

Technical Proposal Question & Answer- #5- Additional questions to DHS response to previous 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 # | Q&A Posting Date | Question # (related to Q&A) | Question | Answer |
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| 1 | 9/14/2011 | 39 | For patient's determined to meet disability criteria by the Social Security Administration, as opposed to the ADRC process, is the timeline for transition the same? What is the process to facilitate transition if it is not completed within the expected time frame? | When the health plans provide DHS with disability criteria from the Social Security Administration, these individuals will have an effective date of enrollment in the QExA program of no later than the first of the month following the receipt of the supporting documentation. This enrollment may be retroactive. |
| 2 | 9/14/2011 | 47 | Is there a process to facilitate transition to QEXA if the transition does not occur within the expected time frame? | DHS will be reexamining its ADRC processes in the future and does not have information to answer this question at this time. In addition, this question refers to program implementation and not to submission of proposals. DHS will respond to this question after contract award. |
| 3 | 9/14/2011 | 79 | Can a provider charge a no-show fee on a visit (e.g. 25 th visit) that has exceeded the Adult benefit limit? | This question refers to program implementation and not to submission of proposals. DHS will respond to this question after contract award. |
| 4 | 9/14/2011 | 116 | Mental health parity law (see tab on bottom noted parity law) sets forth specific benefits which appear to be higher than the limits proposed in this contract; allowing for equal number of | QUEST Adult replaces QUEST-ACE and QUEST-Net as MQD's new limited benefit package. Section 431M-4, HRS does not apply to policies for limited specialized coverage (see Section 431M-2, |

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| | | | visits for both medical needs and behavioral health 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. | HRS). |
| 5 | 9/14/2011 | 126 | Are any day treatment services (partial hospitalization, IOP, etc) a covered benefit for Adult, Non-SPMI members? If so, what is the service limitation? | Day treatment services are not identified as a covered benefit for adult, non-SPMI members. However, if the services are medically necessary, they may be provided as treatment of behavioral health services as described in Section 40.740.2.a.iv. |
| 6 | 9/14/2011 | 169 | "The health plans are responsible for outpatient BHS services that are civilly committed." Please clarify as persons who are civilly committed are usually in an inpatient facility. | <p>There are QUEST members who are in ambulatory mental health care settings who are on conditional release to the Department of Health (DOH).</p> <p>These QUEST members may need outpatient behavioral health services such as psychiatric or psychological treatment from a behavioral health provider or psychotropic medications. The QUEST health plan is responsible for providing coverage of these behavioral health services.</p> |
| 7 | 9/14/2011 | 170 | Clarification. Licensed crisis residential services (LCRS contracted crisis service through AMHD) versus Specialized Residential for Special Populations (SRSP | Licensed crisis residential services are a different benefit from Specialized Residential services provided by organization such as Hina Mauka or |

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| | | | services such as Hina Mauka or Po'ailani) | <p>Po'ailani.</p> <p>In general, licensed crisis residential will provide services to someone that is in crisis for a limited period of time (typically less than a week). The crisis residential services are provided to stabilize the individual in crisis and develop a treatment plan for further required services.</p> <p>Specialized Residential treatment tends to be for those members with a dual diagnosis (both SPMI and substance abuse). This service tends to be for an extended period of time.</p> <p>In addition, this question refers to program implementation and not to submission of proposals. The impetus to this question might best be resolved after contract award.</p> |
| 8 | 9/14/2011 | 171 | Please provide definition of additional intensive interventions of behavioral health services versus standard behavioral health services. For patients under conditional release from the courts to the Department of Health, specifically what services are covered by the state. | The services provided as standard behavioral health services are described in Section 40.740.2.a. The services provided as additional behavioral health services are described in Section 40.740.2.c. When an adult member is under conditional release to the DOH, the QUEST health plan is responsible for provision of standard behavioral health |

