

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
1	10.400	2	1	What does the second sentence mean, particularly the following "...meet all required experiences." Specifically, please clarify what "required experience" references and where those are enumerated in this RFP.	See #1 of Amendment #4.
2	20.100	5	1	RFP Timeline - Is it possible to have the commencement of service to members begin on 7/1/09? This would allow more time to transition member care, and ease health plan and MQD requirements as they relate to plan, benefit and reporting (including financial) administration for the program.	DHS is not considering a change to the commencement of services date of 11/1/08.
3	20.100	5	1	All QExA enrollees will be transitioned into the health plans on November 1, 2008. Would MQD consider a longer transition time or a phased in approach to ensure all members are reached and understand the change?	DHS is considering neither a longer transition time nor a phased-in approach.
4	20.100	5	1	Where is the State in the process of obtaining their waiver from CMS and is there a potential that a delay in CMS approval will affect the RFP timeline and implementation?	DHS is working with CMS to obtain waiver approval. At this time we do not anticipate that a delay will affect the RFP timeline and implementation.
5	20.100	5	1	What process will be available for health plans if they have questions regarding the RFP after October 26, 2007?	See #2 and #3 of Amendment #4.
6	20.500	7	1 & 2	For jointly submitted proposals, would tax clearance be required of both parties or just the prime applicant?	Section 10.400 describes all joint applicants other than the prime applicant as subcontractors. Section 70.500 requires all subcontractors to submit a tax clearance to the health plan. General condition 3.2 (see App. K) requires subcontractors to submit a tax clearance to the State. DHS will amend section 80.230 to reflect that tax clearances for the prime applicant and subcontractors should be submitted to DHS upon proposal submittal and upon request. See #67 of Amendment #4.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
7	20.700	9		Please provide a spreadsheet compatible electronic version (such as a comma-delimited text file) of the current Medicaid fee schedule.	An excel version is available on the Med-QUEST website in the RFP documentation section listed on the left navigation bar. The MQD website is: www. med-quest.us .
8	20.700	9	1	Can you provide an update on the status of the documentation library materials and when they will be made available?	<p>These documents are located on the Med-QUEST website in the RFP documentation section listed on the left navigation bar. The MQD website is: www. med-quest.us.</p> <p>However, 2 documents are not available: Current QUEST Formulary and the Information on the Development of the QExA Capitated Rate Ranges. Please see amendment #4</p>
9	21.300	14	2 nd	The RFP states: <i>"Both the technical and business proposals shall be received by the Issuing Officer no later than the Proposal Due Date identified in Section 20.100, or postmarked by the USPS no later than the date identified in Section 20.100. All mail-ins postmarked by USPS after the Proposal Due Date will be rejected. Hand deliveries will not be accepted after 4:30 p.m. (H.S.T.) on the Proposal Due Date."</i> Is it correct that if the applicant's proposal is post marked on or before December 7, 2007, then the State considers the proposal to be received by the issuing officer and it will be accepted for consideration? Also, will the State conduct a formal bid opening on December 7, 2007 at 4:30 p.m. (H.S.T.)?	Yes, post marked on or before December 7, 2007 is considered on-time. DHS will not conduct a formal bid opening.
10	21.300	14	4	In addition to the option of submitting the electronic version of the business proposal in MS Word or Excel, can a health plan submit in PDF format?	A health plan can submit it in PDF but a Word or Excel version is still required. It is preferred that the bid forms be submitted in Excel format.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
11	21.300	14	4	The RFP indicates that RFP responses need to be received by DHS or "postmarked by the USPS no later than the date in 20.100. All mail-ins postmarked by USPS after the Proposal Due Date will be rejected". Does this mean that responses will be accepted even if they arrive on December 10 (for example), as long as they are postmarked by the USPS on December 7 or earlier? Also, to clarify, if applicants use FEDEX or UPS (United Parcel Service), these are considered hand-deliveries that must be physically received by 4:30 HST on December 7 th ?	Yes to both.
12	21.300	15	Whole Page	The RFP is clear that the technical and business proposal should be submitted separately. Should we submit the mandatory requirements section with the technical proposal? Can we submit the mandatory requirements in a separate binder than the technical proposal?	Please submit the mandatory requirements section with the technical proposal.
13	21.400	16	Bullet 9	This bullet requires applicants "show proof of accreditation by National Committee for Quality Assurance (NCQA), American Accreditation HealthCare Commission/URAC or Joint Commission on Accreditation of HealthCare Organizations (JCAHO) in any state in which the applicant is currently operating." (1) Is applicant's accreditation by the "Accreditation Association for Ambulatory Health Care (AAAHC)" acceptable for bid qualification? This is a required accreditation in our Florida market.	See amendment #1 issued on October 22, 2007.
14	21.400	16	Last bullet	The RFP includes a bullet point stating, "failure to show proof of accreditation by National Committee for Quality Assurance (NCQA), American Accreditation HealthCare Commission/URAC, Accreditation Association for Ambulatory Health Care (AAAHC) or Joint Commission on Accreditation of HealthCare Organizations (JCAHO) in	See #5 and #65 of Amendment #4.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
				<p>any state in which the applicant is currently operating” will result in the disqualification of the applicant. This contract item is not required by Hawaii statute or regulation concerning health plans.</p> <p>CMS does not require accreditation of health plans participating in the Medicare Advantage program. Also, accreditation is NOT a contract requirement for the many States that have existing Medicaid LTC programs including Arizona, Florida, Massachusetts, Minnesota, Texas and Washington. We believe that it is inappropriate for DHS to require accreditation relative to business operations in other states, where State and Federal customers themselves do not have such requirements in place.</p> <p>Many States have not required NCQA, URAC, AAAHC and JCAHO accreditation for LTC programs because these standards are designed to evaluate acute medical systems and programs. In particular, LTC operations are predicated on and require knowledge of community-based services and providers that are not recognized by these accreditation standards. These standards must be supplemented and adapted to maintain appropriate compliance for a LTC population.</p> <p>Lastly, it appears that inability to demonstrate accreditation in any state where the applicant has current operations was not grounds for disqualification from the procurement for the QUEST program in 2006.</p> <p>We respectfully request that DHS remove the requirement in the last bullet of Section 21.400.</p>	

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
15	21.400	16	1	The RFP requires health plans to be accredited in their current state(s) of operation. For some lines of business (specifically Medicare and Medicaid in most states), accreditation is not mandatory. If accreditation is not required for health plans in state(s) that they are currently operating in, will the Department of Human Services (DHS) allow these health plans to submit a response to the RFP?	See #5 and #65 of Amendment #4.
16	21.400	16.	1	Or, will the DHS allow health plans that are in the process of securing accreditation to submit a response to the RFP, provided that these health plans supply the DHS with sufficient evidence of the accreditation process prior to the Commencement of Services?	See #5 and #65 of Amendment #4.
17	30.200	22		The term "affiliate" is mentioned in various forms within the RFP. Could you please provide a definition for this term?	See #7 of Amendment #4.
18	30.200	30		Enrollment counselor - has DHS selected a vendor to perform this function? What specifically is their role?	No, DHS has not selected a vendor. Specifics about the role of the Enrollment Counselor will be included in any procurement or contract negotiation activities.
19	30.200	44		Workforce development requirement. Will this requirement and related health plan activities be factored into the administrative cost assumptions used by the State actuaries in rate setting?	Yes.
20	30.300	44		Enrollee (potential) - What types of FFS members can "voluntarily" elect to enroll in a MCO, and, who is mandated?	See #7 of Amendment #4.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses												
21	30.300	45	Whole page	The Program Population Description does not explicitly state that dual eligibles who are not in an HCBS waiver or are not in a nursing facility are included in the QExA Program, although Appendix C and other areas of the proposal notes that non-NHC duals are included in QExA. Please clarify, are non-NHC duals eligible for QExA?	Yes, non-NHC (nursing home care) duals are eligible for QExA.												
22	30.300	45	2 nd Main bullet- Last sub-bullet	Regarding the DD/MR population: 1. What is the total number of the DD/MR members broken down for each island? 2. Where are the DD/MR member's medical costs accounted for in the databook (i.e.; HCBS, Institutional)? 3. For purposes of service coordinator ratios, would DD/MR members be considered based on the case management services and oversight from DHS, to be non-NF LOC, NF LOC (community), or NF LOC (institutional)? 4. What is the number of children who are SEBD and adults who are SMI?	<p>1. The approximate number of DD/MR waiver clients by island as of 10/15/2007:</p> <table border="0"> <tr> <td>Oahu</td> <td align="right">1170</td> </tr> <tr> <td>Hawaii</td> <td align="right">321</td> </tr> <tr> <td>Maui</td> <td align="right">159</td> </tr> <tr> <td>Kauai</td> <td align="right">149</td> </tr> <tr> <td>Molokai</td> <td align="right">23</td> </tr> <tr> <td>Lanai</td> <td align="right">3</td> </tr> </table> <p>2. Because the HCBS services for DD/MR clients are removed from the QExA program, the non-institutionalized DD/MR members are located in the Medical Only rating categories.</p> <p>3. Because the DD/MR members will have case managers as part of their services within the Developmental Disabilities Division of Department of Health, the health plans should consider these members as in the Non-NF Level of Care Service Coordinator ratios.</p> <p>4. DHS does not have exact figures on the number of members with these diagnoses and is therefore, unable to respond to this question.</p>	Oahu	1170	Hawaii	321	Maui	159	Kauai	149	Molokai	23	Lanai	3
Oahu	1170																
Hawaii	321																
Maui	159																
Kauai	149																
Molokai	23																
Lanai	3																
23	30.300	45	2 nd Main bullet-includin	Regarding the State's waiting lists: 1. Can the State provide the number of persons on each of its waiting lists (i.e.; 1915 (c), Personal Assistance Services)?	1. As of November 6, 2007, 27 people were on a wait list for the NHWW waiver; no other waivers had a wait list; approximately 820 people were on a wait list for the State funded Chore Services Program. Chore services will be a												

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
			g sub-bullets	<p>2. What are the number of members in each eligibility category identified by the State as "other relatively small specialized ABD populations" and "other populations who meet QExA eligibility criteria"?</p> <p>3. Is information available with respect to how long the individuals on the waiting list have been waiting since their placement on the list? It would be helpful if the State could provide the average time a member spent on each of the waiting lists during the last 12 months.</p>	<p>part of the QExA personal assistance services Level I,</p> <p>2. DHS' information system cannot identify members in these special groups.</p> <p>3. Yes. Average wait time for the last 12 months:</p> <ul style="list-style-type: none"> a. NHWW- 3.7 months , b. RACC- NA, c. HIV/AIDS-NA, d. DD/MR-NA , e. Personal Assistance Services Level I (State funded Chore Services Program) - seven (7) months.
