Department of Human Services (DHS)
Med-QUEST Division (MQD)
Summary of Information Provided in Response to the QUEST Expanded Access (QExA) Request for Proposals (RFP) Summary
Request for Information No. RFI-MQD-2008-006 (RFI)

The QExA 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 DHS and between the State and Center for Medicare & Medicaid Services (CMS) and, as such, there may be program modifications and changes made prior to the official release of the RFP.

10 Organizations Responded to the RFI

I. Program Goals and Objectives

HCBS Eligibility RFP Summary pg. 3

RFI Response 1
On page 3 it states that Home and Community Based Services (HCBS) will be provided to persons with neurotrauma—does this mean only to them? If these services are available to others, please specify who or how one becomes eligible.

MQD's Response
All members who meet an institutional level of care and qualify for HCBS will be eligible to receive these services.

Significant Presence in Hawaii RFP Summary pg. 4 and 20

RFI Response 1
The RFI states that all health plans will be required to have a significant presence in Hawaii. Further, health plans will not be permitted to operate their business solely from the continental United States (page 4). We support this stipulation within the RFP. Additionally, we believe that due to the fragile and vulnerable nature of the QExA beneficiaries, it is integral that a health plan that wishes to participate in this program be able to demonstrate experience with and knowledge of the unique blends of ethnic, linguistic and cultures in Hawaii and their ability to work with and serve the Hawaii QExA population.

RFI Response 2
On page 4 please define "significant presence" and how that will be determined. Will this be defined by the size of a health plan's provider network, membership, the amount of claims processed or something else?

RFI Response 3
What is the DHS' definition and criteria for the term "significant"? Would it be defined in terms of number of jobs or a percentage of total revenue? In addition to cultural

considerations, we believe that it is incumbent on a State social service program that is partially subsidized by Hawaii tax revenues to support efforts to retain, to the greatest extent possible, monies paid by the program within Hawaii. A health plan's recruitment and employment of Hawaii citizens will benefit and strengthen the communities in which program recipients and Hawaii-based health plan staff live.

MQD's Response to 1, 2, & 3 above
"Significant presence" will be defined in the RFP primarily based upon positions required to be filled by individuals in Hawaii.

Incentives for Increasing Access to HCBS RFP Summary pg. 5

RFI Response 1
We are very supportive of the State offering a financial incentive for plans to increase access to home and community based services (HCBS). To assure that the incentive is fairly applied across plans, DHS must measure the institutional vs. community placement rate for each health plan individually and assess annual performance to that baseline, as different plans may have a different placement mix at the time enrollees first enter the program. In addition, DHS may want to re-evaluate the HCBS performance target annually. As the program matures, it will become more difficult for plans to increase HCBS placement as more people are placed in the community every year. We look forward to additional dialogue with DHS on financial incentives for rebalancing Hawaii's LTC system.

RFI Response 2
How will the baseline be established? Will health plans be penalized if there are shortages of HCBS in the community? How will sanctions be implemented once utilization begins to plateau?
Suggestion: Also consider evaluating access to HCBS by comparing the need of services versus the availability of services.

RFI Response3
This is not merely a request to contract with existing providers, but to actually find/create new providers. We do not believe health plans have the capability to do this.

RFI Response 4
At some point, the number of members who can be safely cared for in an HCBS setting will be exhausted. Given this, does the DHS have a target percentage of members who are using HCBS alternatives vs. those who are in institutions? What is the base period that will be used and how will the DHS measure improvement? What are the services that will be used to determine the HCBS benchmark? Will health plans be expected to increase HCBS utilization by 5% on an annual basis for each contract year?

The RFP Summary states that health plans may be levied sanctions if plans fail to meet this HCBS benchmark. Given that the QExA is a new program, we are concerned about the use of sanctions or other penalties on participating health plans, particularly if there

are plans that require time to develop an HCBS infrastructure. We recommend that the DHS investigate other alternatives to encourage the use of HCBS among health plans and their potential members.

MQD's Response to 1, 2, 3 & 4 above
We will consider the responses provided in formulating the incentive/sanction portion of the RFP. This incentive/sanction will not be implemented the first year of the contract.

Institutional Services RFP Summary pg. 5

RFI Response 1
The State's role in discharge planning and LTC placements needs to be clearly defined. Health plans will need to develop and implement their own LTC processes to manage resources as well as to ensure quality care. For example, if a member "chooses" institutional care, and there is no appropriate institutional bed available, the health plan must have the flexibility to recommend other options, such as residential long term placement, or discharge home (with appropriate care) while waitlisted for nursing home placement.

MQD's Response
We appreciate the suggested comments and will consider them in the development of the RFP.

II. Summary of RFP Section 10 & 20

No comments or suggestions received.

