members should not think that a provider no longer contracted with the health plan is an option for them to choose.
9	51.410	321	Table	Please define “encounter processors” as indicated in the staffing table. Are these positions related to the DHS encounter submission requirement?	Yes. These positions are required to process encounters to DHS.
10	51.520.2	333-334	All	Will the DHS provide a format of this report?	Health plans must use software that plots a health plan’s providers geographically across the State. GeoAccess is one brand name of this software. Other software exists that can perform this function. DHS does not include that it requires nor will DHS provide a specific format for this report.
11	51.520.6	337	1 st paragraph	Does the ‘because of suspected or confirmed fraud or abuse’ criteria in the first sentence also apply to the quarterly report specifications? If not, please provide a definition of a ‘termination.’ If a provider terminates his/her contract with the health plan, does that qualify as a ‘termination’ which would be listed on the quarterly report?	On a quarterly basis, health plans must submit to DHS providers who have been suspended or terminated for any reason to include but not limited to failure to renew license, ended contract, or suspected of fraud or abuse. In addition, if a provider is suspected or confirmed of fraud or abuse, the health plan must submit this information to DHS within

Question #	RFP Section #	RFP Page #	Para #	Question	Answer
					three (3) business days of the suspension or termination.
12	80.315.1.E	439-440	E	Pertaining to the section of the question regarding ‘referral to specialists”, please clarify if the DHS is asking about the health plan’s P&P in relation to how a member may access a referral to a specialist from his or her PCP or is this part of the question in relation to the health plan referring or assigning a member with specific medical needs to a specialist who will act as the member’s PCP.	This question refers to the applicant’s policies and procedures regarding specialists who serve as a PCP for members with chronic conditions. The requirements of specialists serving as PCPs are outlined in Section 40.250, third paragraph.
13	80.315.2	441	Table	Can a health plan add more columns to the table for easier present? So that table headings would be Provider type, Specialty, Island/County (for Oahu include the city), Affiliated clinic if applicable, Provider Name (Last, First, MI), ‘Accepting new QUEST members (Y/N)?’, ‘Any limit on QUEST members (Y/N)?’	The health plan may display information on provider types in three columns (i.e., PCP in the first column, Family Practitioner in the second column, and the affiliated clinic in the third column). Applicants may also list the affiliated clinic on a separate line since multiple services may be provided by that clinic.
14	80.315.2 A	441	A	Do non-physician PCPs get listed under section A or under section B? We were not sure how the second sentence should be interpreted in section A: ‘Nurse midwives, pediatric nurse practitioners, and family nurse practitioners shall be	If a non-physician provider is functioning as a PCP, they should be listed in Section A. If a non-physician provider is not functioning as a PCP, but is in the applicant’s provider network, then they should be listed in Section B.

Question #	RFP Section #	RFP Page #	Para #	Question	Answer
				listed separately.’. Does that statement mean that the non-physician PCPs should be listed in section A or in section B?	The applicant should not list the provider twice.
15	80.320.4.C	448	C	Please clarify what type of documentation (“documentation to verify the statistics”) would suffice for meeting the section questions.	The use of the CMS 416 provides documentation for statistics for Section 80.320.4.C.1 and 2. For Section 80.320.4.C.3 (percentage of children so identified who actually receive follow-up services), documentation may include a sampling of either chart audits or claims data.
16	90.200	464	1 st and 2 nd paragraphs	If the premium tax is to be “excluded” in the capitation rate as stated in the 2 nd paragraph of Section 90.200, how does DHS intend to include the premium taxes as stated in its answer to question 378, released September 14, 2011, and maintain compliance with HRS 103F-401.5(b)?	<p>The insurance premium tax and/or general excise tax (GET), if applicable to a health plan, is excluded from the administrative load. Those pass-through taxes are not excluded from the capitation rate as stated in the question. DHS will comply with State law.</p> <p>An amendment clarifying that the administrative load excludes GET as well as insurance premium tax is being made to RFP section 90.200.</p> <p>As this question pertains to capitation rate development, further questions can be addressed in the capitation rates Q&A.</p>

Question #	RFP Section #	RFP Page #	Para #	Question	Answer
17	90.200 and 90.300	464-466	1 st and 2 nd paragraphs	<p>The first paragraph of 90.200 states that the capitation rate will be computed as a base rate subject to “certain other adjustments described in the next section.” But the second paragraph mentions adjustments such as administrative expenses, risk margin and care management expenses “but excluding premium tax”.</p> <p>The adjustments described in Section 90.300 include an adjustment for PPS, an adjustment for SMI, and a risk margin.</p> <p>Will DHS include the premium tax on for-profit plans in the calculation of the base capitation rate? If not, will DHS offer a different rate to plans that are subject to the premium tax?</p> <p>Alternatively, will the premium tax due for for- profit plans be added on to the base capitation rate?</p>	See answer to question #16, above, and question #378 in the Technical Proposal Question and Answer issued on September 14, 2011.
18	Entire RFP, including Appendices and Amendments			Please provide the entire RFP, including appendices and amendments, in Word format. This will give health plans the ability to produce one comprehensive RFP with amendment revisions included.	DHS cannot release the Word version of the RFP at this time. Anything released to a potential applicant needs to be shared with all interested parties. Thereby, DHS would need to post any

Question #	RFP Section #	RFP Page #	Para #	Question	Answer
				It will also allow health plans to respond to the Attachments in Section 80.230 as a soft copy rather than re-typing the document or printing the PDF and filling in the responses. In particular, we'd like to request D, E, F, G & H in word format.	Word version of the RFP on the State Procurement Office (SPO) website. Any Word document may be altered. DHS would not be able to maintain its accuracy.
19	N/A	N/A	N/A	Will the DHS provide health plans with an updated version of the RFP that incorporates amendments or a Word version so plans may make their own updates?	Health plans that have been awarded contracts may request a copy of the Word version of the RFP after contract award. DHS will not provide an updated version that incorporates amendments.
20	N/A	N/A	N/A	Will the final capitation rates paid to each plan be made public?	The final capitation rates paid to each health plan is considered public information once the capitation rates are approved by the Centers for Medicare & Medicaid Services (CMS). Health plans may request this information from DHS once it is considered public information.