Question and Answers from QUEST Expanded Access (QExA) Roundtable
August 29, 2007

The QExA Request for Proposals (RFP) continues to be drafted. The answers to questions listed below are effective as of September 7, 2007. The RFP is undergoing continuous review and discussion both internal to Department of Human Services (DHS) and between the State and the Centers for Medicare & Medicaid Services (CMS) and, as such, there may be program modifications and changes made prior to the official release of the RFP.

	Question	Answer by Med-QUEST Division (MQD)
	General Questions	
1	Will the PowerPoint presentation be on the web?	Yes. The PowerPoint presentation is on the Med-QUEST (MQD) website which is http://www.www.med-quest.us/.
2	As a new interested health plan, what is important?	• Quality is very important. Improvement of quality and health care outcomes. Saving money will naturally occur with the improvement but not overnight. • Care has to be culturally sensitive and competent. Acknowledgement of local talent and care is important.
3	When is the go live date?	November 2008
4	Are we modeling Hawaii's plan after any state?	The State is taking the best from what has worked well in other States with comparable programs and populations. Those States include: Arizona, Texas, Florida, and Minnesota.
5	How long is the RFP process? And when will the plans receive the data to assist with financial modeling?	• The RFP response process will be 2 to 3 months. • The State is working with Milliman, the State's actuarial contractor, to get financial data for interested health plans to start developing their financial modeling. • The State will accept letters of intent (LOI) from providers. The State will not require signed agreements at the time of the proposal submittal.
6	Are we at an irreversible state with regard to managed care?	Managed care is the approach the State will use to provide services to the aged, blind or disabled populations. There are good and bad managed care health plans. Our goal is to maximize the good and minimize the not so good. The QExA program will be successful because the State is building in proven quality, program designs, qualifications, and accountability that monitor the success of the program. The State is responsible for assuring the success of QExA. Hawaii has a small population so we can monitor the services given. We are in the process of re-organizing MQD to ensure that on-going monitoring will occur.
7	Has Hawaii looked at what has happened to the beneficiaries of other States? Are there are quality and reimbursement issues?	Yes. Hawaii has looked at other States and what has occurred with beneficiaries. Hawaii is learning from the successes and failures from other States.

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8	Are we looking at some financial advantage [for providers]?	Health plans are able to develop incentive plans for providers. This is a better system than the Fee-For-Service (FFS) model that does not allow reimbursement for quality or improved outcomes.
9	I have a concern about the 2 to 3 month period. It seems very short. Will there be a formal question and answer format during the RFP?	Yes.
10	Following this meeting, can plans still submit questions?	Not at this time. DHS will have a formal question and answer period during the RFP process.
11	How long will the contract be for?	The QExA contract is a multi-year contract contingent on funding.
12	This question is directed to Lois Lee who has worked with Medicaid Waiver and is now with Med-QUEST. Knowing what you know, do you think that QExA is good for Medicaid Waiver clients and RACCP (Residential Alternative Community Care Program) providers?	(Lois Lee) From the very beginning, I signed on to the QExA Waiver because I truly believe it will be good for our clients who experience difficulty accessing medical care. Right before I accepted the MQD Acting Administrator position, the staff working in the Medicaid Waivers was faced with a resident being discharged by a physician and it took five days for the RACCP case manager to find another physician willing to accept this man as a patient. In the meantime, the man was without needed medication for one day. I also believe that the transition of people who are Aged, Blind or Disabled (ABD) into the QExA Waiver will be beneficial to the RACCP providers who are, at this point, in time somewhat unknown in the community. With the advent of the population into managed care, many more people in the health industry will become educated about home and community based services and will begin accessing these services.
13	Is anyone looking at the 1147?	MQD is planning on revising the 1147 form in response to various people in the community. Anyone who is interested in participating on this task force should contact Patti Bazin at pbazin@medicaid.dhs.state.hi.us.
14	How is the State going to staff the required positions necessary for the implementation of QExA?	MQD is in the process of filling positions. Also, MQD intends to partner with the University of Hawaii to help us meet the needs of MQD for QExA.
	Program Goals and Objectives	
15	Increase in Home and Community Based Services (HCBS) of 5% annually. Request that number be decreased as this may become unattainable.	DHS will work with the QExA health plans on determining an accurate percentage when the 5% starts becoming unattainable.
16	What are the details in determining the 5% increase in home and community based services (HCBS)?	This is being worked on; more information will be provided in the RFP.
17	The State expects health plans to increase HCBS utilization by a minimum of 5% annually. What has been the average increase in HCBS utilization over the past 5 years? Can the State share this information? Can the State provide reasons the current average utilization of HCBS vs. the	The RFP will provide information on the HCBS incentives.