24	30.300	46	1 st Main bullet	<p>The RFP states that "...Children age eighteen (18) or younger who are wards of the State (including but not limited to those whom the State has placed in foster care) and meet QExA eligibility criteria." Could the State define these eligibility criteria?</p>	<p>QExA eligibility criteria for this category would be a child who is either blind or has a disability.</p>
25	30.300	45	Whole page	<p>Are Medicaid-eligible individuals with ESRD included in the QExA population? If so, can DHS provide the number of individuals with ESRD who will be enrolling in QExA?</p>	<p>Yes. DHS does not have access to the number of members with ESRD.</p>
26	30.400	47	6 th Bullet	<p>Has there been a change to the SMI evaluation process? Doesn't the State SMI evaluator make the SMI determination, and not AMHD? Could you please describe the evaluation process as it currently exists?</p>	<p>In QExA, when a health plan determines that a member is diagnosed with a SMI, the health plan will refer the member to the AMHD for an evaluation. If AMHD denies the SMI designation, the health plan shall refer the member to the DHS for determination as to whether he or she is eligible for the BHMC program. If a member's SMI designation is denied, the health plan shall continue to be responsible for the member's behavioral health needs. The process described in the QExA RFP is the process that will be utilized for the QExA population.</p>
27	30.510	49	1	<p>Since the State is the sole authority on eligibility, is the State also responsible for recertification?</p>	<p>Yes.</p>

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
28	30.520	49	1	Will the Dept use an enrollment broker to perform the functions defined in this section? Will the Dept consider adding the following demographic elements to the member information included on the enrollment files: date of eligibility; name of non covered parent/guardian?	DHS and the enrollment counselor will perform these functions. The eligibility date is included in the enrollment file. DHS does not have non-covered parent/guardian information in the enrollment file.
29	30.520	49	4	The RFP states "Enrollment into the health plan will be effective on the day DHS determines eligibility". Will DHS provide retroactive FFS coverage from the date of application to the date DHS determines eligibility?	No.
30	30.520	49-50	Enrollment overview, auto-assignment	Usually auto-assignments are made by most States based on quality performance of the Plan or cost to the State (saves the tax payer money) or a consolidation. Since there is not yet experience with serving the member it would seem that cost would be the primary driver. This is not the case with auto-assignment in the RFP. Please share the goal and rationale used to design the described goal and auto-assignment method.	DHS has determined that this approach to the auto-assignment is in the best interest of the QExA program.
31	30.520	49		Will a QExA member ever be enrolled in the FFS program after commencement date?	Yes, a QExA member can be enrolled in the FFS program after the Commencement date. One example is if a QExA member is enrolled into the SHOTT program.
32	30.520	49		Please provide an example of a recipient's enrollment timeline using the individual's date of application, the date individual meets eligibility requirements, the enrollment date into FFS program if applicable, and enrollment into the health plan.	November 2 nd : An application received by MQD December 5 th : Eligibility determination is made (approved) with health plan enrollment effective November 2 nd
33	30.520	49	1 st bullet	The RFP states "within ten days of the individual being determined eligible, the DHS will provide information and assistance in selecting a Plan". What type of assistance and information is the State planning to provide to the member?	Enrollment Counseling and general Medicaid eligibility information will be provided to the member.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
34	30.520	50		If a recipient does not select a health plan within 15 days, the recipient will be auto assigned to a health plan. When does the 15 day period begin?	The period begins on the receipt of the enrollment letter taking into account approximately five (5) days of mail time. See #12 of Amendment #4.
35	30.520	50	Enrollment in LTC & Non-LTC	Will the State allow Plans to work out a Plan-to-Plan change process among themselves if possible during TOC to better coordinate care?	Yes.
36	30.520	50	1	Will the state be using an enrollment broker?	Yes.
37	30.520	51	Enrollment section	How will the Enrollment process work initially if FFS members don't have a PCP currently? How will the State define "an established relationship with a physician"?	The enrollment process will work as described in the RFP and the enrollment counselors will help members identify PCPs in each plan. If the FFS member does not have a PCP, DHS will look to an established relationship with a physician (a relationship where the member has previously received medical services from a physician or provider) using utilization and claims data.
38	30.520	52	1 st	The RFP states: <i>"If no members of a household have selected a health plan, the entire household shall be auto-assigned to the same plan."</i> Will the State enroll the member's entire Medicaid eligible household in the QExA health plan even if the rest of the household does not meet the QExA eligibility criteria?	No, only QExA eligible family members will be enrolled in that health plan. See #12 of Amendment #4.
39	30.530	52	1	The RFP indicates that QExA members will have 60 days prior to the Commencement of Services to choose a health plan. During this transition period, how does the DHS or its designee intend to notify all members about enrollment options (e.g. provide written notifications, conduct community meetings, schedule home visits, etc.) and what is the process to assist all individuals with	The DHS and/or its designee plan to use media campaigns, public meetings, facility visits and individual mailings to notify members. The choice process will be described during these meetings and in the information provided. The DHS will work to achieve the optimal balance between freedom of choice and the membership caps.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
				making a health plan choice? How will DHS balance freedom of beneficiary choice against the membership caps that have been established?	
40	30.530	52	1	How will the DHS or its designee ensure that there are enough staff members available to assist with member enrollment during this transition period?	The DHS has recent experience with a choice period and so is aware of staffing requirements during such activities. Any designee will be appropriately monitored to ensure there is sufficient staff.
41	30.530	52	1	What type of provider and member educational activities, if any, will health plans be able to participate in during the transition period?	The health plans will be responsible for providing education to their providers. DHS will be using enrollment counselors for education and outreach to the members. DHS 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). In addition, DHS will include health plans in outreach events as appropriate.
42	30.540	52	2	Will the Dept pay a maternity case rate?	No.
43	30.550	53	90 Day Grace Period	Will members have the opportunity to transfer during the 90 day grace period with only two plans and the cap at 50%? Could you explain how that would work?	Yes, members will have the opportunity to transfer health plans so long as the cap is not met. The transfer will occur as any plan change would occur.
44	30.550	53	1	The RFP indicates that members will be allowed to change health plans without cause within the first 90 days of Commencement of Services. How will the DHS facilitate transitions of care between health plans during this 90-day period? How will DHS balance freedom of beneficiary choice against the membership caps that have been established?	The DHS will be responsible for facilitating coordination of care with the health plan the member is initially assigned to. Plan changes and transitions of care that occur during the 90-day period will be the responsibility of the 2 health plans as required in Section 41.500. The DHS will work to achieve the optimal balance between freedom of choice and the membership caps.
45	30.550	53	3	How and when will the DHS educate PCPs on the process to assist members in changing health plans during the 90-day grace period?	The DHS will educate PCPs prior to the date of Commencement of Services to Members. This education will likely be in the form of direct mailings to all current FFS providers.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
46	30.550	53	3	During the first 90 days of enrollment, will a member be able to change health plans more than once? Is there a limit to the amount of times a member can change health plans during the? Does the member receive a 90 grace period from the date of each plan change?	A member will be able to change plans once per month, so in the 90-day period they will be able to change more than once provided caps are not in place. There is a limit to the number of times a member can change because the period is only 3 months long. No, the member does not receive a 90-day grace period from the date of each plan change.
47	30.550	54	1	How will the 'month of request' be determined? How is the request date determined? Is it the month the call/form is received? Is there a specific form to use or phone number to call? How will the request be approved by the member? Who is submitting or calling the DHS to request the change? How will DHS verify that the request was properly authorized by the member?	The month of request is the month in which the DHS receives the request. There is a specific form/phone number which will be provided during Readiness Review. The member or an MQD authorized representative shall submit or make the call to the DHS requesting the change. The MQD confirms that all requests are approved by the member and has protocols in place to ensure this is true.
48	30.550	54	1	What if the request is near the end of the month and can not be made in time for the beginning of the next month?	If the change request is received by MQD on or before the last day of the month, the change will be effective the first day of the following month.
49	30.550	54	1	Are changes retro-active?	See response to question #48; changes can be retroactive. See #15 of Amendment #4.
50	30.550	54	2 nd bullet	If a member has had a 60-day break and lost eligibility and came back during the annual plan change period, is the member re-enrolled to the previous plan and given a choice that will be effective for the next contract year or is the member allowed to enroll into the new plan as of the re-enrollment date?	The member would be re-enrolled into their previous plan and given a choice that would be effective for the next contract year.
