

**Wisconsin Department of Health Services  
 Questions and Answers - #4  
 Southeast Wisconsin Medicaid Managed Care Organizations RFP (1684 DHCAA-SM)**

**Please note: This is the final posting of Questions and Answers planned for this RFP.**

Question Number	RFP Page Number	RFP Section Reference	Question	DHS Answer
1		General	What were the benefit and/or other program changes between 2006 and 2007?	<p>Specific information on past benefit and/or program changes can be found in the provider handbooks and updates posted on the ForwardHealth website:  <a href="https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/Provider/Updates/Index.htm.spage">https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/Provider/Updates/Index.htm.spage</a></p> <p>Information on other changes can be found on the ForwardHealth website under Provider-specific resources:  <a href="https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/provider/medicaid/index.htm.spage">https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/provider/medicaid/index.htm.spage</a>. For example, hospital information and rates can be found at:  <a href="https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/provider/medicaid/hospital/resources_01.htm.spage">https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/provider/medicaid/hospital/resources_01.htm.spage</a></p>
2		General	Please provide data on the duration of enrollment (aka churn) in current plans.	The Department expects to post data on duration of enrollment in current plans by December 31, 2009 under “Data

				Resources” on the website: <a href="http://dhs.wisconsin.gov/medicaid/ratereform/managedcare/index.htm">http://dhs.wisconsin.gov/medicaid/ratereform/managedcare/index.htm</a>
3		General	Please provide current/recent dental utilization rates in Regions 5 and 6. What percentage of the current membership of these regions access dental care annually, using this formula: Numerator being the "number of unique members who accessed dental care which generated a paid dental claim during the 12 month period" and the denominator being "the total number of member months for this same 12 month period divided by 12".	Data on dental utilization rates in Regions 5 and 6 has been posted under “Data Resources” on the website: <a href="http://dhs.wisconsin.gov/medicaid/ratereform/managedcare/index.htm">http://dhs.wisconsin.gov/medicaid/ratereform/managedcare/index.htm</a>
4	20	4	Please explain the scoring evaluator process and the type of evaluators who will be used.	Evaluators are chosen for their varying expertise relevant to the areas of service being procured. Basic requirements of an evaluation committee are: a minimum of three evaluators comprise the committee; one member must not be employed in the procuring agency; and when possible, one member may be sought from outside state government.
5	20	4	Please give an example of how the scoring will be calculated. A suggested example would be to compare two proposals where one of them has the highest cost score but the lowest technical score. Will the scoring use percentages or convert these to points (e.g. 1,000 total points)?	The evaluation team scores the technical proposals and does not have access to cost proposals. The Procurement Lead and/or designee will score the cost proposals. The score for the technical proposal will be combined with the score for the cost proposal to establish a final composite score for each Proposal.

6	20	4.3	Please provide more details on scoring criteria and how points will be given for sub items – i.e. 6.1, 6.2, 6.3.	No additional details will be made available in this regard until after letters of intent to award are issued.
7	27	6.1 - #4A	The RFP requires health plans to submit evidence of NCQA certification for submission of prior HEDIS metric data results. On the same note, the State has already indicated at the Vendor Conference that health plans aren't required to submit their HEDIS data to NCQA, but the Department actually collects that data and reports it and has it audited. So can you provide clarification as to whether or not you will accept that historical data from plans doing business in this state that has been certified by your vendor under your reporting?	For the HMOs the Department currently contracts with, the Department will accept HEDIS data which was previously collected and reported out by the Department, provided it is submitted according to the guidelines indicated in the RFP. If a Proposer submits HEDIS data which was provided by the Department, the Proposer must still submit a statement of certification from an NCQA-certified auditor. Such a statement may be obtained from DHS' Managed Care Contract Compliance Section Chief, Makalah Wagner.
8	27	6.1 - #4A	Under Section 6.1 Quality Performance 4A and 5A. For HMOs with existing contracts, DHS provided HEDIS scores 2006 through 2008. Can we assume you received them from a vendor who was NCQA certified to produce HEDIS scores and a separate statement of certification from the HMOs would be unnecessary? Or would it be our responsibility to contact your vendor to request a statement of certification for the HEDIS results they submitted for our HMO?	All HEDIS data submitted by Proposers must be accompanied by a statement of certification from an NCQA-auditor. HMOs with existing contracts with the Department can obtain a statement verifying that the HEDIS data calculated by the Department was certified from DHS' Managed Care Contract Compliance Section Chief, Makalah Wagner.
9	2	Amendment #2:	Please explain specifically what the	This data field “continuously enrolled