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	institutional setting?	
18	How did the State arrive at a 5% figure and is this realistic? What types of financial incentives are being considered at this point and can plans have input? Are sanctions really necessary, depending on the type of data gathered and how that is interpreted this could significantly impact a Plan.	• The State arrived at 5% based upon needs of the community. • Financial incentives will be developed based upon success of the health plans in achieving these objectives. • Sanctions are necessary to encourage health plans to provide services in the community and to ensure that members have access to needed services.
19	All health plans will be required to have a significant presence in Hawaii. Can you quantify the term "significant"? Will the threshold be based on total numbers of employees or positions or departments that are locally based?	The RFP will outline the requirements for health plan personnel.
	Section 30	
20	Will there be a link between Medicare and Medicaid with regard to the auto assignment?	At this time, MQD does not believe that there will be a link between Medicare and Medicaid with regards to auto-assignment.
21	Is it expected that the Plan will also be a Medicare Plan?	Not necessarily.
22	Could you please explain the dual eligible? I know it was mentioned by the Director, but I couldn't quite understand. Will they still be processed separately? I can't see Medicare, HMSA 65C+ and the Medicare Advantage Programs crossing over the claims to these individual plans. But I wasn't sure if she was saying that the dual eligible will not be a part of this program.	Dual eligibles will be part of the program. Claims for Medicare (or a Medicare Advantage or Medicare-like plan) will be processed as they are today. Claims for Medicaid will be processed through the QExA health plans. QExA health plans will need to process claims for Medicare deductibles and co-payments.
23	How many plans will be awarded per island?	The State is working with our actuaries to determine the number of plans per island.
24	Does the State have a percentage regarding enrollment cap?	The State is working with our actuaries to determine the percentage regarding enrollment cap.
25	1. What type(s) of methodology is the state thinking about as it relates to enrollment caps. 2. Will enrollment caps be used on all N.I.? 3. Will enrollment caps be applied if a member is in LTC facility that doesn't participate with other plans (would this and the PCP criteria stated earlier be an exception to enrollment caps)?	1. See answers to questions #23 and #24 above. 2. The State is working with our actuaries to determine the best number of plans per island and any enrollment caps. 3. Enrollment cap information will be described in the RFP.
26	Do you know how many plans you expect to accept	The State is working with our actuaries to determine the best number of plans per island

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	into the program? I want to be prepared as to how many contracts we might be dealing with.	for QExA.
27	Related to Auto-Assignments 1. These members don't have PCPs currently so how is this related to initial enrollment. 2. So members can only be enrolled in certain Plans that participate with that members' LTC facility? 3. What thoughts have been given to and methods will be utilized in constructing the algorithm. Is it going to be weighted by bid and quality?	1. These members have physicians who treat their medical conditions. 2. Enrollment cap information will be included in the RFP. 3. Auto-assignment algorithm information will be included in the RFP.
28	Can you provide an example of the auto-assignment algorithm using the factors described – long-term care residence and PCP presence in the network?	All details of any algorithm will be provided in the RFP.
29	Please clarify who will be the employers of the Enrollment Counselor and the Service Coordinator.	The Enrollment Counselor will be a designee of the Department of Human Services. The Service Coordinator will be a service offered by the health plan who will either hire in-house or hire out.
30	Can we get more clarification and definition of what the Enrollment Counselor will be responsible for and their role?	We will provide this detailed information on our website once it is approved through our 1115 Waiver amendment with the CMS. This information will not be included in the QExA program RFP.
31	What qualifications would the State specify for its Enrollment Counselors?	We will provide this detailed information on our website once it is approved through our 1115 waiver amendment with the CMS. This information will not be included in the QExA program RFP.
32	When Medicare Part D came around the corner earlier this year, it was havoc with the Social Workers of our facilities. Families wanted advice and recommendations on which plans to choose. We were unable to assist them but pointed them to other organizations such as SAGE. I know you mentioned that each member/family will be met with individually (hopefully), but would there be posters, mailings, etc. provided to facilities to visually display in common areas? Also, will they be available in different languages?	DHS recognizes that enrolling members in a managed care health plan is a vital part of the QExA process. DHS will have a contract with enrollment counselors to support this process. Enrollment counselors will have written materials in different languages to provide to members/families and will be required to offer translator services. DHS will ensure that enrollment counselors provide visual materials to organizations that have large numbers of ABD members.
33	Who will determine Medicaid eligibility?	The Department of Human Services
34	Will there be a change in Medicaid eligibility criteria making more members eligible for	At this time, no.