51	30.560	54	2 nd bullet	Is the State required to have its first annual Plan change in May 2009? If members have 90 days to change Plan from November 1, 2008, it seems like the annual Plan change period would make Care Coordination more difficult during the first year of the contract.	No, DHS is not required to have the annual plan change in May.
52	30.560	54	2	Is the annual health plan change period only one month (May)?	Yes.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
53	30.560	54	4	Will the first annual health plan change period be May 1 – 31, 2008 or will it be a portion of the month?	It will be the full month.
54	30.570	55	2	Please clarify 'The DHS will implement enrollment caps during the transition period enrollment described in Section 30.530.' Section 30.530 does not provide health plan enrollment cap guidance during the transition period.	The reference is to Section 30.530, transition period. Section 30.570, the section in which the reference appears is the section on enrollment caps.
55	30.570	55	3	Will health plans be able to self impose a cap and restrict enrollment into their plan?	No.
56	30.570	55	4	Because members have 90 days from the date of plan selection to change plans without cause, can a member enroll in a previously capped health plan once the cap is lifted? How will DHS notify members who are still within 90 day grace period that the cap has been lifted?	Yes. If the member or member's representative contacts MQD or its designee to change plans, they will be notified of the plans that are available.
57	30.570	55	4	The RFP states that the enrollment cap on Oahu will be 60% of island enrollment (for the health plan receiving the most points for its technical and business proposals). Does this mean that the 2nd place plan is capped at 40% of the island enrollment?	Yes.
58	30.570	55	4	Why is the state allowing a higher concentration of recipients in a single plan on Oahu than on other islands?	DHS has determined that allowing a higher concentration of recipients on Oahu is in the best interest of the QExA program.
59	30.580	56	3	Does the existing QExA population meet the citizenship, alien status, photo and identification documentation requirements as required by DRA?	Yes.
60	30.580	56	6 th bullet	Please define what should be considered a 'change in health status'. Can you provide examples.	A change in health status as used in this section is a change that would result in a change in eligibility category or eligibility status.
61	30.580	56	9 th bullet	Could you provide a breakdown of the percentage of QExA members who have dual coverage (with Medicare) versus an active TPL (the other coverage being other than	DHS does not have a breakdown of the percentage of dual eligible members who have a TPL in place of Medicare. TPL updates are processed approximately two weeks within

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
				Medicare)? Could you please describe timeframes for processing TPL updates submitted via the 1179 form?	submission of the 1179 form.
62	30.600	57	2	Reasons for disenrollment. There are reasons for disenrollment from the Program and reasons for disenrollment from a plan. The bullets listed in this section combines both. For clarity, we suggest that the reasons be grouped by Program disenrollment reasons and plan disenrollment reasons. Bullets 10+ are reasons to be disenrolled from the plan and not the program.	Good suggestion. See #19 of Amendment #4.
63	30.600	57	8 th bullet	Please explain why the member becomes disenrolled as a result of Medicare Special Saving Program.	See #18 of Amendment #4.
64	30.600	58	2	Please define how the 'month of request' will be determined when a member/health plan files the request. Will the 'month of request' be determined based on the month the request was physically received by the DHS? When does the time line for determining the 1st day of the second month begin?	See response to question #47 for the first 2 questions. The timeline for determining the 1 st day of the 2 nd month is the month prior to the month prior, e.g. for January 1, the applicable dates would be November 1 - 30.
65	30.710	59	1	Children are defined as 'those from birth through the month of their twenty-first birthday'. In other sections of the RFP, children are defined as 'under the age of twenty-one' (RFP 30.730) and in other sections as through 20. Can the definition of a child be standardized? We would recommend this definition: 'those from birth through the month of their twenty-first birthday'.	No, the state will not standardize the definition of child because there are program differences. Also see #20 of Amendment #4.
66	30.710	59	1	Please explain the timeline associated with SHOTT. If the DHS and SHOTT contractor determine the individual meets the transplant criteria, what is the timeline for disenrollment from the health plan and onto SHOTT.	Upon receipt of the 1144 by the MQD Medical Consultant, the request is reviewed and the date of approval is the SHOTT effective date. The date of disenrollment from the health plan and into SHOTT is identified through the 1144 process.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
67	30.710	59	1	When the member has been determined a SHOTT candidate, does SHOTT take over cost associated with the transplant regardless of when the member began their hospitalization? In other words, if the member moves to the transplant facility on 11/5/09 and SHOTT is determined 11/07/09, does SHOTT take coverage responsibility effective 11/5/09?	DHS will determine coverage on a case by case basis.
68	30.720	59	1	The RFP states that DHS will cover services for persons eligible for PACE. How many people are in this program? What is the eligibility criteria? How many people do you anticipate will meet the eligibility criteria?	There are not currently no PACE programs in the State. DHS is working to develop one on the island of Maui.
69	30.740	60	1	Who is going to be the BHMC? Please explain the AMHD and BHMCP process. If AMHD members are deemed SMI, are they also enrolled into BHMCP? Is everyone in AMHD Service deemed SMI? If not, could you please explain why and also explain the exceptions, if any?	DHS is in the process of negotiations with the prospective BHMC. Once this contract has been finalized, it will be shared with the public. AMHD members are not served by the BHMC. AMHD services MQD members who are diagnosed with SMI.
70	30.820.1	61	1	The RFP reads "MQD will not reimburse Plans for any privately acquired vaccines which can be <u>obtained</u> by VFC." Would MQD reimburse Plans for privately acquired vaccines during a shortage when VFC has no stock?	MQD will make this determination at the time that this situation occurs.
71	30.820.3	62	1	Does the state have an estimate of how many enrollees in the program are SEBD or SMI/SPMI?	No.
72	30.820.4	62	1	Will CAMHD or MQD reimburse a Plan at the Plan paid rates when a member chooses to use Plan services rather than CAMHD services? For these members, will the State pay for drug coverage for psychiatric meds as well? If CAMHD cannot provide the service and the Plan can, will CAMHD/ MQD reimburse the Plan?	Yes, if a child who meets SEBD criteria chooses to use the health plan services instead of CAMHD. Yet, MQD would reimburse at the Medicaid rate, not health plan rates. No, the plan is responsible for psychiatric medications. Yes, but MQD would reimburse at the Medicaid rate, not health plan rates.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
73	30.820.5	62	1	Please provide clarification of the services that will be the responsibility of the health plan for members in the DD/MR program and which services will be covered by the DOH Developmental Disability Division. Who will be responsible for drug coverage?	The health plan will be responsible for primary and acute services to members in the DD/MR program. The DOH Developmental Disability Division will be responsible for long-term care services (case management, overseeing 1915(c) HCBS waiver, and ICF/MR services) for members with DD/MR. Prescription drugs are a primary service, therefore, a responsibility of the health plan.
74	30.910	62	2	What are the standards that the DHS will be using when monitoring and evaluating a health plan? Please define the standards for each of the monitoring responsibilities listed on page 63.	The DHS will use standards that are appropriate to the specific activity. The State declines to define the specific standards for each of the monitoring responsibilities in the RFP as the list is comprehensive and will evolve based upon prior performance and specific areas that may require additional monitoring of the health plans. The DHS will provide the standards at a later date.
75	30.910	63	3	Please state the period of time that the DHS will allow the health plan to comply to/with activities or new requirements that will be monitored by the DHS based on the statement 'the DHS may add additional monitoring activities at any point'.	The period of time will vary depending on the monitoring activities. The DHS will work with the health plans to ensure that there is sufficient time for the monitoring activities.
76	30.920	64	bullets	Should the 'Health information systems' bullet read 'Health plan information systems'? If not, please provide a definition of a 'Health information system'?	Yes. See #21 of Amendment #4.
77	30.930	65		Can the DHS indicate in the RFP the expected release month of monitoring tools?	No, this information will not be provided in the RFP. As this section discusses the EQRO's monitoring activities, the DHS will provide the monitoring tools prior to the EQRO review.
78	30.930	65	1	EQRO monitoring - Would the DHS consider the use of deeming in which Plans who have been accredited and audited by CMS for their Medicare products are able forgo an EQRO monitoring review?	No, the DHS will not consider the use of deeming.
79	30.930	66	1 st bullet	Is the correct reference for the CAHPS survey 'CAHPS 4'?	Yes. See #22 of Amendment #4.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
80	30.930	66	2 nd bullet	Since DHS will be surveying providers regarding 'how satisfied providers are with reimbursement', how will the DHS help with improving the results of future surveys? Will the DHS be providing specific guidance in the reimbursement assumptions used by the State actuaries so there can be a positive impact to future surveys in relation to this question?	The DHS will help with improving the results of the survey by providing, to the health plans, the results of the survey such that the health plan can address any issues or concerns. If providers are unhappy, DHS will direct actuaries to increase rates to allow for higher payments to the extent that these higher payments are funded by the legislature.
81	30.950	67	2	Will the existing QUEST memorandums be applicable to the QExA health plans or will new QExA memorandums be issued prior to the start of the program?	Some QUEST memorandum will be applicable to QExA health plans. New QExA memorandum will be issued prior to the start of the program.
82	30.960	67	1	What is the expected time frame for the Readiness Review? In particular, what is the anticipated timeline for the onsite review?	The Readiness Review period includes the entire time period from Contract Award to Commencement of Services to Members. The DHS expects to conduct the onsite review in June.
83	30.960 51.600	67, 272		Is there a corrective action/appeal process for the Readiness Review findings?	Yes, the health plan shall have 10 days from receipt of the Readiness Review findings to appeal any decision of findings of non-readiness or problems. The DHS will make all final decisions in this area and those decisions shall be binding. In addition, if necessary, the DHS will work with the health plans on any corrective action plans with the goal of making the health plan ready to receive members.
