

Technical Proposal Question & Answer on Amendment #1

Issued on: September 22, 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 #	# (first column of list of amendments)	Question	Answer
1	4	This amendment allows applicants to submit questions only on previously posted amendments. Some of the answers in the Q&A document did not provide sufficient clarity or didn't answer the question asked. In order for both the health plans and the State to have a successful program, we are requesting one more opportunity to ask clarifying questions to answers already provided in the Q&A.	DHS will allow a third round of questions. DHS is interested in assuring that applicants have adequate information to submit a proposal. If questions are asked regarding the implementation of the program, DHS will attempt to answer these questions but may need to defer answering them until after contract award. See #1, #3, #10, and #11 of Amendment #2.
2	9	Since the QUEST-NET and QUEST-ACE members will be enrolled in the QUEST-Adult Benefit Package, does this mean that they too will be eligible for referral for SPMI services if appropriate? Currently, the SPMI members under these plans receive their SPMI services through the Adult Mental Health Division. Does this mean that there will be a transition of these members back to the base QUEST plans? If so, how will this occur?	1) Yes. They will receive all of their SPMI services through the QUEST program. 2) DHS will obtain transition of care information from Adult Mental Health Division (AMHD) to provide to health plans to transition behavioral health services to their QUEST health plan.
3	13	This amendment adds the following as another reason for DHS to disenroll a member: "The member missed Annual Plan Change due to temporary loss of Medicaid eligibility and was	This amendment refers to QUEST members who have lost their ability to participate in Annual Plan Change (APC) due to temporary loss of Medicaid eligibility who regained their eligibility within

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		<p>reenrolled in their former health plan as described in Section 30.570." Section 30.570 appears to intentionally differentiate a "cap" (initiated by DHS) from a "limit" (initiated by the health plan). Does the added language refer to members affected by an enrollment limit <u>and</u> a cap? If so, the four exceptions to the policy should be revised to also reflect enrollment limits. Also, please confirm if the last sentence in this section refers only to the DHS initiated enrollment cap, and not the health plan initiated enrollment limit. Naturally, we would be concerned if this last sentence in the section means that DHS can unilaterally lift membership limits enacted by the health plans and agreed to by DHS at any time during the term of the contract. That would undermine the whole purpose of the provision in the first place, and make it nearly impossible for health plans to meaningfully plan and budget with any precision or confidence.</p>	<p>sixty (60) days and are reenrolled in their former health plan. These members will be allowed a chance to change their health plan (i.e., participate in APC), or they can choose to remain in that health plan. If the individual chooses to change health plan, the health plans that will be offered to them for choice will NOT be those that are affected by either an enrollment limit or cap.</p> <p>A health plan that initiates an enrollment limit will only be required to accept new members who meet one of the four exceptions identified in Section 30.570. Amendment #13. This amendment does NOT allow DHS to unilaterally lift enrollment limits enacted by the health plans and agreed to by DHS.</p>
4	14	<p>Is there a process to facilitate transition to QExA if the transition does not occur within the expected time frame? We understand that the State will eventually retroactively disenroll the member from the QUEST health plan, but transition to QExA may be delayed if the member still shows QUEST coverage.</p>	<p>There is a process to transition members from QUEST to QExA. Part of the ADRC process is determining the date for the QUEST program to end and the QExA program to start. This date is entered into the HAWI eligibility system and enrollment to a QExA health plan occurs following the change in program in the HAWI system. As the question describes, this may be a retro-disenrollment from QUEST and retro-</p>