III. Summary of RFP Section 30

Dual-Eligible Members and Coordination of Benefits RFP Summary pg. 6
RFI Response 1
Please explain how dual-covered members are educated about coordination of benefits? How do Medicare Managed Care Organizations (MCOs) coordinate services with Medicaid MCOs if they are in different health plans?

MQD's Response
The enrollment counselors will educate members about coordination of benefits. The Medicare MCOs and the Medicaid MCOs through service coordinators shall be responsible for working together to coordinate services.

RFI Response 2
The DHS had indicated in the past that health plans that offer a Medicare Special Needs Plan (SNP) would receive special recognition as a main objective of SNPs is to serve recipients who are dual eligible (have both Medicare and Medicaid coverage). By

recognizing and giving special status to health plans that offer a SNP, a recipient who may be medically needy, fragile and vulnerable would benefit by having the ability to enroll into a health plan in which both programs are offered, thus promoting enhanced coordination, continuity and integration of care. The RFI does not contain any reference to this consideration. We urge the DHS to consider its inclusion into the QExA RFP since enhanced integration and coordination of care is a major goal of the RFP.

Additionally, if a health plan that already has a Medicare SNP program was awarded a QExA bid, mandatory enrollment into the QExA program of dual eligible recipients who are established members of the same health plan's SNP program would significantly promote and foster continuity and integration of care.

RFI Response 3
Successful managed long term care programs either coordinate Medicare and Medicaid benefits for dually eligible individuals through Special Needs Plans and Part D or fully integrate these two programs into a single capitated funding stream (e.g., MN model and PACE programs).

Even if the State of Hawaii does not wish to address the integration of Medicare and Medicaid for the dually eligible population at this time, it is important to have a strategy for phasing the duals into an integrated model. Therefore, we would recommend that plans serving the aged and disabled also be required to obtain a contract to be Medicare Advantage SNPs.

MQD's Response to 2 & 3 above
We appreciate the suggested comments and will consider them in the development of the RFP.

Auto-Assignment RFP Summary pg. 6

RFI Response 1
In addition to considering factors such as long-term care facility residence and PCP presence in the networks, the State should also consider current enrollment in a Medicare Advantage plan in making auto-assignments. Specifically, if a consumer has already chosen to enroll in a Medicare Advantage plan, he/she should be auto-assigned to the QExA plan where they are already receiving their Medicare coverage. This auto-enrollment approach is consistent with DHS' policy goal to integrate delivery of Medicare and Medicaid services and allows the health plan to coordinate all services through a single care coordinator. The scenario that DHS would want to avoid is having a member who has selected Plan A for Medicare Advantage who enrolls (either by choice or DHS auto-assignment) to Plan B for QExA benefits. In this situation, coordinating Medicare & Medicaid benefits is fragmented for the consumer and provision of care coordination is challenging for both health plans involved.

MQD's Response
At this time, MQD does not believe that there will be a link between Medicare and Medicaid with regards to auto-assignment.

RFI Response 2
We would be most interested in receiving additional details on the factors that will be considered as part of the algorithm, as well other alternatives and options that may have been considered by the DHS.

MQD's Response
The State is working with our contracted actuaries to rework the RFP summary description of the auto-assignment algorithm. Also, the RFP will provide all details on the auto-assignment algorithm that may be used.

Enrollment Counselors RFP Summary pg. 6

RFI Response 1
If the cost associated with enrollment counselors are the responsibility of the health plan, each plan should pay an equal amount since eligible members are not enrolled into a managed care plan yet. However, we ultimately believe MQD should be responsible for this cost since it involves enrollment activities which are the responsibility of DHS.

MQD's Response
The State will bear the costs of the enrollment counselor program. The health plans may be required to pay for a portion of the printing costs for informational brochures as is done in the QUEST program.

RFI Response 2
We strongly recommend that the health plans be allowed to participate in training of these people [enrollment counselors and ombudsman] as their role is critical to the health plan's ability to successfully provide quality care and ensure member satisfaction.

Health plans have had vast experience in planning for and participating in successful outreach events. Please consider tapping into their expertise to plan, coordinate and promote outreach events.

MQD's Response
The health plans will not be trainers to enrollment counselors or ombudsmen staff due to the appearance that the health plans may have a self-interest or conflict of interest; however, the State will request that the health plans participate in MQD's enrollment counselor orientation by providing information about their specific health plan (perhaps by conducting a presentation).

RFI Response 3
The RFP Summary states that the DHS will be responsible for overseeing the activities of enrollment counselors or other delegated entity that will help individuals enroll into health plans. As a current health plan in another state we understand that the enrollment process can be extensive and requires significant staff resources and training. We recommend that the DHS speak with staff from this state's program [AHCCCS] to understand the staffing requirements related to enrollment activities.

MQD's Response
Thank you for providing the information about the AHCCCS' programs use of Enrollment Counselors. We will contact Arizona to obtain information regarding their program.