84	30.960	68	2	What would be the expected time frame for curing any deficiency identified during the Readiness Review or in completing a corrective action plan?	The timeframe for curing any deficiency will depend upon the deficiency; there is no blanket timeframe.
85	31.100	69	Last	Is the member monthly premium cost factored into the spend-down the Plan is to track? If so, how will this be shared with Plans?	No. No members in QExA will have premiums. See #23 of Amendment #4.
86	31.100	69	Last	Will the DHS will be responsible for billing and collecting all member share of cost?	No.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
87	40.200	71	n/a	If a member goes to a non-par provider because services cannot be accessed in the network, may the plan pay 100% of the Medicaid fee schedule and are providers required to accept the rate?	The health plans must provide the required services but DHS will not determine the reimbursement arrangement made between the health plan and providers.
88	40.200	71	5	Will MQD share the current Medicaid Fee-for-Service provider network? If shared, will the listing include provider specialties and identify HCBS providers?	MQD's provider network is listed on the MQD website in the RFP documentation section listed on the left navigation bar. The MQD website is: www.med-quest.us The provider network lists specialties for physicians. HCBS providers are included in the provider network.
89	40.220	77	1	Please provide clarification on which physician specialties must be available at a hospital.	The health plan is responsible for ensuring that all physician specialties are available as needed by members.
90	40.220	77	1	RFP section 40.220 requires minimum standards of at least 1 PCP for every 600 members. However, the RFP states that dual eligible (Medicare/Medicaid) members do not need to be assigned to a PCP. Does the 1 PCP for every 600 members requirement apply to members that are eligible for Medicaid only, or to all members (including those that are dually eligible for Medicare and Medicaid)?	All members are to have a PCP. Section 40.260 states, "The health plan shall ensure that each member has selected or is assigned to one (1) PCP who shall be an ongoing source of primary care appropriate to his or her needs." The 1 in 600 requirement applies to all members.
91	40.220	78	Bullet 1 & 2	Please provide a list of Adult Day Care Centers and Adult Day Health Centers the State has contracted with for FFS.	A list of these providers is listed on the MQD website in the RFP documentation section listed on the left navigation bar. The MQD website is: www.med-quest.us .
92	40.220	78	Bullets 11, 12, 17	Can DHS share a list of who has been used in FFS to provide home maintenance services, home modifications and personal care assistance?	Agency providers for home maintenance are: Maui Economic Opportunities, Inc., Child and Family Services, Nurse Finders, Hawaii County Office of Aging. There is no list of providers for home modifications. Rather, any licensed contractor in the State of Hawaii can perform these services provided they have been prior authorized by the case manager.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
					A list of providers for personal assistance and homemaker services is provided on the MQD website in the RFP documentation section listed on the left navigation bar. The MQD website is: www.med-quest.us . These are home care/home health agencies.
93	40.260	82	1	Please confirm that a specialist willing to be a PCP would only need to file once his/her willingness to be a PCP instead of multiple times for each member that chooses the Specialist as a PCP?	Yes, that is true.
94	40.260	82	1	Can the health plan obtain blanket agreements to cover all members for which Specialists are willing to serve as a PCP or is the documentation required to be member-specific?	Blanket agreements are fine; the documentation does not need to be member-specific though the health plan is responsible for knowing which members are assigned to a specialist serving as their PCP.
95	40.260	83	1 st bullet	The RFP reads a "Plan will not establish limits on how frequently and for what reason a member may chose a new PCP." Frequent PCP changes impacts care particularly when members change PCPs to doctor shop or as a result of drug seeking behavior. Could the State reconsider this stipulation and allow Plans to limit PCP changes in situations when a member exhibits egregious behavior that could be mitigated by limiting PCP changes?	No, DHS will not allow health plans to limit PCP changes.
96	40.440	147	Whole page	Are there individuals in the HCBS waiver programs who are currently self-directing their personal care services? How many individuals are taking advantage of self-direction today? How many additional individuals does DHS anticipate will be interested in self-directed personal care under the QExA Program?	Yes, as it relates to the QExA program the following are the number of recipients that are self-directing their care. This information is not available by service type: <ul style="list-style-type: none"> • NHWW: approximately 430 • HCCP - 24 • State funded Chore Services Program (chore services is a component of the QExA personal assistance services Level I) – approximately 1,150.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
					The State anticipates that approximately 820 additional people will qualify for and be interested in self-directed personal assistance services Level I.
97	40.500 40.630	95 102	2	For the purposes of early network development activities, is there any opportunity for bidders to submit model contracts and the provider manual for DHS review and approval prior to the Contract Award?	No, model contracts and provider manuals will not be reviewed prior to the Contract Award. It is acceptable, but not a requirement, for the applicants who are awarded a contract to submit their model provider contracts and provider manuals after Contract Award but prior to the date they are due.
98	40.500	90	Bullet #17	Could the requirement for the 'submission of complete and accurate encounter data on a monthly basis' be removed from this section? This requirement is normally dealt with in the provider contract/agreement.	This section is the provider contract/agreement section— Section 40.500 and that is where this requirement appears.
99	40.500	90	Bullet #17	Please clarify whether the submission of medical records to support encounter data requires consent of the member. Can the requirement just state that member consent is not required? Suggest that member consent requirement be similar to bullet 42.	See #25 of Amendment #4.
100	40.500	93	Bullet #39	Should this bullet reference the emergency medical condition definition in RFP section 30.200 instead of the 'provider manual'?	No, the provider contract should reference the provider manual since that is the document to which the providers will have easy access. The provider manual shall incorporate the definition in RFP Section 30.200.
101	40.500	93	Bullet #40	Please clarify that this requirement is not for all providers. Suggest that additional language be added similar to bullet 52 '(if they will be providing EPSDT services)'.	See #26 of Amendment #4.
102	40.500	94	1	Providers are required to submit annual cost reports to the MQD. What data elements are required to be included in this report? What will MQD do with this report?	Hospitals and Nursing Homes are required to file annual cost reports to DHS or its Audit & Reimbursement contractor to include QExA members, inpatient days and facility costs. This report will be a component of MQD's monitoring activities.
103	40.500	94	Bullet #49	Please clarify what annual cost reports are required under this bullet.	See response to 102.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
104	40.500	94	Bullet #50	Suggest that the reference to 'provider manual' be amended to specific RFP requirement.	The reference in the provider contract needs to be to the provider manual since that is the other document to which the providers have ready access. The definition in the provider manual must be the one specifically provided in the RFP.
105	40.610	95	1	Does this section require that all providers attend a provider education event or just to make provider education events available for the provider community to attend?	This section requires that provider education events are made available.
106	40.610	95	1	To ensure the availability of health care providers to meet the medical needs of health plan members, bidding Plans will most likely have provider networks that are much larger than the minimum required for bid submission. This section stipulates a provider training schedule that at minimum, requires 2 training sessions every year. Is it necessary to educate <u>all</u> Providers two months prior, then every six months thereafter? Many providers already participate in the QUEST program and are familiar with the common requirements that are similar to the QExA program.	Provider education must be conducted and offered to all providers at the times identified in the RFP. Although many providers may also be QUEST providers there are specific requirements in QExA that all providers should be made aware of, for example, the requirement that all members will have care plans whose development requires the input of providers.
107	40.630	99	1 st bullet	Please clarify what is meant by "formulary information." Do you mean a listing of our formulary or information about our formulary? Our formulary is a separate document that is not included in the provider manual, however the provider manual does include information about the formulary.	The health plan should provide enough information to providers such that they understand what is in and what is excluded from the formulary. The complete formulary listing does not need to be included, though reference as to where it can be found would be helpful.
108	40.630	100	2 nd bullet	Please provide examples of what is meant by 'a description of cost sharing responsibilities'.	If the provider is expected to collect a cost share from the member, the details of this process need to be outlined in the contract with the provider.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
109	40.630	100	3 rd bullet	What is meant by 'description of reporting requirements including encounter data requirements'? Should the provider manual contain an explanation of the DHS encounter submission requirements that health plan is required to meet? Or is it that all fee-for-service or capitated claims must be submitted to the health plan?	This bullet means a description of any reporting activities the health plan is going to require of the providers in order for it to meet their reporting obligations with the DHS as outlined in the RFP. As part of this description the health plan should outline what is expected of providers as it relates to encounter data submissions.
110	40.630	101	3 rd major bullet	Please provide examples of what is meant by 'specialized communication (braille, large print, etc)'. What types of documents need to be provided in this format?	Specialized communication means any activity that will facilitate the providers' interaction with the member/patient. This bullet is not referring exclusively to formats for documentation—rather it might include sign language translation or the presence of a language translator if the provider and member do not speak a common language.
111	40.630	101	Last Bullet	How much detail should be provided in the provider manual regarding 'adjudication procedures'?	The provider manual shall include enough information to ensure that the providers understand adjudication procedures.
112	40.640	102	1	Can Provider and Prior Authorization call centers be separate call centers? The requirement seems to indicate that there should be one call center.	Yes, they can be separate call centers though each is required to meet the minimum requirements.
113	40.640	102	2	Can an existing QUEST plan combine its call center with QExA?	Yes, provided there is sufficient staffing to manage both programs and that all contract requirements for each program are met.
114	40.650	103	1	Last sentence in 1st paragraph. Please clarify what types of inquiries the provider should be able to make using the health plan web site?	It is expected that the web-site be an additional way for providers to seek assistance from the health plans. At a minimum, providers should be able to make inquiries about billing procedures, how and where to obtain information on cultural competency, queries about program changes and updates, etc.