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			enrollment into QExA.
5	25	Please provide examples of the services considered ‘other practitioner services’.	Other practitioner services are listed in Section 40.740.1.j. A few examples include optometry services and certified nurse midwife services.
6	25	To ensure consistent application of limited services within the QUEST program can the DHS provide a cross walk of the category of services that are listed in 20 outpatient visit section to applicable CPT/HCPCS/Revenue Codes? (e.g. what revenue codes and/or CPT codes would map to the home health category, etc)	No. However, health plans that are awarded contracts may seek specific guidance related to CPT/HCPCS/Revenue Codes and limited benefits after contract award.
7	25	With the deletion of “Rehabilitation Services” with this amendment, PT/OT/ST services would no longer be covered under the QUEST-Adult Benefit Package. Is that the intent of this amendment?	Yes.
8	25	Rehabilitation services were removed from the services making up the 20 outpatient visits for the QUEST Adult Benefit Package. Does this mean rehabilitation services are not a benefit of the QUEST Adult Benefit Package? If it is a benefit, will it be added back to Section 40.710.1?	Yes. This is what this deletion means.
9	25	With the deletion of “therapeutic services” with this amendment, was the intent that these services will be covered under ‘Cancer-related treatment’?	Yes.
10	25 & 41	Mental health parity law sets forth specific benefits which appear to be greater than the limited QUEST Adult benefits proposed in this contract; allowing for equal number of visits for both medical needs and behavioral health	A member’s access to either behavioral health or substance abuse services shall be no more restrictive than for accessing medical services. Because behavioral health and substance abuse service limits are not more stringent than for

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		including chemical dependency. This contract allows the health plans to use a maximum number of visits for either one, but does not account for parity. Please address this discrepancy.	<p>medical services, mental health parity is addressed with the limitations in the QUEST Adult program. Under the benefit structure, a member can receive a maximum of 20 medical visits or a maximum of 26 behavioral health visits.</p> <p>See #1 of Amendment #2 for further clarification.</p>
11	26	Smoking Cessation and Interpreter Services/Translation Services were removed from the QUEST Adult Benefit Package. Does this mean Smoking Cessation and Interpreter Services/Translation are not a benefit of the QUEST Adult benefit package? If these are benefits, will it be added back to Section 40.710.1?	<p>Smoking cessation is listed as a benefit in Section 40.740.1 (see amendment #25, bullet point #2, sub-bullet point #9).</p> <p>Interpreter Services/Translation is a service that is provided to anyone in the QUEST program (see Sections 50.430 and 50.495) that has Limited English Proficiency (LEP). Because this is a benefit to all members in the QUEST program, it does not need to be included under the list of benefits for QUEST Adult.</p>
12	29	Dialysis was added to the QUEST Keiki benefit package in this amendment. Should Dialysis also be added to the QUEST Adult benefit package, Section 40.710.1?	As described in question #105 of the Q&A posted on September 14, 2011, chronic dialysis as an additional benefit for end stage renal disease is NOT provided as a benefit for the QUEST Adult benefit package. These individuals will be considered disabled and enrolled in QExA.
13	36	Does this amendment mean that there would not be any limitations on behavioral health services related directly to postpartum depression as provided by a behavioral health and/or non-behavioral health Provider for up to sixty (60)	Yes. There are no limits to services provided to women up to sixty (60) days postpartum that impact the health of the woman, to include depression.

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		days?	
14	39	<p>Are Cornea procedures part of the three outpatient hospital/ASC procedures?</p> <p>If so, can additional language be added to the second sentence of the amendment so that the Cornea procedures are ‘included as part of the 3 outpatient hospital procedures’?</p>	<p>Cornea transplants may be provided in multiple locations to include inpatient hospital, outpatient medical visit, or outpatient hospital/ambulatory surgical center procedure. This service shall be provided in the most appropriate service location for the member.</p>
15	42	<p>This amendment would move “methadone management” to the coverage available to SPMI members only. 90% of our members using this service are non-SPMI members. We would advocate that these services be covered for all QUEST-Adults.</p> <p>Is the intent of this amendment to limit these services to the SPMI population?</p>	<p>The intent of this amendment is to assure that there is no benefit limit applied to methadone management. DHS shall amend the eligible diagnoses listed in Appendix G to include those with diagnosis of opioid dependence.</p> <p>See #8 of Amendment #2.</p>
16	46	Reference to 50.240 should be 50.420.	<p>Yes.</p> <p>See #4 and #5 of Amendment #2.</p>
17	47	What if it is the preference of the Member to have a friend or family member accompany them to their appointments and that person is their designated interpreter?	<p>DHS shall allow a friend or family member to accompany someone with LEP to their appointment as their designated interpreter if it is their preference. Health plans will be responsible for documenting the preference since it is the health plan’s responsibility to provide interpreter services, not the member.</p>
18	54	For clarification, can the new language be written as “A member shall be able to make a request to	<p>Section 42 C.F.R. § 431.201 describes that a managed care enrollee shall be able to request for</p>