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	Medicaid?	
35	Could you explain the eligibility branches role? I understand that they will continue to process applications and operate status quo. But as an example, how would the following situation be handled? An applicant hands in an application on September 1st. The interview is set up and the application is approved and processed on November 3rd. However, since the applicant was eligible from the date of application it is retroactive to September 1st. The person chooses a plan within 30 days on December 1st. Does the facility bill the chosen plan dating back to September 1 (Medicaid approval)? If not, what would be the procedure?	In your example, the member will be eligible for Medicaid effective September 1, 2007. The process for billing for services provided to this member will be included in the RFP.
36	Will members be getting coverage under Medicaid FFS during the initial 15 day time period?? Or are members retro-enrolled to a plan?	The information about retro-enrollment will be included in the RFP.
37	1. Will the plans have to go thru the same SMI/SEBD referral process to carve members into the BHMCO? Will there be additional qualifying diagnosis provided for the ABD/LTC group? 2. Should the Plan identify members who are DD/MR within its membership, what is the process for getting them retro-disenrolled? Will the Carve Out programs for DD/MR and SMI/SEBD be providing a full range of services (including medical/drug) or are they only facilitating a portion of a shared benefit?	1. The information regarding the health plan's responsibilities with SMI/SEBD will be included in the RFP. 2. QExA members who have Mental Retardation/Developmental Disabilities (MR/DD) will receive their primary and acute care benefits through QExA. The primary and acute care benefits will be outlined in the RFP. QExA health plans will not be permitted to retro-disenroll these QExA members.
38	Has DHS proposed any monitoring activities to date? Can plans have input into the activities? Also will the State provide a copy of the monitoring activities at the same time that it issues the RFP for plans to consider? Can you provide a sample monitoring tool to the plans at the same time that the State issues the RFP?	The information about monitoring activities will be included in the RFP. Specifics about the monitoring tools will not be provided with the RFP, but will be provided when available.
39	Has an EQRO been decided upon and selected? If	The External Quality Review Organization (EQRO) is determined through a

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	not can plans have input into the selection of an EQRO?	procurement process. Health plans will not have input into selection of the State's EQRO.
40	Would the persons chosen plan be posted on the AVRS system? How will facilities receive updates during open enrollment on plan changes?	Yes. The plan will be posted in the AVRS system. Facilities will need to verify plan changes through the AVRS system during open enrollment plan changes. Facilities could also request plan change information from their residents and/or the resident's family.
	Section 40	
41	Continuing education for the provider is important. What safeguard will be in place to ensure continuing education?	Good point. The RFP will provide guidance to QExA health plans for provider education.
42	1. Will the State be providing a listing of mandatory training topics for the Plan to provide to ABD/LTC network? 2. Is it really necessary to require a minimum of semi-annual training for the provider network? Doesn't the next sentence really get to the State's concern "Health plans must provide one-on-one education to providers who are having difficulty meeting the contract requirements."?	1. The RFP will provide guidance to QExA health plans for provider education. 2. Yes. It is necessary to assure that all providers are afforded the opportunity for education in this new managed care system for the State of Hawaii.
43	Can the plans use their QUEST provider manual and add in any specific additional requirements for the ABD/LTC within that document rather than creating a separate manual?	The information about provider manual submission will be included in the RFP.
44	Can you discuss more detail about what would be needed in this section [Network Development and Management Plan], or what the State would hope to see/require in these documents?	The information about Network Development and Management Plan will be provided in the RFP.
45	Can the plans assume that their Provider Contracts that were previously reviewed by the State under the last RFP are approved templates by DHS for use with the ABD/LTC network?	No.
46	There is an asterisk to qualify or clarify the "Urban" column of the provider geographic access table but no explanation is provided. Could you please provide an explanation?	A definition of urban will be provided in the RFP.
47	In the Rural section of this part of the RFP summary it may not be possible to achieve a 60 minute drive	More information about rural providers will be provided in the RFP.

