QUEST Expanded Access (QExA) Roundtable Request For Proposals (RFP) Summary

August 29, 2007

9:00 to 11:00 am

QExA RFP Summary- Overview

- The RFP Summary was developed by the Department of Human Services for stakeholders to better understand the design of the RFP that will form the basis of the QExA program
- The QExA RFP is still being drafted and is undergoing continuous review
- Discussion is still occurring both internal to DHS and between the State and the Centers for Medicare & Medicaid Services (CMS)
- DHS is currently making program modifications and changes prior to the official release of the RFP

QUEST Expanded Access (QExA)

QExA is a program the DHS is developing for our Medicaid Aged, Blind or Disabled (ABD) members, who are currently receiving services through a fee-for-service (FFS) system. The design of QExA is for our members to receive service coordination, outreach, improved access, and enhanced quality healthcare services coordinated by health plans through a managed care delivery system.

Program Goals and Objectives

- Goals and objectives, that influence the design of the RFP, are far-reaching and obtaining all of them will take time
- Some of these goals will be achieved immediately, others will be realized incrementally

Program Goals and Objectives

1. Assure coordination of care and decrease care fragmentation across the benefit continuum including primary, acute, behavioral health and long-term care benefits;
2. Assure access to high quality, cost-effective care that is provided, whenever possible, in a member's own home and/or community, if the member so chooses;
3. Provide Home and Community Based Services (HCBS) to persons with neurotrauma;
4. Build on the already established HCBS community network;
5. Support choice of services for members; and
6. Develop a program design that is fiscally predictable, stable, and sustainable over time.

Program Goals and Objectives

- DHS will achieve these goals through contractual relationship with managed care health plans
- All health plans will have a significant presence in Hawaii and will not be permitted to operate their businesses solely from the Mainland
- The RFP is being developed to reflect these goals and objectives

Program Goals and Objectives

- Health plans will be responsible for providing and coordinating all services

  (primary, acute, behavioral health

  and long-term care)

Program Goals and Objectives

- Members are able to receive the care they need in their choice of setting
- For many, this is by using HCBS, for others it is in an institutional setting
- DHS will continue to use cost-effective principles for HCBS
- DHS expects health plans to increase HCBS utilization by a minimum of 5% annually
- Institutional services will remain an essential component of the QExA program for those that need and/or choose these services

Section 30

- Some DHS Responsibilities in QExA are:
  - Overseeing the activities of the enrollment counselor or other entities to whom the State delegates the responsibilities of assisting people in selecting a health plan and educating new members;
  - Overseeing the activities of the ombudsmen program which will be available to all members to assure access to care and to promote quality of care and member satisfaction;
  - Conducting on-going monitoring of the health plans; and
  - Making all eligibility determinations.

Section 30

- Enrollment Activities
  - Enrollment counselors will assist ABD individuals transitioning from FFS into QExA
  - Members will have 60 days to choose their health plan

Section 30

- Enrollment Activities
  - Those who have not made a health plan selection will be auto-assigned via a pre-determined algorithm
  - Once the QExA program is operational, members will have 15 days to select their health plan
  - Enrollment counselors will continue to support members in their choices after the initial transition into QExA
  - All members can change health plans within the first 90 days of QExA implementation, after that, change in health plans is for cause and with every annual open enrollment
  - Enrollment caps will be implemented on any health plan that reaches a specified percent of membership

Section 30

- Benefits and Services that will remain outside of QExA
  - For the Mental Retardation/Developmental Disabilities (MR/DD) population, these services are carved out: case management, HCBS, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR) benefits to include 1915(c) waiver services for MR/DD members;
  - Dental services;
  - School health services;
  - Department of Health (DOH) programs such as the Vaccines for Children Program and Early Intervention Program; and
  - Only for behavioral health services, adults with SMI and children who are SEBD.

Section 40

- Provider Network
  - Health plans will be required to develop a provider network that is able to provide all covered benefits and services
  - There are requirements for acceptable wait times as well as for geographic access for providers
  - Health plans will submit annually a Network Development and Management Plan which describes the health plans' ability to develop provider networks that are diverse, flexible, and able to meet members' needs

Section 40

- Provider Network
  - Members will have a PCP who will be responsible for coordinating care
  - Members must choose their PCP within 15 days of being a member of a health plan
  - Members can change PCP at any time

Section 40

- Provider Agreement, Manual and Services
  - Health plans will need to set up contractual relationships with providers
  - Health plans are prohibited from having providers sign agreements until the health plan's template is approved by DHS
  - All providers will be given a manual which outlines interaction between health plan and provider
  - Health plans will offer provider education regularly
  - Providers will have a complaint, grievance and appeal process
  - Health plans must have a provider call center during business hours

Section 40

- Covered Benefits and Services
  - All of the current services covered by Medicaid in either the FFS system or in the 1915 (c) waivers (except MR/DD) will be included in QExA
  - Self-direction, the ability for the member to have decision-making authority over providers of allowable services, will be offered for personal assistance, respite and attendant care services

Section 40

- Service Coordination System
  - All members will have a service coordinator and can change service coordinator at any time
  - Responsibilities include:
    - Conducting a Health and Functional Assessment (HFA) for each member annually;
    - Developing a plan of care and arranging for services through collaboration with the member and his/her family, which describes the health care services the member needs and chooses; and
    - Nursing facility level of care functional eligibility review process (DHS' 1147 process).