RFI Response 4
We understand that the DHS intends to enroll all eligible ABD individuals into managed care over a relatively short period of time. However, given the magnitude of this transition, we recommend that the DHS consider staging the implementation process over a longer period of time to allow for greater adoption of QExA by both providers and members. The DHS can choose to expand the program either by geographic region or by number of eligible individuals or by a combination of both strategies.

MQD's Response
We thought about staging the implementation process of the ABD individuals, but decided not to utilize this option.

RFI Response 5
Explain in detail the role of the Enrollment Counselor Program and how they will collaborate with health plans as well as members.

MQD's Response
We will provide this detailed information on our website once it is approved through our 1115 waiver amendment with the Centers for Medicare & Medicaid Services (CMS). This information will not be included in the QExA program RFP.

Ombudsman Program RFP Summary pg. 6

RFI Response 1
Explain in detail the role of the Ombudsmen Program and how they will collaborate with health plans as well as members.

MQD's Response
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.

Enrollment Issues Including Cap RFP summary pg. 6

RFI Response 1

a. The RFP Summary states that the first wave of ABD individuals will be transitioned from fee-for-service into managed care within 60 days. How many individuals will be part of this first wave and what will be the criteria used to determine which individuals fall into this first wave?
b. How many subsequent waves will be included in this enrollment transition and how many individuals will be in each wave?
c. How long will the complete transition period last?

MQD's Response

a. All of the Aged, Blind or Disabled (ABD) members in the Medicaid program will be transitioned into QExA in the first wave.
b. There will be no other subsequent waves.
c. The transition period will be adequate to assure successful transition of individuals into QExA.

RFI Response 2

a. What methodology will be used to determine the enrollment caps? If contracting for this program will be done statewide rather than by island, will the enrollment cap be based on statewide enrollment?
b. Will health plans be able to self impose a cap and restrict enrollment into their plan?

MQD's Response

a. The State is working with our contracted actuaries to determine enrollment caps based upon population and the QExA program design.
b. No.

RFI Response 3

a. The RFP Summary states that the DHS will implement an enrollment cap on health plans that reach a specified percentage of membership. Please describe the proposed enrollment cap and how does the DHS intend to monitor the cap (e.g. how will the DHS know when to lift the cap)?
b. Will this enrollment cap be used to determine the number of health plans that will be allowed to participate in QExA?

MQD's Response

a. The State is working with our contracted actuaries to determine enrollment caps based upon population and the QExA program design.
b. The State is working with our contracted actuaries to determine the number of health plans in QExA. There will be a cap on the number of health plans per island as well as a cap on the maximum enrollment of members per health plan per island.

Health Plan Changes RFP Summary pg. 7

RFI Response 1
On page 7, it states that members will be allowed to switch health plans for cause and during the annual plan change period. Please define "for cause".

MQD's Response
The definition of "for cause" will be provided in the RFP and it will be similar to the current QUEST program.

Additional DHS Responsibilities RFP Summary pg. 7

RFI Response 1
Pg 7 – the RFP Summary notes that "for individuals under age 21: dental services" will be provided directly by the State. Is adult dental care part of the QExA benefit package?

MQD's Response
No. Adult dental services will be provided to all Medicaid members on a Fee-For-Service (FFS) basis for now.

Readiness Review RFP Summary pg. 8

RFI Response 1
Please consider alternative methods for existing QUEST health plans to show they've met readiness requirements without the State and the health plans having to go through the entire readiness review process once again.

MQD's Response
All health plans that are awarded a contract will be required to undergo a complete readiness review process. This includes existing QUEST health plans. Because the QExA program differs from the current QUEST program and will serve a different population (the ABD) with some services that are not part of the current QUEST program (e.g., long-term care residential placement and services), the readiness review will not cover the exact same topics. However, the QExA readiness review will incorporate lessons learned from the QUEST readiness review process.

IV. Summary of RFP Section 40

Provider Network RFP Summary pgs. 8-9

RFI Response 1
MQD should provide this information to interested parties as soon as possible so that health plans can mirror as much as possible the current provider network so there are no disruptions in care.

MQD's Response
The State will provide the current FFS provider network to the interested QExA health plans that request this information upon release of Letters of Intent (LOI) requirements.

RFI Response 2
Provide a definition of "Appointment" since appointments can be provided in various ways – in person, telephone, home visit, etc.

MQD's Response
The State will utilize the current QUEST definition for appointment. Also, this definition will be provided in the QExA RFP.

RFI Response 3

a. What is the intent of basing the geographic access solely on driving time rather than distance?
b. Describe what the annual Network Development and Management Plan entails.

MQD's Response

a. The State utilized driving time instead of distance to focus on the member's health care needs. The State will consider adding distance as well as a geographic access indicator.
b. The description of the Network Development and Management Plan will be provided in the RFP.