115	40.700	104	2	Health plans are required to provide medically necessary services that are no less than the amount, duration, and scope for the same services furnished to recipients under Medicaid fee-for-service. Does the criteria currently exist? Will the current criteria apply to QExA? When will the	Yes. Yes. The criteria is in the QExA RFP. The medically necessary services definition is outlined in section 30.200 of the QExA RFP.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
				criteria be shared with health plans?	
116	40.720	105	1	Please provide guidance on how prior period coverage will be communicated via the 834.	Prior period coverage will be communicated on the 834 through the rate code for prior period coverage.
117	40.720	105	1	Please provide guidance on when prior period coverage will be communicated via the 834 in relation to the eligibility effective date. Will the process date of the transaction be close to the eligibility effective date?	The process date of the transaction may or may not be close to the eligibility effective date. There are too many variables to make any assumptions regarding timing of these two dates.
118	40.750.1	107	3	Is there a limit on inpatient acute days for Adults in the FFS program?	No.
119	40.750.1	118		Can you provide listings of Cyrca's Dental Network for Plans to coordinate with as necessary?	The health plan should contact Cyrca for the most updated information about their dental network.
120	40.750.1	119	Items 1 & 2	Can you provide the Plans a listing of providers you have used for companion services and homemaker services?	See question #92.
121	40.750.1m	119	1 st	Regarding Level 1 personal assistance services, what was the average number of hours per week of Level I personal assistant services for those recipients who received such services for the last 12 months? Are these members/services included in the rate cell 3 data in the data book? Do the billing units in the data book reflect 15 minutes of service, 1 hour of service, or some other increment?	Part 1: A summary of average hours of CHORE data will be included in the data book. Part 2: Yes. Part 3: The vast majority of Level 1 services are billed in 15 minute increments.
122	40.750.1	121	2	Which therapeutic classes are considered psychotropic medications?	The Provider Memorandum P07-11 provides this information and is located on the Med-QUEST website in the RFP documentation section listed on the left navigation bar. The MQD website is: www.med-quest.us .
123	40.750.1	125	6	Can costs to transport providers be posted as a benefit cost? If yes, how would the health plan report the cost?	Transportation of providers is not a Medicaid benefit and should be considered administrative; the health plan could build this cost into the reimbursement rate provided to the member but it can not be reported as a benefit cost.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
124	40.750.1(t)	125	1	How are costs mapped in the data book between emergent and non-emergent transportation?	Emergency transportation services were identified by HCPCS coding contained in the detail claim records from the DHS fee-for-service payment system. Non-emergency transportation data was not contained in the claim system, but was provided as described in the data book summary.
125	40.750.1	126	1st paragraph	What types of members could be disenrolled and enrolled into FFS? Or who is left in FFS after QExA is implemented?	Members who may be disenrolled from QExA and enrolled into FFS are described in Section 30.600. For example, individuals eligible for SHOTT.
126	40.750.1	128	2 nd bullet	Are Clozaril and Clozapine considered excluded BH drugs on the formulary for QExA members?	No, these drugs are not excluded drugs and should be included in any formulary. See #27 of Amendment #4.
127	40.750.1	128	1	The RFP reads "individuals 21 and older are limited to 30 days of hospitalization per year". Does this requirement apply for QExA members with a parity DX?	This requirement applies to all QExA members.
128	40.750.1	129	1 st & 3 rd	Substance abuse residential care has not been considered a mandated benefit and is generally paid by ADAD - is it different for QExA members? Can QExA members access ADAD funded beds?	No, It is not different for QExA members. Yes, QExA members can access ADAD funded beds.
129	40.750.1	129	2 nd – 4 th bullets	The RFP reads the Health Plan is not obligated to provide BH services to AMHD, CAMHD members. Please clarify if this includes non-coverage of prescription medications for members in these programs.	Prescription drugs are a health plan covered service in QExA. Medications used for treatment of SMI are covered by the health plans.
130	40.750.1	130	2 nd	The RFP reads room and board in STF for adolescents is not covered but therapy/treatment provided in the facility is the responsibility of the Plan. If the member is in this type of facility wouldn't they be SEBD and thus all paid under CAMHD? Additionally, most STF facility services are paid an all-inclusive rate in which therapy/treatment services are already rolled in.	Most children/youth who are in a STF would be the responsibility of CAMHD. In these cases, CAMHD would reimburse for services through an all-inclusive rate. However, members are given a choice to receive services from CAMHD or through the health plan. If, for some reason, the youth is not enrolled in the CAMHD SEBD program and is placed for treatment in an STF, it is correct to say that room and board

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
					is not covered. Only the treatment provided in the program is included in the rate.
131	40.750.1	130	b.	Please outline the process for SMI designation - i.e., should the Plan refer to the Access Line (AMHD) or use the usual process?	The process for initial determination of whether a member has a diagnosis of SMI is outlined in Section 40.750.1. In summary, the health plan is responsible for making the initial determination of whether or not an adult member has a diagnosis of SMI. Once this determination is made, the health plan shall refer the member to the DOH AMHD. Details of how an AMHD referral will occur will be communicated to health plans after Contract Award. If AMHD denies the SMI designation, the health plan shall refer the member to the DHS for determination as to whether he or she is eligible for the BHMC program. If a member's SMI designation is denied, the health plan shall continue to be responsible for the member's behavioral health needs.
132	40.750.2(b)	130	3	Will members be able to refuse referrals to AMHD and use BHS services of the QExA health plan instead?	No.
133	40.750.2(b)	130	3	Will the adult SMI carveout include pharmacy, behavioral health inpatient care, & behavioral health emergency room services?	No.
134	40.750.1	131	#c, 1 st paragraph	Please provide the DOE contact information and specifically who we are to refer to. Additionally, how long does the determination process usually take? How long should a Plan wait for a determination? If it takes a long time to make a determination, will members be retro-enrolled to CAMHD or can the Plan bill CAMHD for services the member utilized pending the determination? Also, don't Plans refer to CAMHD for SEBD services and not the DOE?	QExA members of school-age may be identified by the DOE for referral to CAMHD for evaluation. A plan can also make the referral to CAMHD directly and is not required to have the referral made by the DOE. Details of how a CAMHD referral will occur will be communicated to health plans after Contract Award. Upon referral to CAMHD, a plan should expect the evaluation process to be completed within approximately four weeks or longer depending upon individual circumstances.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
135	40.750.1	132	2	Please provide the billing format for a Plan to submit claims to DHS for reimbursement when an SEBD member chooses to use Plan services instead of the benefits provided by CAMHD. Additionally, can Plans bill DHS when a member is SEBD and has not made an "active choice" to use Plan services for their BH benefits under the Plan?	This information will be provided after Contract Award to health plans awarded a contract.
136	40.750.1	134	#e	If a Plan decides not to contract with CMAs, is the Plan still required to submit LOIs for CMAs with the RFP bid submission or just indicate that we intend to have CCMA services performed by in-house staff?	As described in Section 80.315.2, the health plan may submit either LOIs with CCMA or proof of in-house capacity. See #59 and #74 of Amendment #4.
137	40.750.1	135	#g	Would a plan be able to contract with an agency for the hiring of PCAs? The agency would be responsible for training family members and other care givers, as well as the member, regarding PCA activities. Does the State see a problem with this type of arrangement? Is this considered formal delegation?	Yes. No. Yes.
138	40.750.1	136	#h	Can a Plan deny environmental adaptations if the costs grossly exceeds available and appropriate alternate settings?	No. The definition of cost-neutrality in the RFP is based on the aggregate cost of serving people in the community and not on the cost for each individual.
139	40.750.3	137	#k	Can the State please provide a listing of medically fragile day care centers they have used in FFS?	At this time, the DHS does not have any active medically fragile day care centers; the DHS is in negotiations with a potential agency to provide this service.
140	40.750.3	137	#1, 1 st bullet	Can FFS provide a list of who they have used in the past for moving assistance?	DHS uses any cost effective available vendor. In the last year, DHS has used Island Movers, Town and Country Moving & Storage, and Oahu Moving Service.
141	40.750.3	137	#1	Can the State provide any utilization information on moving assistance? What contractors have you used in the past? Can the State provide Plans with some general guidelines around how approvals/denials decisions were made in the past in FFS?	Since January of 2005, the DHS has provided moving assistance on 8 occasions. Contractors are listed in question #140.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
					<p>Denials have been rare and made, for example, when the client was moving into an unsafe environment where his or her needs could not be met. Services have been approved for reasons such as:</p> <ul style="list-style-type: none"> • clients having to move from an unsafe home due to deterioration, • wheelchair-bound clients living in a building with no elevator, • home unable to support the member's additional needs for equipment, • the member can no longer afford to live in the home due to a rent increase. or • moving a hospital bed or other piece of equipment because vendors are not willing to do for free.
142	40.750.3	138	#m	In what instances in the past has FFS denied non-medical transportation?	<p>Non-medical transportation is used when family and friends are unavailable to transport the client and must be specified in the service plan. Non-medical transportation is appropriately used to:</p> <ul style="list-style-type: none"> • Pick up medications and grocery shopping at the closest store/ grocery/ pharmacy to the member's home; and • Attend support group, Med-QUEST Office, seek housing, seek services such as legal services (living will, advanced directives) meetings. <p>Examples of excluded non-medical transportation are:</p> <ul style="list-style-type: none"> • Errands to and from the bank; • Shopping for goods other than groceries; • Travel to and from restaurants, movies, other kinds of entertainment or social functions; and • Visiting friends and family. <p>Infrequently, exclusions may be authorized for socialization. Plane travel is not authorized.</p>

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
143	40.750.3	132-140		What are the current minimum thresholds for services in each HCBS waiver program including hours of care provided, the types of services provided and the minimum number of ADL's for each member before entering the program?	DHS requires at least one unit of service a month for the person to be in an HCBS waiver. The waiver services include adult day care, adult day health, assisted living services, attendant care, Community Care Management Agency (CCMA) services, Community Care Foster Family Home (CCFFH) services, counseling and training, environmental accessibility adaptations, home delivered meals, home maintenance, medically fragile day care, moving assistance, non-medical transportation, personal assistance services - Level II, Personal Emergency Response Systems (PERS), private duty nursing, residential care, respite care, and specialized medical equipment and supplies. Also, there is no specific number of ADL's for each member before entering the program. Regarding ADL's for meeting nursing facility level of care, the member must require significant assistance with ADLs. The Nursing Facility Level of Care criteria will be posted on the MQD website at www.med-quest.us .