Section 40

- Service Coordination System
  - Responsibilities include (cont.):
    - Providing options counseling regarding institutional placement and HCBS alternatives for members at nursing facility level of care;
    - Assisting members in the transition to and from nursing facilities/residential facilities;
    - Coordinating services with other providers;
    - Facilitating access to services; and
    - Seeking to resolve any concerns about care delivery or providers.
  - Ratios of member to service coordinator will be provided in the RFP

Section 40

- Additional Services
  - Disease Management Programs (possible examples)
    - Diabetes mellitus, obesity management, behavioral health, and renal disease (that has not yet reached end-stage)
    - At least two (2) other programs to be selected from the following:
      - Hypertension
      - Drug abuse
      - Cardiovascular disease

Section 50

- Health Plan Administrative Requirements
  - Enrollment;
  - Member services;
  - Marketing and advertising;
  - Quality improvement programs;
  - Utilization management program;
  - Information systems;
  - Fraud and abuse;
  - Health plan personnel;
  - Health plan reporting; and
  - Readiness review.

Section 50

- Enrollment and Member Services
  - Membership packet sent to member within 10 days of enrollment
  - Member handbook (details specified in RFP) provided
  - Member education outlined
  - Toll-free hotline- 24 hours a day, 7 days a week staffed with a nurse who can answer medical questions
  - Oral and written translation in languages other than English and for the hearing impaired
  - Written material at 6th grade level

Section 50

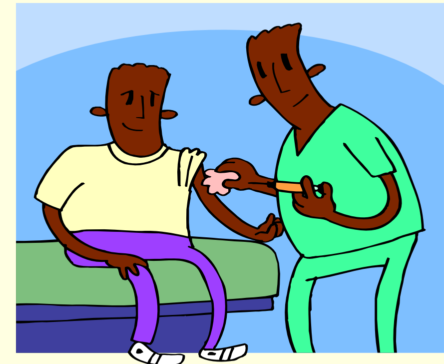
- Health Plans' Quality Improvement (QI) and Utilization Management (UM) programs
  - At a minimum, QI and UM programs will have:
    - A DHS approved quality assessment and performance improvement (QAPI) program;
    - Performance standards that are monitored on an on-going basis in which the health plans must show demonstrable and sustained improvements;
    - Performance improvement projects (PIPs);
    - Adopt practice guidelines that are based on valid and reliable clinical evidence and disseminated to all affected providers; and
    - A Utilization Management program that is connected with their Quality Improvement program.

Section 50

- Member Grievance System
  - Health plans will have a member grievance system that is compliant with federal regulations
- Reporting Requirements
  - DHS will monitor health plans' compliance with the RFP through reporting
- Readiness Reviews
  - DHS will conduct readiness reviews of health plans to assure readiness for providing health services to members

Section 60

- Financial Responsibility of DHS
  - Make monthly capitation payments to health plans
  - Manage health plan incentives
  - Manage catastrophic care program
  - Implement and manage the risk sharing program

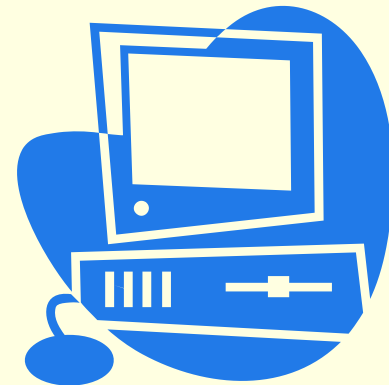


Section 60

- Financial Responsibility of Health Plans
  - Reimburse providers:
    - By utilizing the Medicaid FFS schedule as a floor for negotiating rates with providers for the first year of the contract and if needed thereafter
    - On a timely basis
      - 90% of clean claims paid within 30 days of receipt
      - 99% of clean claims paid within 90 days of receipt
  - Utilize current billing practices (forms and electronic billing)
  - Collect spend-down amounts from members with those requirements
  - Comply with specific 3rd party liability requirements

Conclusion

- Comments were provided to RFP Summary
- Comments are compiled and will be available on the Med-QUEST website soon
- Website address is www.med-QUEST.us



Questions and Answers