RFI Response 4
The RFP Summary indicates that the DHS will impose provider access and availability standards. What allowances will be made if there are no suitable providers (e.g. certain types of specialists) on islands other than Oahu? How will the DHS determine compliance with access and availability standards under such circumstances?

MQD's Response
The State will allow for a waiver of network adequacy if access or availability of providers on any island is non-existent and cannot reasonably be made available to serve the member's imminent needs. Yet, the health plan will be required to ensure that the member will be able to receive these specialty services somewhere in the State (or other viable location).

RFI Response 5
What will be a health plan's obligations to provide HCBS benefits to people on their resident island versus transporting them to other islands? What allowances will be made if there are no suitable providers/HCBS services on islands other than Oahu?

MQD's Response
All members, whether on Oahu or other islands, should receive needed services in their own community where they reside. Members should not be forced to leave their island home to receive HCBS on another island. Health plans will need to find a method for

providing services that the member needs in their own community. The State may allow for a waiver in extreme cases where HCBS providers cannot reasonably be made available to serve the member's imminent needs. It is one of the State's key purposes of the RFP and resulting contract(s) to incentivize health plans to invest and expand HCBS capacity on all islands, as needed, to serve QExA members in their own community where they reside.

RFI Response 6
To make the most effective use of limited resources, the State should permit MLTC plans to utilize Nurse Practitioners to provide regularly scheduled, non-emergent care to residents of nursing facilities. Physicians should supplement the NP visits at least every 60 days or more frequently if needed.

MQD's Response
Nurse Practitioners will be a covered provider in the QExA program.

RFI Response 7
The issue of paying family caregivers to provide home-based care is a topic of on-going debate among elder care practitioners and public policy makers. There is currently no federal policy in place, but there are a number of state-level demonstration projects designed to test the costs and benefits of such an approach.

The overall goal is to keep elders in their homes and communities and out of long-term institutional care by extending the definition of caregiver to include qualified family members.

MQD's Response
Paying family caregivers to provide HCBS will be described in detail in the RFP.

Primary Care Providers RFP Summary pg. 10

RFI Response 1
Members eligible for QExA will be given 15 days to select a health plan before being auto assigned by MQD. For consistency across the QUEST and QExA programs, we request that the timeframes for plan and PCP assignments be the same.

MQD's Response
The State is attempting to be consistent between QUEST and QExA wherever it makes sense, but will make decisions based upon what is best for the QExA population.

RFI Response 2
The draft RFP requires that the health plan must ensure that all members have a PCP as written on the bottom of page 9. However, on page 4 (last sentence of 2nd paragraph), the draft RFP states that a QExA member who also has Medicare coverage is exempt from this requirement. We strongly suggest that this requirement be reconsidered. A single physician advocate who is responsible for and has the ability to manage the recipient's

care needs is fundamental to ensure coordination, continuity and integration of care, while decreasing duplication and fragmentation of services.

MQD's Response
We appreciate the suggested comments. A PCP for all members will assure the coordination of services that the State is trying to achieve in QExA. We will add this requirement to the RFP.

Provider Agreements RFP Summary pg. 10

RFI Response 1
Are the provider agreement requirements for the QExA program vastly different from the QUEST program provider agreement requirements? Could our current QUEST contracts suffice?

MQD's Response
The requirements for QExA provider agreements will not be vastly different from those for the QUEST program. Nevertheless, 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.

RFI Response 2
"The RFP requires that health plans set up contractual relationships with providers, and describes the specific requirements and clauses that must be included in the provider agreements"
Will DHS provide the specific contract language that will be required for provider agreements with the RFP? If DHS only provides required contract language after plans have obtained LOIs for the RFP response, adding DHS' language may impact provider decision-making with regard to contracting with plans. The process will be more straightforward if plans can inform providers from the beginning of contract negotiations of DHS' ultimate contract requirements.

MQD's Response
Yes. The State will provide specific contract language required for provider agreements in the RFP.

RFI Response 3
"The health plan will be prohibited from seeking and obtaining signed provider agreements until a template has been reviewed and approved by the DHS" –

a. At what time will DHS approve contract templates?
b. Will DHS only approve templates for plans that are ultimately selected thru the procurement?
c. Do we submit a template with our RFP submission?
d. Does this mean that DHS will only expect to see LOIs from plans during the procurement process?

MQD's Response

a. The State will approve contract templates shortly after QExA contracts are awarded.
b. Yes.
c. The State is still determining RFP submission requirements.
d. The State does not expect to see signed contracts and will accept LOIs for network adequacy at RFP submission.

HCBS Alternatives RFP Summary pg. 11

RFI Response 1

We understand that the DHS currently has programs in place that promote HCBS alternatives, such as the Nursing Homes Without Walls program. How does the DHS intend to integrate these programs into the proposed QExA program?