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	time for certain specialists and MH providers. Will the State provide more specific criteria (i.e.; provider type etc)?	
48	1. Will the network requirements follow a similar specification of the number of and types of provider by Island? 2. Will the provider Agreements be any different than what was required in the last QUEST RFP. 3. Can plans leverage the same provider contracts it has in place with QUEST for the ABD/LTC population. 4. Will the State also provide a listing of services that are considered "non-covered services" as it does in the QUEST RFP?	1. Yes. 2. The requirements for QExA provider agreements will not be vastly different from those for the QUEST program. 3. No, current QUEST contracts will not suffice. If a current QUEST health plan is awarded a contract for QExA, then a contract amendment to the QUEST contract will be required for QExA. 4. The information on non-covered services will be provided in the RFP.
49	Specialists may be allowed to serve as Primary Care Providers (PCPs) provided specific requirements are met. Could you please elaborate on these specific requirements?	The information on requirements for specialists acting as a PCP will be provided in the RFP.
50	NCQA standards and guidelines will be used for credentialing and recredentialing of providers. Does this mean that recredentialing should occur every 3 years?	The information on credentialing and recredentialing will be provided in the RFP.
51	What happens if a person is in a QExA plan but is in another Medicare Advantage Plan?	If this happens, we would expect coordination between the plans.
52	How will this work with the Dual Eligible members (where some benefits are shared between funding sources and the principles of a managed care plan don't easily apply without a PCP assignment).	The State expects health plans to coordinate all benefits (QExA and non-QExA) for members.
53	It is good that there are incentives for the plan to show improved health care options. However, it should be remembered that this population may not improve. What is important is the keeping of these people in the least restrictive environment for as long as possible.	Absolutely. This is the reason for emphasizing the importance of home and community based services.
54	What is the Department's role in enhancing capacity in the community?	With the implementation of QExA, there are two fundamentals: 1. Plans will have financial incentives to increase utilization by 5% per year. A sanctions component will be built in as well. The waitlists will be eliminated and

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		services on all islands will be expanded. There will be an emphasis on client choice. Honoring choice will lead to an expansion of services and capacity. 2. With the inclusion of the ABD population, there will be a smooth transition between the needed services. Now there is fragmentation – i.e. a person has to be discharged from one Medicaid Waiver before they can be admitted into another. The case manager has to change. This will all go away.
55	1. The RFP Summary reads that the Plan will have a DM program for BH. This is way too general and wide to define. Please consider defining the diagnosis or illness you want within BH domain. 2. What "specific" requirements has DHS discussed to date regarding TOC into and out of a health plan as required activities of a Plan?	1. Thank you for the suggestion. DHS will consider it in the development of the RFP. 2. The transition of care requirements will be provided in the RFP.
56	Has MQD determined the qualifications of Service Coordinator?	The service coordinator qualifications are under discussion. These qualifications will be shared upon release of the RFP. Hawaii is using the Arizona model as a reference in setting ratios for service coordinators. Ratio of service coordinator to number of members varies based on the acuity of client.
57	1. Is there a specific tool/format plans are required to follow [for Health and Functional Assessment]? 2. Can you please clarify what a back up plan is?	The information on Health and Functional Assessments and back-up plans will be provided in the RFP.
58	1. "Members can change their service coordinator at any time". This could potentially lead to significant fragmentation. What is the State's intent with, does it need to be a requirement? 2. What thoughts has the State given to case ratios, have any ratios been discussed to date? 3. Can the State provide the training topics it wants plans to perform and not require "all" training to be approved by the DHS? Plans do a lot of training with staff to provide you with "all" training is more than what is really necessary.	1. It is the health plan's responsibility to assure no fragmentation occurs in service delivery. The State has this as a requirement to protect members who have differences in thoughts and ideas from their service coordinators. 2. See answer to question #56 above. 3. The information on training for service coordinators will be provided in the RFP.
59	Where does the 1147 fit in?	The Department will continue to review the 1147 and make the determination for Level of Care (LOC). The plans will not have this responsibility (fox in the hen house).
	Section 50	
60	1. Please clarify what is the intent [of member education].	1. Member education is vital for preventing further health and medical complications. Member education is part of disease prevention.