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| | | | | <p>services only.</p> <p>The Medicaid-covered services that DOH provides to conditional release members are included in Section 40.740.2.c (Additional behavioral health services). DHS is unsure of all of the services that AMHD may provide to their clients on conditional release that are not covered by Medicaid.</p> |
| 9 | 9/14/2011 | 181 | Can the health plans continue to provide PSR outside of clubhouse? Do the existing clubhouses have the capacity for new members? | <ol style="list-style-type: none"> 1) Yes 2) DOH is interested in having QUEST members receive services in the Clubhouse program. DHS is unsure of the exact capacity of the Clubhouse program. |
| 10 | 9/14/2011 | 101 & 104 | Please review response to these original questions. Providing a list of non-covered services would support the consistent application of covered services within the QUEST program. | DHS understands that health plans are interested in knowing what services are not covered in the QUEST program. However, non-covered services are addressed in the Hawaii Administrative Rules and do not need to be listed as an amendment to this contract. |
| 11 | 9/14/2011 | 210 | What is the expected turnaround from receipt of the monthly file by DHS to the entry into HAWI? | This question refers to program implementation and not to submission of proposals. DHS will respond to this question after contract award. |
| 12 | 9/14/2011 | 215 | <p>Please review response to initial question.</p> <p>We were looking for clarification for the difference between the web-site provider</p> | Yes. |

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| | | | <p>'directory' that needs to be updated monthly and the hard-copy provider directory that is updated quarterly. We had assumed that the web-site provider directory requirement could be met using a 'find-a-provider' search tool on the web-site instead of posting a pdf of our provider directory on the web-site.</p> <p>Can a health plan meet the web-site provider directory using a 'find-a-provider' search tool that is updated daily?</p> | |
| 13 | 9/14/2011 | 234 | <p>The original response to this question indicated that 'risk-sharing and/or gain-sharing' agreements could be considered as value driven incentives. Would 'risk-sharing and/or gain-sharing' agreements with PCPs also be considered as a value driven incentive?</p> | Yes. |
| 14 | 9/14/2011 | 291 | <p>Is the administrator expected to have clear lines of authority over all staff within the health plan's QUEST line of business?</p> <p>Please define the "general administration" and "day-to-day" business activities.</p> <p>Is the administrator assumed to only administer the QUEST program or is he/she allowed to conduct other business as long as all activities are part of the QUEST line of business?</p> | <p>DHS requires that health plans participating in this contract have one person (1 FTE) that has the authority to make decisions regarding the day-to-day business of this contract. These activities include implementation of this RFP. This individual cannot have additional non-QUEST line of business responsibilities.</p> <p>The health plan may have other staff performing work for the QUEST line-of-business that is not in the administrator's</p> |

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| | | | | <p>clear lines of authority (i.e., the part-time Medical Director). However, the administrator must have the authority to assure that work that these staff perform for QUEST are performed in accordance with this contract.</p> <p>Finally, as long at the activities are part of the QUEST line-of-business, it would be included as part of the general administration of the QUEST program.</p> |
| 15 | 9/14/2011 | 295 | <p>If the health plan determines that it will request a waiver of the required credentials listed in this section, when is the waiver due? Will a waiver be taken into account as part of the health plan's technical proposal (Section 80.340.3)? How will a waiver request be scored in the technical proposal?</p> | <p>The waiver is due after contract award. DHS cannot approve a waiver prior to awarding a contract.</p> <p>The health plan should describe that they will be requesting a waiver as part of their technical proposal. This should not adversely affect the scoring of the technical proposal as long as the person being proposed is qualified.</p> |
| 16 | 9/14/2011 | 303 | <p>Based on the original response, we were expecting an amendment to change the '..after date of service..' to be replaced with 'after date of receipt'. Will there be an amendment for this change?</p> | <p>Yes.</p> <p>See #2 of Amendment #3.</p> |
| 17 | 9/14/2011 | 353 | <p>To ensure that all applicants understand the page maximum for each section, can the DHS release updated page limit counts for the technical proposal based on inclusion of restated questions to ensure</p> | <p>The page limit maximums have not changed. They are as identified in the RFP. DHS will waive any pages that include the restating of the questions and will enact the page limit requirements as</p> |