MQD's Response

The services offered through four (4) HCBS waivers (Residential Alternative Community Care Program, Nursing Home Without Walls, HIV Community Care Program, and Medically Fragile Community Care Program) will be offered in QExA.

Covered Benefits and Services

RFI Response 1

a. Will the criteria for HCBS require that services or products be medically necessary?
b. Will the Med-QUEST Division, with assistance from health plan Medical Directors, develop criteria for HCBS so decisions are consistent across health plans?

MQD's Response

a. Yes.
b. The current criteria that are being utilized for the HCBS waivers will remain in QExA. Where the State intends to expand Medicaid HCBS, the State will provide criteria in the RFP.

RFI Response 2

a. Will MQD, with assistance from health plan Medical Directors, develop criteria to determine when and for what amount of time a Personal Care Assistant and/or respite care is a covered benefit?
b. Will there be a benefit limit per plan year?

MQD's Response

a. The criteria for Personal Care Assistance and Respite Care will be determined in the RFP.
b. Any benefits limits will be outlined in the RFP.

RFI Response 3

a. Assisted Living Facility should not be included.
b. The HCBS are currently provided by the waiver programs such as RACC-P, Medically Fragile Children, and Nursing Home Without Walls. Do the rules and standards of the current waiver programs continue? Health plans may want some flexibility in "how" to implement these services in ways that promote better care, seamless transitions, and better utilization of resources.
c. Explain the relationship between the health plan and Adult Protective Services, who currently determines and quickly expedites placement and services to members. How is the health plan included in this process and who has the decision making authority?

MQD's Response

a. Assisted Living Facility services are a current service provided through the HCBS waivers and will continue to be a service under QExA.
b. The current Medicaid Waiver program rules and standards for the services provided under the current waiver programs will continue, but the health plans will be given flexibility in implementing those services as outlined in the RFP.
c. There is no official relationship between APS and placement in Medicaid Waivers. APS investigates abuse and neglect of dependent adults through its statutory authority. When there has been abuse and there is imminent risk to a person if they stay in a living arrangement, APS will remove the client and place them in a safe environment. Sometimes placement is into a Medicaid Waiver program or placement in a nursing facility that is a Medicaid provider. The statutory authority of APS will not change due to QExA. However, when seeking needed placement for a client, APS will contact the health plan and recommend appropriate placement.

RFI Response 4

The RFP Summary notes that plans will be responsible for coordinating services with mental health and DD/MR providers at DOH. Does this mean that DD/MR will be included in QExA, with their LTC benefit still in FFS Medicaid? Or will the DD/MR population be carved out of QExA?

MQD's Response

The MR/DD population will be included in QExA for primary and acute care benefits. The long-term care benefits will continue to be provided on a FFS basis as is the current practice.

Service Coordinator/Health and Functional Assessment (HFA)/Disease Management Programs RFP Summary pgs. 12-14

RFI Response 1

a. The Service Coordinators are required to conduct a Health and Functional Assessment (HFA) for each member at least once per year in person (unless the member requests a telephonic assessment). Because phone assessments can be

just as effective, the member should be given the option to have the assessment done in person or over the phone.

b. If the plans are not able to maintain the required Service Coordinator to member ratio, will the health plan be able to restrict enrollment until the ratio is met?
c. Will the cost of conducting the HFA be included in the health plan capitation rate? Since this service is not currently part of the Medicaid FFS program, we would like to assure this and all new services are part of the actuarial assumptions.
d. Currently weight loss programs, obesity treatment, food, food supplements and health foods are specifically excluded benefits of the QUEST program. If an obesity disease management program is required, will this no longer be an excluded benefit? Will the QUEST benefit change as well?

MQD's Response

a. The option for telephonic assessments, per the member's request, will be provided in the RFP.
b. No. The health plans will not be able to restrict enrollment.
c. Yes. The cost of conducting the HFA will be included in the administrative portion of the capitation rate.
d. The State is attempting to be consistent between QUEST and QExA wherever it makes sense, but will make decisions based upon what is best for the QExA population. We appreciate the suggested comments and will consider them in the development of the RFP.

RFI Response 2

We recognize that service coordinators serve an integral role in supporting care coordination and case management initiatives for recipients. We would support the establishment of "guideline" ratios that would consider various levels of care based on the functional status of program recipients.

MQD's Response

The service coordinator ratios will be provided in the QExA RFP.

RFI Response 3

1. MLTC case managers must make contact with a new enrollee within 7 days, conduct a face-to-face assessment within 12 days and initiate services within 30 days.
2. Face-to-face re-assessments should be conducted every 90 days for those in HCBS and every 180 days for those in nursing facilities.
3. Caseloads for case managers should be limited to 48 members in HCBS, 60 members in assisted living and 120 members in nursing facilities. These ratios should also be adjusted depending upon such factors as:
    - The number of non-English speakers;
    - Overall case mix;
    - Mental health co-morbidities;
    - Travel times;

- High intensity acute care needs; and
- Situations in which a member has no informal supports.