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	2. Will the State be requiring or defining any particular topics a plan should be covering in this "member education classes"?	2. The information on member education will be provided in the RFP.
61	1. Why does this need to be done by a nurse [24/7 toll-free hotline]? Service coordinators would be better as they know the patient and Plan and Network and how to get services to that member quickly. 2. Physician provider contracts really cover this concern.	Thank you for the suggestion. DHS will consider it in the development of the RFP.
62	Will the State mandate any particular PIP's of Plans?	Yes.
63	Please describe what DHS has been considering to date as performance measures for this plan line.	The information on performance measures will be provided after contract awards to QExA health plans.
64	Can we get a comprehensive list of requirements [reporting] at the same time as we get the RFP	These reporting requirements will be provided when available.
65	Currently, we receive a monthly mailing of cost share amounts (I believe you referred to it as spend down amounts from ACS). The report is called Hawaii DHS Med-QUEST Division PMMIS Share of Cost Report. Will the plans be issuing these reports to us for their members?	In QExA, DHS will provide the spend-down amount for each member to the health plan for processing. In QExA, it is the health plans' responsibility to collect spenddown (or cost-share) amounts. A health plan can ask a provider, in their contract, to collect the spenddown or cost-share. In this case, the health plan would need to provide the spenddown (cost-share) amount to the provider.
66	Will this follow a similar process as QUEST, what is the State thinking in terms of a readiness review?	The information about readiness reviews will be provided in the RFP.
	Section 60	
67	Is the State considering a re-insurance program and if so what types of financial thresholds are being considered.	Yes. The information about re-insurance will be provided in the RFP. The thresholds that are being considered will be actuarially sound.
68	1. Is this necessary, if a provider agrees to less shouldn't we allow what the market will bear. 2. Will there be an administrative fee given to plans in addition to the capitation? 3. Will payment to plans be based by consumer risk factors? 4. Will the State publish bid ranges prior to the submission of the bid to the State?	1. The State is providing protection to the FFS providers. This protection is being made at the request of the FFS providers. We do not want small FFS providers to be at risk of unfair negotiations. 2. The information on payments to the health plan will be outlined in the RFP. 3. The full information on payments to the health plan will be outlined in the RFP. 4. We are working with the actuaries to determine the best approach regarding publishing of bid ranges. 5. The information on any auto-assignment algorithm will be provided in the RFP.

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	5. Will the bid rate be a component of the auto assign algorithm?	
69	Does the State a have plan in place to clean up its TPL data prior to implementation of the ABD/LTC contract.	The State does not plan to invest resources in making this determination prior to contracting with QExA health plans.
70	Will each plan be required to offer electronic claims/RA's and ACH Payment?	Yes.
71	Is each plan allowed to create their own reimbursement/payment system? I'm just concerned as to how ACT 294 will be monitored if each plan reimburses facilities differently. My fear is that if each plan has their own reimbursement system, it will be difficult for the billing departments to keep these plans straight especially if a number of them are accepted to participate. i.e. Plan A decides to use a modified RUGS, Plan B decides to reimburse using SNF/ICF one rate for each level, Plan C decides to use the acuity based reimbursement, etc. These all fall within ACT 294 but would drive us crazy with so many reimbursement mechanisms.	The State will continue to provide acuity information for nursing facilities to health plans for their use. Providers can negotiate with health plans to determine the reimbursement/payment system with which the health plan will pay a provider.
72	Currently ACS reimburses the majority of claims within 14 days, could you explain why the plans have 30 days to pay us 90% of claims. This would really hurt our cash flow if they are allowed 30 days. We usually send out the claims electronically on the first working day of the month for the previous month. We usually get paid on those claims by the second Friday following submission.	Your current payment structure from ACS is not guaranteed. The State has chosen this payment schedule in accordance with industry standards.
	Section 70	
73	Can the State publish the auditing requirements at the same time as the RFP?	The State will provide some information on its auditing requirements. The State will provide more information to QExA health plans once contracted.
	Section 100	
74	1. Is the State going to specify the number of plans per island? 2. What methodology and criteria will the State use to determine a wining bid/contract	1. Yes. 2. The methodology and criteria will be outlined in the RFP.