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		<p>the health plan for the provision of a service”?</p> <p>What is MQD expecting health plans to do with these requests?</p>	<p>the provision of a service. The health plan is responsible for processing these requests as a request for authorization of services (see Section 50.900).</p> <p>See #6 of Amendment #2.</p>
19	61	<p>Amendment states that the health plan shall report to the Investigations Office (INVO) of the Benefit, Employment and Support Services Division (BESSD) any suspicion of recipient fraud.</p> <p>Is this limited to suspected eligibility fraud (member falsified information to obtain eligibility), or is all suspected fraud and abuse committed by the member submitted to BESSD (for example: fraudulently obtaining controlled substances or other medical services)?</p>	<p>No. All suspected fraud and abuse committed by a member should be reported to the appropriate entity. Eligibility fraud for, medical assistance, financial assistance, or Supplemental Nutrition Assistance Program (SNAP) should be reported to INVO. Fraudulently obtaining controlled substances, other medical services, or collusion between provider and member to obtain services would be reported to the Med-QUEST Division (MQD).</p>
20	68	<p>Does “agency” in this amendment refer to a health plan’s translation vendor?</p>	<p>Yes.</p>
21	80	<p>Section 70.800 of the RFP is amended to prohibit health plans from contracting with the State of Hawaii unless safeguards at least equal to the “Federal safeguards” are met. A reference to the United States Code is included—41 U.S.C. 423, Section 27. That section of the United States Code does not appear to include a Section 27.</p> <p>QUESTION: Since the health plans are required to have these “Federal safeguards” in place, can</p>	<p>The Social Security Act (Sec.1932(d)(3)) requires these provisions specific to Section 27 of 41 U.S.C. 423. DHS shall amend the contract to remove the reference to section 27.</p> <p>It is the State, and not the health plans, that is obligated to have safeguards at least equal to the Federal safeguards.</p> <p>See #7 of Amendment #2.</p>

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		Med-QUEST review the citation, confirm that it is correct, and provide a copy of the citation?	
22	82	<p>The revision to the provision for termination on account of default adds the following language indicated in bold: “The failure of the health plan to comply with any term, condition, or provision of the contract or applicable requirements of Sections 1932, 1903(m) and 1905(t) of the Social Security Act” shall constitute a default by the health plan.</p> <p>Section 1932 [42 U.S.C. 1396u-2] requires as follows: “. . . (I) the entity and the contract with the State meet the applicable requirements of this section and section 1396b(m) or section 1396d(t) of this title, and. . .” (emphasis added)</p> <p>Section 1903(m) [42 U.S.C. 1396b-(m) applies to “Medicaid Managed Care Organizations”.</p> <p>Section 1396(t) [42 U.S.C. 1396d-(t) applies to “Primary care case management services”.</p> <p>QUESTION: Since Section 1932 requires the entity and the contract with the State to meet the applicable requirements of either Section 1396b(m) OR Section 1396d(t), should the provision be reworded as follows: “The failure of the health plan to comply with any term, condition,</p>	<p>This language is included as required managed care contract language with the Centers for Medicare & Medicaid Services (CMS). Amendment #82 only binds the health plan to applicable requirements included in these sections of the Social Security Act. Though DHS is aware that Section 1905(t) does not affect managed care contracts, this amendment does not bind the health plan to these requirements.</p>

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		or provision of the contract or applicable requirements of Section 1932 <u>and either</u> 1903(m) <u>or</u> 1905(t).” (revised language is underlined)	
23	88	This amends Section 72.320 of the RFP. In addition to complying with ADA, civil rights act, the amendment now requires health plans to comply with the Education Amendments of 1972 (probably not applicable to this health plan as the amendments are for educational institutions), Copeland Anti-Kickback Act (applies to contractors engaged in building construction), and Davis-Bacon Act (applies to prevailing wage rates on federal construction projects). How do these laws apply to health plans?	Compliance with all three of these laws are requirements for a managed care health plan to contract with a State in a Medicaid program as described by the CMS. If a law described in this section does not specifically relate to a specific health plan, then it will not need to be followed (as described in the first paragraph of Section 72.320).