4. Tele-monitoring technology should be employed to permit those who can safely remain in their own homes to do so.
5. In addition, the State should allow case managers to authorize the most cost effective placement and service package for eligible members.

MQD's Response
We appreciate the suggested comments and will consider them in the development of the RFP.

RFI Response 4

a. The RFP Summary states that the DHS will specify a ratio of members to service coordinators. Will this ratio reflect case mix and/or acuity levels?
b. What allowances will be made if staffing shortages in Hawaii are such that health plans may have significant challenges meeting this requirement?

MQD's Response

a. Yes.
b. The State has tried to develop staffing ratios for service coordinators with the understanding of the current staff shortages in Hawaii.

RFI Response 5
The RFP Summary states that the DHS will require health plans to have disease management (DM) programs for a total of six (6) illnesses or conditions. We are concerned that this requirement may be too extensive for participating health plans, particularly if the level of membership in each health plan is not large enough to warrant investments in all 6 DM programs. We recommend that the DHS require health plans to have DM programs in place that are relevant to the plan's membership case mix.

MQD's Response
We appreciate the suggested comments and will consider them in the development of the RFP.

Transition of Care RFP Summary pg. 14

RFI Response 1
As written, there is a requirement for exchange of information and honoring of prior approved services for certain members. The health plans should have an opportunity to develop the list of services needing to be honored as all plans do not prior authorize the same services. Utilize the QUEST health plans' recent experience with "transition of care" to develop the best model to ensure a successful transition of member from the fee-for-service setting to managed care.

MQD's Response
The winning QExA awarded health plans will be included in the "transition of care" planning. In addition, the State will incorporate lessons learned from the current QUEST "transition of care" into QExA.

RFI Response 2

a. Health plans will be required to honor prior authorizations during the transition of care. Does this include prior authorizations made by Medicaid FFS? If yes, what medical policies and criteria does Medicaid FFS use to authorize services?
b. Is there a length of time for which a health plan must honor a prior authorization?

MQD's Response

a. Yes. The medical policies and criteria that Medicaid FFS uses to authorize services are outlined in the Medicaid Provider manual which can be located at www.med-quest.us/providers/Reference/manual.html.
b. The timeframe for honoring prior authorizations will be provided in the QExA RFP.

V. Summary of RFP Section 50

Enrollment RFP Summary pg. 15-16

RFI Response 1
If clinics can act as a PCP, a choice form should only be required for true PCP selection. Only the state can disenroll a member. Please provide the health plans with the procedures to include in the member handbook.

MQD's Response
We appreciate the suggested comments and will consider them in the development of the RFP.

Member Services RFP Summary pgs. 16-17

RFI Response 1
The RFP Summary states that the DHS will require health plans to translate written materials into five (5) ethnic languages. We are concerned that this requirement may be cost-prohibitive for health plans, particularly if the plan's membership mix does not warrant the need for these translations. We recommend that the DHS require health plans to translate written materials based on a threshold that is specific to the plan's membership needs. For instance, the health plan will be required to translate materials into Ilocano if 10% or more of the plan's membership speaks Ilocano as their primary language.

MQD's Response
This language requirement is consistent with that for the QUEST program. The State is attempting to be consistent between QUEST and QExA wherever it makes sense; however, the State will make decisions based upon what is best for the QExA population.

We appreciate the suggested comments and will consider them in the development of the RFP.

RFI Response 2
The plans are required to have a toll-free hotline that is accessible 24 hours a day, 7 days a week, staffed by a registered nurse who can answer medical questions. Because of the nursing shortage, we would ask that you reconsider requiring a registered nurse be available 24 hours a day, 7 days a week.

MQD's Response
We appreciate the suggested comments and will consider them in the development of the RFP.

RFI Response 3
MQD will require health plans to send information including a class schedule for member education classes to members within 10 days. Are you referring to health education classes?

MQD's Response
Member education will be defined in the RFP.

RFI Response 4
Health plans will be required to provide an up-to-date provider directory on the plan's website. Does up to date mean monthly, quarterly, semi-annually, or annually?

MQD's Response
Specific requirements for up-dating the provider directory will be defined in the RFP.

RFI Response 5
Grievance and appeals which are not resolved through the health plan can be referred to the State's grievance and appeals systems. Does "which are not resolved" mean a member who is not satisfied with the health plans initial decision or does it mean after the member has exhausted the health plan appeal process?

MQD's Response
The Health Plans will be required to have a grievance and appeals system. The details of the system will be outlined in the RFP.