		6.1 - #4A	Department is asking for from the proposer in the column entitled “Continuously Enrolled Population.”	population” has been deleted. See Amendment #6 to this RFP.
10	2	Amendment #2: 6.1 - #4A	Because of space issues, we request the column entitled “MSA Name” be changed to “MSA Number”.	See Addendum 5 to this RFP for clarification on the field name definitions in Addendum 2.  Proposers may indicate MSA Name or MSA Number in the column entitled “MSA Name.”
11	2	Amendment #2: 6.1 - #4A	The Department has included a column for proposers to enter the contract commencement date in the HEDIS data Section 4A required format. Should this date be the most recent contract date, the first date contracted, or both dates? Should the proposer note, in instances where a contract has been effective for many years but HEDIS data submission was required only recently, a note to this effect? And if so, where should this note be included?	See Addendum 5 to this RFP for clarification on the field name definitions in Addendum 2.  For the field “Contract Commencement Date,” the Proposer should list the date on which it first contracted with the given state to provide services to the Medicaid, SCHIP or Commercial population.  It is not necessary for a Proposer to note that a contract has been effective for many years, but HEDIS data submission was only recently required. However, as stated in Section 6.1 - #4A of the RFP, a Proposer must provide the following information if applicable: “If you do not have results for a particular measure or year, please provide the results you do have and explain why certain data is not available. If data is not available for your Medicaid population,

				please submit commercial data in that state and explain why Medicaid data is not available.”
12	2	Amendment #2: 6.1 - #4A	<p>Amendment 2 revises section 6.1 4A to state: “If Proposers have Medicaid contracts in an MSA included on this list, it must submit HEDIS data from that MSA separate from the other areas that are covered by that contract.”</p> <p>The file format (Addendum 2) includes a column for the proposer to identify if the contract is in a MSA and the MSA name. We assume that for any contract that includes a MSA, we are to notate what MSA(s) are within the service area.</p>	<p>See Addendum 5 to this RFP for clarification on the field name definitions in Addendum 2 to this RFP.</p> <p><u>For the field, “MSA (Y/N)”</u>: Proposers are to indicate a “Y” if the HEDIS data being reported corresponds to:</p> <ul style="list-style-type: none"> <li>▪ An MSA listed in Addendum 2,</li> <li>▪ A logical geographical area to an MSA listed in Addendum 2, or</li> <li>▪ Wisconsin regions 5 and 6.</li> </ul> <p>Proposers are to indicate an “N” if the HEDIS data being reported does not correspond to any of the three categories listed above. For example, if a Proposer submits state level HEDIS data, the Proposer should indicate an “N.”</p> <p>If a Proposer chooses to submit data for the nearest logical geographical area to an MSA listed in Addendum 2, the Proposer must demonstrate through written narrative that the nearest logical geographical area is a close approximation to the identified MSA based on population density. In this case, a close approximation is defined as a geographic area that incorporates a</p>

				<p>Medicaid population not exceeding 110% of the Medicaid population of the identified MSA. The Department does not consider a close approximation to be data reported on a state level. The nearest logical geographical area must include an MSA listed in Addendum 2.</p> <p><u>For the field “MSA Name”:</u> If a Proposer indicates a “Y” for the field “MSA (Y/N),” indicate the MSA name or number for which the HEDIS data is being reported. If data is being reported for a logical geographical area to an MSA listed in Addendum 2, indicate the MSA name or number for that MSA. If data is being reported for Wisconsin regions 5 and 6, indicate “WI regions 5 and 6.”</p> <p>If a Proposer indicates an “N” for the field “MSA (Y/N),” leave this field blank.</p>
13	26	Appendix A – Article III.C.11	Do HMOs need to collect the CLIA certificates from the physician office labs as well as the independent labs and maintain them on file as part of the credentialing process?	As indicated in Article III.C.11 of the BadgerCare Plus contract, “All laboratory testing sites providing services under this Contract must have a valid CLIA certificate along with a CLIA identification number, and comply with CLIA regulations as specified by 42 CFR Part 493.1 <i>Laboratory Requirements and Basis and Scope</i> . Those laboratories with certificates must provide only the types of tests permitted under the