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| | | | page limits are consistently applied across health plan applicants' proposals? | stated in the current RFP. |
| 18 | 9/14/2011 | 378 | 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 (see #3 of Amendment #3). As this question pertains to capitation rate development, further questions can be addressed in the capitation rates Q&A.</p> |
| 19 | 9/14/2011 | 378 | <p>In response to question 378 of the Q&As released September 14, 2011, DHS states that it “intends to continue its inclusion of applicable taxes in its payment to for-profit health plans, nursing facilities, and physicians in order to help maximize the receipt of federal funding in Hawaii.”</p> <p>Can DHS explain or provide an example of how it receives additional federal funding through the inclusion of applicable taxes for each of the entities described in its answer?</p> | <p>It is not necessary to provide examples for each type of entity listed. The mechanics remains the same. Assuming a GET rate of 4% and FMAP of 50%:</p> <p>Scenario 1 (Nonprofit provider that is NOT subject to GET): If the approved fee schedule to a provider is \$100, the State pays \$50 and the federal government pays \$50. If the provider is not subject to taxes, the State has a net general fund payment of \$50 and has gained \$0 new federal funds.</p> |

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| | | | | <p>Scenario 2 (For profit provider that IS subject to GET): If the approved fee schedule to a provider includes the GET and is \$104, the State pays \$52 and the federal government pays \$52. The provider in turn pays \$4 to the State in GET (\$2 State funds and \$2 federal funds).</p> <p>But remember that the State only paid \$2 in State funds toward the GET. Therefore, the State still has a net general fund payment of \$50 (because the \$2 it paid for the GET was paid back by the provider). The remaining \$2 of the GET paid by the provider was funded by the federal government. Therefore, the State gains \$2 in new federal funds.</p> <p>As this question pertains to capitation rate development and not proposal submission, further questions can be addressed in the capitation rates Q&A.</p> |
| 20 | 9/14/2011 | 386 and 387 | The RFP states “The enhancement is intended to provide for the additional cost for services at [FQHCs] due to the requirement that they be reimbursed at the PPS rate. Rates for health plans shall be increased to cover this additional cost based on historical use rates at these | Health plans are required to pay in-network FQHCs at their respective PPS rates in accordance with contract amendments effective December 1, 2009 of the current QUEST contract (approved by CMS) and previously issued memo ADM 1011A. (This memo will be |

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| | | | <p>facilities for members enrolled in each plan.”</p> <p>DHS, in its response to questions 386 and 387, released September 14, 2011, also indicated that the plans had no pass through obligation to FQHCs, even though CMS has advised State Medicaid programs responsibility for the supplemental or wraparound payments due FQHCs could not be given to the health plans. Has a State Plan Amendment or some other authorization for FQHC payments to become the plans’ responsibility been given?</p> <p>If not, what is the process that DHS intends to use to meet its obligations under 42 U.S.C. § 1396a(bb)(5)?</p> | <p>included among those that remain in effect. DHS will continue to perform reconciliations.) However, the health plans are responsible for managing the health care services provided in a FQHC as they do all providers serving their members.</p> <p>As this question pertains to capitation rate development and not proposal submission, further questions can be addressed in the capitation rates Q&A.</p> |
| 21 | 9/22/2011 | 2 | <p>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.</p> <p>Regarding the transition of care information from AMHD – what information will be provided to the health plans (i.e., Member Name, ID #, Dx, CC Agency assignment)?</p> | <p>DHS will obtain member demographics (i.e., name, Medicaid ID#), paid claims (service provider, diagnosis), and prior authorization transition of care files.</p> |