Quality Improvement/Reporting Requirements RFP Summary pg. 18-20

RFI Response 1

a. In order to ensure a successful implementation, these tools (monitoring and evaluation) should be provided at the same time the RFP for QExA is released.
b. The health plans will be required to establish performance standards that are monitored on an on-going basis. The plans must show demonstrable and sustained improvements. Since not all programs and activities developed to

improve performance do so. Rather than just demonstrating and sustaining improvements, I would also recommend that if a performance goal is not met, that a process be in place to evaluate why it was not successful. In any good quality improvement program, learning from challenges can be just as important as a success.

MQD's Response

a. The tools for RFP implementation will be provided when available.
b. We appreciate the suggested comments and will consider them in the development of the RFP.

RFI Response 2

Because one of the goals of the QExA program is to assure coordination and decrease fragmentation across the continuum of care, health plans should be able to consolidate its operations if the health plan is contracted for both programs (QUEST and QExA).

MQD's Response

We appreciate the suggested comments and will consider them in the development of the RFP.

RFI Response 3

Provide details on the frequency and format of the required reports. Please consider the value of call center reports. Health plans are not set up the same so the data may not provide a true picture of the volume of calls. Instead, consider member satisfaction scores as a better metric.

MQD's Response

The reporting requirements will primarily be the same for QExA as in QUEST with some changes based upon the QExA population.

VI. Summary of RFP Section 60

Capitation Payments RFP Summary pg. 21

RFI Response 1

In order for states to accomplish the goal of promoting home and community based care they must provide the financial incentive for health plans to do so. One of the core tenets of managed long term care is capitated risk-based financing that offers financial rewards to health plans that effectively deliver needed services in the most appropriate setting. Basing capitated payments on the mix of institutional and home-based care provides that incentive.

Arizona's Long Term Care System (ALTCS) is a case in point. First, the capitated rate is all inclusive, incorporating acute medical care, behavioral health, nursing facility and ICF-MR as well as home and community based services. Arizona adds an administrative

percentage (6% for large plans and 8% for small plans), contingencies and a per member per month (PMPM) factor for case management. It is essential that case management be included as a separate factor and not considered part of administration because of its importance to this vulnerable population. The ALTCS capitation rate assumes a certain mix of HCBS and facility services and if the plan improves on that mix (has a higher proportion of HCBS) it achieves profitability.

MQD's Response
The State is in the process of working with our contracted actuaries to develop capitation rates. We will contact the ALTCS program, as needed, to help us in this process.

Reimburse providers and subcontractors RFP Summary pg. 22

RFI Response 1

a. Negotiated Rates
First, we have concerns over the language that implies there will be a "negotiated rate" environment. Our position is simple:
   - We do not agree that it is appropriate to force nursing facilities into a negotiated rate environment for what is commonly referred to as the "routine bundle of services" rendered to the routine long term/skilled care Medicaid population (i.e., those services generally provided by all nursing facilities under the current rate methodology).
   - We do not agree that it is appropriate to depart from the current rate methodology required by Act 294. Consequently, the juxtaposition of "floor" and "negotiating rates" is confusing (and, therefore, potentially worrisome) to us, unless placed in a context making it clear that it refers to negotiating higher-than-the-acuity-based (FFS) payments authorized by Act 294 for the same routine bundle of services or for "above-and-beyond" services, as described below in the "Real Opportunity . . ." portion of our response.
   - The managed care plans must be specifically required to use the rate methodology implemented under Act 294 for the Medicaid custodial care population in nursing facilities.

b. Negotiated Rates For The Long Term/Skilled Care Nursing Facility Population Is The Wrong Approach And Will Not Achieve Managed Care Goals
Although it may save a small amount of money, at the expense of patient health and safety (and survivability of the providers who serve this population), it will not assist in managing the nursing facility population. There is little-to-nothing to "manage" in the existing nursing facility long term/skilled care population. The real opportunity to manage patient care, and to care for patients in a more cost effective manner in nursing facilities, lies outside of the population/services encompassed by the current rate methodology.

c. The Real Opportunity To Use Nursing Facilities and Manage Care
Although there is NOT an opportunity to "manage" care or cost in the long term/skilled care Medicaid nursing facility population, there is significant

potential in utilizing nursing facility capacity in a positive and cost effective way under a managed care initiative. This opportunity lies in the population of "challenging patients".

d. BOTTOM LINE: We seek a clarification (to us and in the RFP) that "basic" nursing facility rates, as previously discussed, will not be subject to negotiation – except in the context of plans offering higher-than-the-acuity-based (FFS) payments authorized by Act 294 for the same routine bundle of services or for "above-and-beyond" services.

   We ask that the managed care plans understand explicitly that they will be required to use the rate methodology implemented under Act 294 for the Medicaid long term/skilled care population in nursing facilities and that the rates so-determined would constitute the "floor."

   We would like to gain a better understanding of the "*floor . . . for the first year*," language, and should it be warranted, an assurance that health plans will be made fully aware that that language is, in no way, to be construed as relieving them of their Act 294 obligations at any time during their participation in QExA.