144	40.750.3	132-140		Are health plans able to maintain the current service limitations of the HCBS waiver programs, including Personal Care Services - Level I and II?	The limits for current HCBS waiver programs will not necessarily apply to the QExA program. The service parameters for HCBS under the QExA program, including any relevant service limits, are described in Section 40.750.3. The health plan must assess members to determine their need for services. Health plans will be required to address these assessed needs in keeping with the QExA defined service parameters.
145	40.750.3	132-140		What is MQD's expectation if a health plan finds that a member requires more HCB services than allowed according to the limitations set within the HCBS waiver programs, and the health plan does not feel an exception to extend services is warranted because the cost of institutional care is less costly?	It is MQD's expectation that if a member wants to be in the community the health plan shall provide all HCBS required; the limitations set by the HCBS waiver programs are not applicable. The health plan must receive prior approval from the DHS or its designee prior to disapproving a request for HCBS (Section 40.820).

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
146	40.750.3	132-140		Will MQD consider developing an add-on rate for high acuity patients (members with care costs greater than the average daily nursing home rate) in order to keep them in the community?	No.
147	40.750.3	133	2	Would adult day health programs licensed under HAR §11-94 meet these requirements as well?	Yes. See #28 of Amendment #4.
148	40.750.3	142	#s	If a Plan provides for respite services, can it be given to family members who are the primary caregivers for a member who is homebound in an independent living situation?	Respite care services, like all other QExA services, are provided to eligible members. The service parameters, defined at 40.750.3.s, clearly allow for the provision of respite care services for a member who is homebound in an independent living situation, if the member is assessed to need the service.
149	40.750.3	143	1	What services are currently not available under the Medicaid State Plan?	HAR§ 17-1737-84 contains a partial list of services that are not included in the Medicaid State Plan.
150	40.750.3	143	1	How will the State actuary factor in costs associated with the specialized medical equipment and supplies which are currently not available under the Medicaid State Plan?	Waiver client experience will be relied upon. These services have been available to waiver clients.
151	40.750.3	144	2 nd , all bullets	How will the State actuary factor in costs associated with recipients who are currently on a waiting list for services (such services as personal assistance services)? Will these members be removed from the denominator when calculating per member per month costs?	See response to question # 486.
152	40.750.4	143	#s	Can the State provide a listing of specialized medical equipment and supplies that are not available under the Medicaid State Plan?	DHS does not have a list of specialized medical equipment and supplies that are not available under the Medicaid State Plan.
153	40.750.4	144	2	What is the basis for the detailed expected reduction in the State waiting list for personal assistance service? Has this been the experience of other states?	The annual thresholds were developed based on sound policy practices, experiences of other states and in consultation with CMS.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
154	40.750.4	144	1	Will the State send a TOC file listing all members receiving these services (EPASLI) prior to enrollment and then right through the 90 change period?	Yes.
155	40.750.4	144	2	Will MQD provide the names of members that are on wait lists for long-term care services? If so, by when?	Yes; this will be provided in mid-to-late October.
156	40.750.4	144	3 rd	The RFP states: "Approximately 400 recipients are on the State's waiting list for personal assistance services Level I." Could the State provide a detailed description as to how they currently manage their waiting lists?	Currently, personal assistance services Level I are not offered in the State. Instead, the State offers a State funded Chore Services Program that allows persons the opportunity to self-direct their services. Chore services will be a part of the QExA personal assistance services Level I. Persons on the wait list for the Chore Services Program are served on a first come, first served basis. See #30 of Amendment #4. For HCBS, an assessment of member acuity and the services that are needed to maintain the member outside of an institution is the way priority is determined.
157	40.750.4	145	3 rd bullet	What information would be required on the Progress note to satisfy that the member is receiving needed care? What would the State do with the Progress Note?	At a minimum, progress notes should include: projected timeframes for delivery of services, availability of providers, any outstanding issues preventing delivery of needed services and member health status. The progress notes will be kept on file by the DHS and used to determine the health plan's adherence to contract requirements for management of waiting lists.
158	40.750.5	144	2 nd - including bullets	Regarding the expansion of personal assistance services Level 1: 1. How will the State take into account unmet community needs ("wood-work effect ") that could potentially increase HCBS services and Personal Assistance Level 1 services? 2. Has the State or its actuaries performed an analysis of	No such analysis has been performed at this time. We have added language to establish a cap on the number of people served receiving personal assistance services Level I. See #30 of Amendment #4.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
				the "wood-work" effect, meaning that with the increased availability and accessibility of these services, will additional individuals apply for eligibility and move into this service?	
159	40.750.5	146	2	Plans will have to increase the number of members receiving HCBS by 5% above the number of members receiving these services in the previous year. How will sanctions be adjusted when utilization begins to plateau?	This will be evaluated and determined by the DHS at a later date.
160	40.750.5	146	2 nd paragraph, 2 nd bullet	What is the basis for the detailed expected reduction in the State waiting list for HCBS. Has this been the experience of other states? These percentages seem arbitrary and could result in "forcing" people into services that are not appropriate.	The annual thresholds were developed based on sound policy practices, experiences of other states and in consultation with CMS. Since members must be first assessed to determine their need for HCBS prior to being placed on a waiting list for services, we do not believe they will be "forced" into receiving inappropriate care. The DHS will reconsider a health plan's need to comply with the prescribed annual increases in the number of people receiving HCBS above the previous year if a health plan can reasonably demonstrate to the DHS' satisfaction that it has provided HCBS services to all persons assessed to need such services.
161	40.750.5	146	3	Could you please provide a report showing the number of individuals on the waiting lists (HCBS lists, personal assistance services Level 1, etc.) by island of residence and what eligibility/rate category those people are currently in?	As of November 6, 2007, there are 27 people on the NHWW wait list; all are on the Island of Hawaii on the East side. As of September, 2007, for personal assistance services Level I (Chore Services) the wait list numbers are: Oahu-475; Kauai-14; Maui-48 East Hawaii-210; West Hawaii-64; TOTAL: 811.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
					The members receiving services through the 1915(c) waivers are in the Home and Community rate category. The members receiving services through the personal assistance services Level 1 are in the Medical rate category.
162	40.770	147	1 st - including bullets	If a member is self-directing their care and has a caregiver employed for 20 hours or more per week are they (as the employer) obligated to provide health insurance benefits to the caregiver? If so, how is this cost to be accounted for in the individual's self-directed budget?	No. See #31 of Amendment #4.
163	40.770	147	Whole page	Are there individuals in the HCBS waiver programs who are currently self-directing their personal care services? How many individuals are taking advantage of self-direction today? How many additional individuals does DHS anticipate will be interested in self-directed personal care under the QExA Program?	See response to question #96.
164	40.770	148	Bullets	If a member chooses self direction and selects a family member as a provider, is it necessary to document all these bullets? Also can a surrogate who is outside the family unit be appointed?	Yes to both questions.
165	40.770	148	3	Is there a pre-determined self-assessment form the State wants Plans to follow? Will the State provide a template form?	No to both questions. The health plan shall develop its self-assessment form.
166	40.770	149	4	Why is the member allowed the flexibility to negotiate provider rates? How will the State actuary factor in costs associated with a member negotiating a higher rate than the health plan has as a contracted rate?	Allowing a member to have the flexibility to negotiate provider rates is key to fostering true choice and control of providers. Other states have found this flexibility to contribute to a member's program success and quality of care. The actuary has not factored in the higher costs associated with negotiating a higher rate because it is the health plan's responsibility to monitor negotiated provider rates to ensure that rates are reasonable and in keeping with the member's allocated budget.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
167	40.770	149	4	What happens if a self-directed member exceeds his/her budget?	The service coordinator will need to determine why the member exceeded the budget, which may require reassessing the member to determine if the allocated budget is appropriate to meet the member's needs.
168	40.770	150	1	Members or their surrogate choosing self direction are able to hire spouses and parents of minor children. The chosen services must not be activities the family would ordinarily perform or is responsible to perform. Can MQD share the criteria currently used to determine what services are not ordinarily the responsibilities of spouses or parents?	Standard state criteria to determine those services that are not ordinarily the responsibility of spouses or parents do not exist. Health plan's will need to make this determination on a case by case basis and consider the extent to which an individual who is the same age without a disability would need the requested level of care or assistance as the member with a disability. See #32 of Amendment #4.