				terms of their certification.”
14	30	Appendix A – Article III.D.10	Members Living in a Public Institution: “public institution” is defined as an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control as defined by federal regulations, including but not limited to prisons and jails. Please clarify that the term “public institution” does not include (consistent with federal regulations in 42 CFR 435): A medical institution An intermediate care facility A publicly operated community residence that serves no more than 16 residents A child-care institution	Yes, the BadgerCare Plus contract defines “public institution” consistent with federal regulations, including 42 CFR 435, which states that “the term <i>public institution</i> does not include-- (a) A medical institution as defined in this section; (b) An intermediate care facility as defined in Sec. Sec. 440.140 and 440.150 of this chapter; (c) A publicly operated community residence that serves no more than 16 residents, as defined in this section; or (d) A child-care institution as defined in this section with respect to-- (1) Children for whom foster care maintenance payments are made under title IV-E of the Act; and (2) Children receiving AFDC--foster care under title IV-A of the Act.”
15	35	Appendix A - III E 7.e	Will DHS permit flexibility in the reimbursement approach for the dental benefit, as long as the net effect is at or above the FFS reimbursement?	The Department will permit flexibility to the extent that <u>each service provided</u> is paid at or above the FFS reimbursement rate.
16	49	Appendix A – Article III.H.2	Can you please clarify the roles and responsibilities of the Department’s patient navigator referred to in the HMO Contract, Art III, H, 2?	The Department’s patient navigator’s responsibilities include, but are not limited to, working with members who are pregnant: <ul style="list-style-type: none"> <li>▪ To resolve eligibility or enrollment issues;</li> </ul>

				<ul style="list-style-type: none"> <li>▪ To locate providers who are in their HMO’s network and taking new members; and</li> <li>▪ To refer them to local agencies for appropriate services, such as PNCC programs.</li> </ul> <p>Currently the Department has a patient navigator located in Kenosha County.</p>
17	62	Appendix A – Article III.I.5	We must have a system in place to ensure well managed care with systems that clearly specify referral requirements to providers and subcontracts. Item d requires: “The HMO must keep copies of referrals (approved and denied) in a central file or the patients medical record.” Is the state here using the term “referral” for prior authorizations, or does this requirement mean that all services that a PCP sends to a specialist require a documented referral, which is a process that most MCOs no longer use?	In this instance, the term “referral” is to be defined by the organization.
18	67	Appendix A – Article III.I.11	Please define translation versus interpreter services. Our understanding is interpretation refers to spoken/verbal services and translation refers to written materials.	<p>Although translation and interpretation share the common goal of taking information that is available in one language and converting it to another, they are two separate processes and require distinct skills.</p> <p>Translation is generally written - it involves taking a written or recorded text</p>

				<p>(e.g., a book or an article, a voice message) and translating it in writing into the target language. The translator usually works in isolation to find the meaning of what is being said; sometimes this may involve additional research. The translator is concerned with the nuances of the language and the meaning of words.</p> <p>Interpretation is oral and it occurs in real time. The interpreter must grasp the meaning of the issue immediately and proceed from that point. It involves listening to something spoken (e.g., a speech or phone conversation) and interpreting it into the target language – either orally or in sign language. Because the practitioner is focused on the “here and now,” some informational details and nuances may be lost in this simultaneous interpretation.</p>
19	69	Appendix A – Article III.K	Is the State basing the HealthCheck data on the 416 CMS report format? If not, what are the data requirements?	Yes.
20	69	Appendix A – Article III.K	For data about HealthCheck; will we get a complete historical data feed of members’ claims history and pharmacy data, dental and any additional behavioral health data?	<p>The Department produces a monthly report for HMOs that contains historical data on FFS members who enroll in HMOs. For more information on this report, see “HealthCheck Report” at <a href="https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/managed%20care%20organization/reports_data/hmomatrix.htm.sp">https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/managed%20care%20organization/reports_data/hmomatrix.htm.sp</a></p>

				<p><a href="#">age</a></p> <p>The Department is considering the production of a report for HMOs who are awarded a contract through this RFP that contains historical health check data on all members who are enrolled in the HMO as part of the enrollment transition period in Summer 2010.</p>
21	69	Appendix A – Article III.K	Will the State be providing a historical feed of HealthCheck visits to the HMOs? If not, what is the State’s expectation to determine who needs to be called?	<p>The Department produces a monthly report for HMOs that contains historical data on FFS members who enroll in HMOs. For more information on this report, see “HealthCheck Report” at <a href="https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/managed%20care%20organization/reports_data/hmomatrix.htm">https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/managed%20care%20organization/reports_data/hmomatrix.htm</a> <a href="#">page</a></p> <p>The Department is considering the production of a report for HMOs who are awarded a contract through this RFP that contains historical health check data on all members who are enrolled in the HMO as part of the enrollment transition period in Summer 2010.</p> <p>Article III.K in the BadgerCare Plus contract found in Appendix A to this RFP details the HMOs’ responsibilities regarding HealthCheck.</p>