RFI Response 2
We request that the Health Plans reimburse providers and subcontractors no less than the current Medicaid FFS floor, with certainty that increase is provided to follow annual cost-of-living-expense schedules.

Individual Providers also do not want to directly negotiate rates with the Health Plans. Providers reserve to negotiate rates, no less than every two years, through an association with the Health Plans.

RFI Response 3
What happens after the first year? How are the FFS rates going to be determined after the first year? Can any plan come in and negotiate either lower or higher? If it is open for negotiation, what is the intent? Would be a rate negotiable with DHS, but such rate should not be put into a statute, is this the intent?

MQD's Response to 1, 2, & 3 above
The State is interested in offering the opportunity for providers and health plans to work collaboratively to obtain negotiated rates that are win-win for both the providers and health plans. The State is assuring Medicaid FFS schedule comparability for the first contract year. The State will communicate with both the providers and the health plans to determine if this provision needs to remain for the following contract years. The QExA RFP will also require the health plans to comply with Act 294 and explain how they propose to do so.

RFI Response 4
For the first year of the contract, the draft RFP proposes that health plans utilize the Medicaid FFS schedule as a floor for negotiating rates with providers (page 22). The DHS placed significant importance on health plan competitiveness during the last QUEST contract re-bid. An integral factor in remaining competitive is a health plan's ability to negotiate contracts that are sustainable and "win-win" for both the provider and the health plan. If a health plan were able to negotiate a contract for 98% of the current Medicaid FFS schedule, and this rate is acceptable to the provider (perhaps with or without additional considerations such as a preferred status), this stipulation would preclude such an arrangement. Is that the DHS' intent?

MQD's Response
We appreciate the suggested comments and will consider them in the development of the RFP.

Spend-down Amounts RFP Summary pg. 22

RFI Response 1
On page 22 of the draft RFP, it states that it is the responsibility of the health plan to collect spend-down amounts from members who have spend-down requirements. Although as part of our case management activities, we will assist and help provide guidance to recipients who are affected by this requirement, we believe that this is a component of the eligibility function and therefore, should be performed by the DHS. However, we will be happy to evaluate this activity as a possible health plan responsibility once the DHS provides a detailed description of the program criteria and requirements.

RFI Response 2
The RFP will require health plans to collect spend-down amounts from members who have spend-down requirements. Since eligibility determinations is a DHS function and because a member with spend-down requirements is not eligible until the spend-down is met, DHS should monitor spend-down and then let health plans know when the member is eligible for services.

MQD's Response to 1 & 2 above
The State will continue to determine eligibility for those members who have spend-down requirements. But, it will be the health plans' responsibility to collect spend-down amounts monthly.

Third-Party Liability

RFI Response 1
Please specify the provisions of the third-party liability.

MQD's Response
The RFP will provide details about the third-party liability provisions.

VII. Summary of RFP Sections 70, 80, 90, 100

No comments or suggestions received.

VIII. Other Questions

RFI Response 1

What is the size of the children with special health care needs (0-21) population that would be eligible for QExA?

MQD's Response

The State will provide up-to-date information regarding the QExA population with the release of the RFP.

RFI Response 2

a. Will MQD provide health plans Medicaid FFS claims history for the ABD population? What information will be provided and for what date of service range? When will this information be given to the health plans?
b. Will MQD provide health plans with the current Medicaid FFS fee schedule? If so, by when?

MQD's Response

a. The State will provide information on Medicaid FFS claims history upon release of the RFP.
b. The State will provide information on Medicaid FFS fee schedule upon release of the RFP. Also, some of the current Medicaid FFS fee schedule is already available on the Medicaid website at www.med-QUEST.us.

RFI Response 3

When does MQD expect to fill the Medicaid Medical Director position?

MQD's Response

The State is currently in the process of filling this position.

RFI Response 4

Some reports indicate that long term care facilities in Hawaii have reached maximum capacity. Based on the DHS' research, what is the current occupancy rate of long term care facilities in the state of Hawaii?

MQD's Response

The information on occupancy rate of long-term care facilities can be found on the State Health and Development Agency's website at www.state.hi.us/health/shpda/.

RFI Response 5

It will be extremely helpful to health plan contracting efforts if the DHS could include release with the RFP data on Medicaid FFS providers currently serving the QExA population. The following data fields would be very useful:

- Provider ID (either MPIN or state-assigned Medicaid provider ID number)
- Provider Name
- Provider specialty (family practice, neurology, etc.)
- Provider city
- Provider state
- Provider zip code
- Date of service (MM/DD/YYYY)
- HCPCS code (CPT or HCPCSII code)
- # Units Billed per CPT Code
- Billed charge
- Medicaid payable amount

State Response

The State will provide information on our FFS providers. The State will provide the information in the requested format, if we are able.