169	40.770	151	3 rd , 4 th , 5 th bullets	<ol style="list-style-type: none"> 1. The services must meet for PAS I & II - Please provide the qualification and training standards for parents and spouses. 2. In general, what rate of pay would the state recommend? What are the upper and lower limits for the rate of pay? 3. Please provide a general list of activities that would not ordinarily be the responsibility of a family member. 	<p>The provider qualifications for personal assistance services Level I will be provided at a later date. The provider qualifications for personal assistance services Level II are found in 40.750.3.o.</p> <p>The DHS will not recommend a rate of pay. The health plan will need to make this determination.</p> <p>A general list of activities is not available. The health plan will need to make this decision on a case by case basis and consider the extent to which an individual who is the same age without a disability would need the requested level of care or assistance as the member with a disability. See #32 of Amendment #4.</p>
170	40.770	151	1 st -all 3 bullets; 3 rd -all 3 bullets	What if a member who chooses self-direction and opts to utilize/hire a family member does not want to participate in the activities as bulleted in this section of the RFP. What happens then? Should the service coordinator document the refusal and move on or does the service coordinator become solely responsible for performing these functions even though the choice was made by the member? If a member chooses not to participate in monitoring activities	<p>See #32 of Amendment #4, for revised requirements for hiring family members.</p> <p>The service coordinator can fire a provider on behalf of a member for health and welfare issues.</p> <p>No, the service coordinator cannot designate a surrogate on behalf of a member. Only a member has the ability to designate a surrogate.</p>

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
				and chooses not to designate a surrogate, can the service coordinator fire a family member that is the self-direction provider in the event that the monitoring activities indicate the provider is not performing or in violation of the terms of the service agreement? Can the service coordinator designate a surrogate in lieu of the member in these situations?	
171	40.770	151	2	What are the State required components of a claim/invoice from a 'self-directed provider'? Would the State require that these be submitted on a CMS 1500 form?	Providers of self-directed services are required to submit time sheets and not claims/invoices.
172	40.770	151	2	What are the State required components of a 'self-directed provider' agreement?	At a minimum, the agreement must: 1) specify the roles and responsibilities of the provider and the health plan; and 2) indicate that the health plan has the ability to fire a provider on behalf of a member for health and welfare issues. Each health plan must develop its own agreement template and submit to the DHS for Readiness Review as a part of its policies and procedures.
173	40.770	151	4	For self-directed members who recruit their own providers, is there a template agreement for non network providers to complete? If not, what provisions are required in the agreement? Is the plan required to credential these providers?	There is no template agreement for these providers. Each health plan must develop its own agreement template and submit to the DHS for Readiness Review as a part of its policies and procedures. At a minimum, the agreement must specify the roles and responsibilities of the provider and the health plan and specify that the health plan has the ability to fire a provider on behalf of a member for health and welfare issues. No, the health plan is not required to credential non network self-direction providers.
174	40.770	152	2	Is the member the 'employer of record' or the health plan?	The member is the employer of record.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
175	40.770	152	2	If the health plan is the employer of the member's self-directed provider, does the health plan's cost (payroll tax and benefit costs) of employing the provider get deducted from the member's budget? If not, why?	N/A. The health plan is not the employer of the member's self-directed provider. See #31 of Amendment #4.
176	40.770	152	3	What are the State requirements around background checks and screenings of providers involved with consumer direction? How long of a process does this take? What type of data repository exists around this process?	The member is given the option to require or not require background checks on their providers. The member signs a form (DHS 1672) indicating that he/she understands that he/she has the right to ask that a background check be conducted. See #33 of Amendment #4.
177	40.770	153	1	Can the State share all training materials it currently uses in FFS?	Not at this time. Training materials will be shared during Readiness Review with health plans awarded contracts.
178	40.770	154	1	Will health plans be able to discontinue self direction if the plan thinks it puts the member's health in jeopardy?	Yes, the process must be delineated in the plan's policies and procedures.
179	40.780	154		Will the sub-acute level of care rates by facility be made public? If not, why not?	Yes. Only facilities that have a sub-acute level of care rates will be posted. The DHS will post the sub-acute level of care rates on the Med-QUEST website in the RFP documentation section located on the left navigation bar. The website is located at: www.med-quest.us .
180	40.810	155	5th Bullet	Can a QExA recipient who also has a Medicare Advantage (MA) plan that's not the same as their QExA plan remain on their MA plan? If YES, is the QExA plan required to pay the MA plan's co-pay (even as a non-participating provider)?	Yes to both.
181	40.810	156	3	Can MQD share the total number of members by island in each of the four service coordination categories?	MQD does not have this information.
182	40.810	156-257		Can MQD share what model they adopted to establish service coordinator ratios?	Service coordinator ratios were developed taking into consideration: the experience of states with comparable programs, best practices, intensity of needs of the QExA population, and CMS guidance.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
183	40.810	157	Last	Are there specific minimum requirements/qualifications for service coordinators working with non-NF LOC members?	See #34 of Amendment #4.
184	40.810	157	Last	Regarding the minimum qualifications for service coordinators, it is our experience in serving ALTCS members in Arizona, that care coordination services for many persons with disabilities and the elderly can be adequately and efficiently provided by non-clinical, non-licensed personnel. Will the State consider allowing the contractor to hire and train persons with appropriate education and experience to serve as service coordinators, even though they are not nurses, social workers or other health care professionals, so long as they are supervised by licensed clinical staff?	We believe that it is important for service coordinators for nursing facility LOC members to have clinical experience, given the level of care needs of this population. However, we have broadened the definition of health care professional to include certified professionals. See #34 of Amendment #4.
185	40.820	159	1	Does the State have a standard HFA it wants Plans to use or can we develop our own?	The health plan shall develop its own. Per the requirements in Section 51.610 this form shall be submitted to the State for review and approval 30 days after Contract Award.
186	40.820	159	Last	Does MQD's MSB process all the 1147s for FFS? And will they continue under QAeX?	The DHS contracts with an external agency to process the 1147's. The DHS will continue to contract for this service under QExA.
187	40.820	159	3	Would you provide more information on the state's criteria for determining "NF LOC"?	The DHS will post a table which outlines the LOC criteria we utilize on the Med-QUEST website in the RFP documentation section. The website is located at: www.med-quest.us .
188	40.820	159	3rd	In order to determine staffing and pricing, especially during startup, it is necessary for the State to provide the total number of 1147 applications received and the total number of 1147 applications denied.	The health plan does not process 1147 applications. 1147 applications are processed by an external agency who has a contract with DHS. The health plan is responsible for completing the 1147 application for each member who is assessed at NF level of care and forwarding the assessment to the State. The State processes the 1147 and makes the LOC determination. All members receiving NF level of care services must have a valid 1147 in order to receive payment for these services.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
189	40.820	159	4	This section states “the health plan shall offer the choice of institutional services or HCBS to members who meet the NF LOC when HCBS are available and are cost-neutral.” How does the State define “cost neutrality”?	We refer you to the service definition for cost-neutral in Section 30.200. We have made accompanying changes in the RFP to ensure consistent use of the term. See #35 of Amendment #4.
190	40.820	160	Para 1	<p>To clarify, at the time of program implementation, is DHS requiring that health plans complete face-to-face assessments for ALL QExA enrollees within the first 90 days after Commencement of Delivery of Services?</p> <p>Completing assessment for 20,000 members in 90 days is a significant one-time operational challenge. In order to complete 20,000 assessments, a plan would need over 80 care managers assuming 2 hours per assessment, with no travel time and no other activity for the care managers for the first 90 days. We propose that the plans should be required to complete assessments for all HCBS waiver clients, all nursing home residents within the first 90 days from the program start date. In addition, plans should be required to conduct telephonic risk stratification to identify those members who do not require NH LOC but are at highest risk for negative health or functional outcomes. Plans should submit risk stratification process to DHS for review. Plans should complete face-to-face assessments for the highest risk non-NHC members within the first 90 days. For those at lower risk levels, plans should be required to complete assessments within the first 6 months of operations.</p>	See #36 and #37 of Amendment #4.
191	40.820	160	2	The RFP indicates that HFA and LOC assessments for members enrolled within the first 90 days of the Commencement of Services will remain in effect for the entire 90-day period. However, if a member chooses	Yes. See #36 and #37 of Amendment #4.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
				another health plan during this 90-day period, will the new health plan be required to conduct a new HFA and LOC assessment?	
192	40.820	161	Para 2	The RFP states that "For members enrolling after the transition enrollment period, the health plan shall complete a HFA and LOC assessment within fifteen (15) business days following enrollment". Many State MLTC programs require that face-to-face assessments be completed within 30 days from the time of enrollment. Please consider modifying this requirement to be consistent with practice from other State MLTC programs.	We have considered this request but this requirement will not be modified.
193	40.830	162	Last	Is the PCP's signature on a member's Care Plan required?	No, the PCP is not required to sign the care plan.
194	40.830	163	1	Can the Care Plan be completed by day 60 matching the BBA requirement to screen and develop a plan for those with special needs?	No.
195	40.910	164	Last	Would the posting of the Cultural Competency Plan on the Plan's website be enough to meet this requirement?	See #38 of Amendment #4.
196	40.920	165	2	Please describe the transition period, if any, that will be allowed for health plans to develop and implement all four (4) required disease management programs (diabetes, obesity management, and cardiovascular disease plus one other program).	See #39 of Amendment #4.
197	40.950	171-172	Bullets	Please provide a list of DOE Providers who deliver the services bulleted out in this section.	The bulleted services refer to CAMHD responsibilities not DOE responsibilities. See #40 of Amendment #4.
198	40.950	171	4	For behavioral health services provided by DOH or DOE, will the DOH or DOE provide any information or reporting to the health plans where the plan is responsible for medical services when behavioral health services are provided by the State?	It is the responsibility of the health plan and DOE/DOH to provide coordination of services.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
199	41.100	172	5	Regarding second opinions, the RFP states that the second opinion shall be provided by a qualified healthcare professional within the network or the health plan shall arrange for the member to obtain a second opinion outside of the provider network. Must the health plan honor a member's request to see a specific provider or will the provider be chosen by the health plan when the health plan identifies a need for the member to see a provider outside of its network?	The health plan does not need to honor a member's request to see a specific provider; the health plan may choose the out-of-network provider who is providing the second opinion.
