

Technical Proposal Question & Answer- #7- Amendments

Issued on: November 17, 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 #	Amendment #	# (first column of list of amendments)	Question	Answer
1	5	9	<p>Are optometry services covered under the Adult benefit?</p> <p>Is this deletion trying to address Adult “routine vision” services provided by an optometrist for vision correction (e.g. need for eye glasses)?</p>	<p>No. Optometry services are not covered under the Adult benefit. This includes routine vision services by an optometrist for vision correction (i.e., need for eye glasses).</p>
2	5	10	<p>Are ophthalmologic exams with refraction no longer a covered service under the Adult benefit or is this deletion specific to exams related to vision correction (e.g. need for eye glasses)?</p> <p>Is this deletion trying to address “routine vision” services?</p> <p>What if refraction is required for a vision exam related to a medical condition?</p> <p>If an adult member requires glasses due to diabetes or another medical condition, would the glasses be a covered benefit?</p>	<p>See #1 of Q&A #7.</p> <p>Ophthalmologic exams to include refraction or provision of visual appliances such as glasses are not a covered service under the Adult benefit.</p> <p>Eye exams for medical conditions that would be performed by an ophthalmologist are a covered service. Visual appliances such as glasses are not a covered service even if prescribed by an ophthalmologist. However, treatment of the underlying condition such as laser photocoagulation for diabetic retinopathy may be covered.</p>

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3	5	13	When will DHS inform us about what measures they will require to be included in value based purchasing and in provider contracts?	Amendment #13 states that DHS “may require that certain measures are included in value-driven health care contracts, as applicable, based upon providers’ scope of services.” DHS does not have a timeline for selection of measures at this time. The specific measures selected is an implementation issue and not necessary for procurement purposes.
4	5	17	When will DHS inform us about what measures they will require to be included in value based purchasing and in provider contracts?	See #3 of Q&A #7.
5	5	19	Please clarify if PPS is the mandatory reimbursement for the contracted FQHCs and there are no exceptions.	PPS is the mandatory reimbursement for PPS eligible services provided by contracted FQHCs with no exceptions. This reimbursement methodology does not preclude the use of financial incentives for high quality care.
6	5	19	Amendment #5 essentially states that for covered and eligible services provided by contracted FQHCs or RHCs, PPS reimbursement will continue, and by inference, the DHS methodology to reimburse health plans for PPS payments made to FQHCs or RHCs will also remain the same. Health plans are currently	The handling of FQHC/RHC services in the capitation rate development is no different from that for other services. Actuarially sound rates are developed and the health plans assume full risk in accepting those rates. In addition, any additional questions regarding proposed capitation rates may be submitted by the

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			<p>reimbursed for FQHC or RHC services based on historical FQHC or RHC utilization. This methodology does not address when there is an increase in the number of PPS-eligible services utilized or when the scope of PPS-eligible services expands.</p> <p>Since plans are in effect ‘standing in’ for the DHS with regard to ensuring appropriate reimbursements are made for PPS-eligible services, what is the DHS’ plan to reimburse health plans based on actual utilization, not historical services, that address current FQHC or RHC utilization trends and that ensure that health plans are ‘held harmless’ or that the DHS is not over- or under-capitating health plans for PPS services?</p>	<p>date specified in Section 20.100 of the RFP.</p>