200	41.410	175	1	Under QUEST, residential care is not a mandated benefit per se. Where QUEST is the payor of first resort - is it same for QAeX?	Residential care is a mandated benefit under QExA. Medicaid is always the payor of last resort, so under QExA, the health plan should only reimburse for residential care services when all other payor sources have been exhausted.
201	41.510	177	1	Section 41.510 states that the plan shall be responsible for the costs of continuation of medically necessary services at beginning of enrollment. Does this include inpatient? Is the plan responsible for inpatient stays if member was enrolled in acute care setting prior to enrollment?	Yes to both questions.
202	41.510	177	1 st	If a member who is transitioning into our plan as a new QExA recipient is currently undergoing treatment with a non-Medicaid provider, can the health plan negotiate a Letter of Agreement with that provider even though the provider is not a Medicaid participating provider (does not have a Medicaid provider ID)?	Yes.
203	41.510	177	1 st	The RFP states that QExA contractors must continue to pay a newly enrolled member's previous provider for medically necessary services that s/he was receiving the day before enrollment, with no prior authorization or irrespective of whether the practitioner is a network provider. Does this requirement apply to members who	This section applies only to individuals transitioning from another Medicaid program or health plan.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
				were previously enrolled in a commercial and/or Medicare plan, or only to those members transitioning into the plan from another Medicaid-contracted health plan or the fee-for-service Medicaid program?	
204	41.520	177	1	Please clarify this section. Is the section referring to sharing of medical information for a transitioning member between health plans? Health plans do not have "medical records." The member's Providers keep medical records and the process for requesting medical records between providers is established. A health plan does not normally get involved in the medical records request process between providers.	Yes, this section is referring to the sharing of medical information for a transitioning member between health plans. Although actual medical records are maintained by providers, in QExA the health plan will have medical information such as service coordination (HFA and care plan) activities, enrollment in disease management programs and prior authorization information that should be shared with other health plans.
205	41.520	177	All	Is the State going to host and facilitate TOC files for Plans to ensure continuity of care? As the current health plan for QExA members, will the State provide auths, referrals, access to current case managers, information on meds, etc., to the winning plans to facilitate TOC? If yes, will this facilitation extend throughout the 90 day grace period? Additionally, how will the State identify an established doctor as a PCP for members initially enrolling, or will that be a Health Plan responsibility?	Yes. The state will provide information that it has available to it and will work with the plans to, to the extent possible, to provide this information to the plans. Yes. The state will work with health plans to help identify potential PCP's for members.
206	50.110	179	3	This section describes the new member enrollment packet that must be sent to the member. The packet includes the health plan member number. Typically, we would not include the health plan member number in the new member enrollment packet. Is this a requirement?	No. This is not a requirement. See #41 of Amendment #4.
207	50.110	180	3 rd bullet	Why is it necessary to have separate hand-outs from the member handbook explaining all of the specified bullets if all of the information required on the handouts are already contained in the member handbook. Requirements for separate forms within this section could be very confusing	DHS believes that separate hand-outs highlight, for new members, specific and important information is helpful and does not believe it will be confusing to a member. No, this requirement will not be changed.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
				to a member since these will probably be multi-page handouts in addition to the member handbook? Could the DHS reconsider this requirement to decrease member confusion?	
208	50.110	180	1 major bullet	What is the intent of the 'PCP selection form'? Is it the DHS' intent that these be completed and mailed back to the health plan? Is a return envelope for the PCP selection form a requirement of the enrollment packet?	The intent of the form is to assist members in selecting a PCP. A return envelope is helpful in obtaining higher response rates.
209	50.110	180		Can the definition of a 'new member' be added to 30.200?	See #9 of Amendment #4.
210	50.110	180	1	This section states that the health plans will auto-assign a member to a PCP if the member does not select a PCP within fifteen (15) days. We typically include a PCP assignment in the ID card. Should we wait to send the ID card until the member selects a PCP?	Yes, you can wait to send the ID card. Section 50.370 requires that the ID card be mailed within 10 days of selecting or being auto-assigned a PCP. The ID card does not need to be sent with the new member enrollment packet.
211	50.120	180		Please add additional clarification to this section that is similar to the QUEST program guidance. (Reference to MQD Financial Responsibility Memo)	Thank you for this suggestion. We will consider it.
212	50.120	181	1	Is this paragraph applicable to a QUEST recipient who is determined eligible for QExA while hospitalized? If so, will the QUEST contract be amended to reflect this?	The reference to member in this paragraph is to a member already in a QExA health plan. Any QUEST member determined to be eligible for QExA during a hospitalization shall be the responsibility of the QUEST health plan according to the terms in the QUEST contract—that is until discharge
213	50.130	181	1	Suggest that the PCP selection guidance mirror the QUEST program guidance for PCP selection (10 days). Can the DHS provide a standard number of days that the health plans should use for 'mail time'?	The standard number of days that the plans should use for "mail time" is five days. See #42 of Amendment #4.
214	50.130	181	1	Which date begins the time frame for PCP assignment? Health plan enrollment date, 834 process date, member eligibility date?	834 process date.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
215	50.130	181	2	Why are QExA recipient allowed 15 days to select a PCP and QUEST recipients allowed only 10 days?	The DHS has determined that this population can benefit from the additional time to select a PCP. QExA members are more likely than QUEST members to require assistance and managed care is new to them.
216	50.130	181	3	This section states that we will assign a PCP based first on historical utilization. Will we receive historical data on our new members so that we will know their historical PCP assignments or claims history?	Yes, the DHS will provide historical data on health plans new members as requested.
217	50.140	181	1	Please add a requirement to the RFP for the DHS to process the 1179 in a timely manner. Please include guideline of what timely processing means in terms of number of days from date of receipt within the DHS.	The DHS will not add this requirement to the RFP, nor will we include guidelines of what timely processing means.
218	50.150	182	1	How does the Newborn Enrollment and payment responsibility work when the newborn is hospitalized during enrollment?	The health plan is responsible for all services for newborns from birth until disenrollment from the health plan. This includes services provided in a hospital.
219	50.150	182	1	Please add a requirement to the RFP for the DHS to process a newborn enrollment back to the health plan in a timely manner.	The DHS will not add this requirement to the RFP.
220	50.160	182	2	Does the existing QExA population meet the citizenship, alien status, photo and identification documentation requirements as required by DRA?	Yes.
221	50.180	182	1	Please clarify and provide examples of what the DHS requires for the plan to be responsible for collecting all spend-down amounts.	The health plan is responsible for collecting all spend-down amounts--the amount of money that the member must spend monthly on medical expenses in order to qualify for Medicaid. See response to question #223 for examples and additional information.
222	50.180	182	1	Will the State provide training for Plans on spend-down processes?	Yes.
223	50.180	182	1	Is there a difference between 'spend-down' and member share of cost? Please provide examples of both.	Yes, these are two separate calculations for two purposes. "Spend-down" is to determine eligibility for a medically needy (MN) individual. The spend-down liability is the difference

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
					<p>between the excess income and the MN standard. Example: MN with \$1,069 income - \$469 = <u>\$600 Spend-down liability</u>. The MN must incur \$600 in medical expense in a month to establish eligibility for that month. Coverage will be for the remaining medical expenses in the month.</p> <p>"Cost share" is the result of the required post-eligibility treatment of income to determine a member's share of cost for long-term care services. <u>After eligibility is established</u>, the cost share is determined by subtracting from gross income a personal needs allowance, spousal allowances, incurred medical expenses. Example: Eligibility: MN with \$1,069 income - \$469 = \$600 Spend-down. Will meet spend-down with NF charges. <u>Post eligibility: \$1,069 income - \$50 PNA = \$1,019 Cost Share</u> (assuming no spouse or incurred expenses).</p>
224	50.220	183	1	Does the member submit the 1144 to MQD or does the Plan or Provider do that?	The provider submits the 1144. See #43 of Amendment #4.
225	50.320	186		What is the expectation for member education classes? Should a health plan conduct member education classes once a month throughout the whole year for the duration of this contract or for the first year of the contract, or during TOC, or until all members have had one class?	The expectation is that these classes be ongoing for the duration of the contract; new members will be enrolling throughout the term of the contract.
226	50.320	186	2	The RFP states the health plan shall conduct an educational class once per month for members. Will this have to be instructor based (face-to-face) or will Webinar sessions be acceptable? Is there a requirement to have this class on every island the plan does business?	Initially, the educational classes should be face-to-face and offered on every island. The DHS will reassess this requirement six months following the Commencement of Services to Members.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
227	50.320	186	1	Can the once per month educational class content be incorporated into the face-to-face meeting or must they be done independently?	We assume this question is asking whether member education class content may be incorporated in the face-to-face assessment meetings and the answer is "no."
228	50.320	186	1 st	The RFP states: " <i>As part of these educational programs, the health plan shall conduct an educational class once per month.</i> " Has the State included in its capitation rate analysis or built in its cost model an educational class on every island each month? Are the costs of these classes accounted for under "health services" (as used in Appendix B, Risk Sharing Program)?	Costs associated with the educational class requirement will be included in the capitation rate development. These costs are considered health services.
229	50.330	187	3	Will the DHS require all written materials, including member handbooks, to be translated in all five (5) required languages prior to the Commencement of Services?	The goal for the DHS is for all documents to be translated in all 5 languages upon Commencement of Services. Other arrangements may be considered by the State on a case-by-case basis.
230	50.340	190	8 th bullet	All services do not require a PA. Should this bullet be modified to indicate 'when prior authorization is required'?	See #44 of Amendment #4.
231	50.360	195	2	Does a 'find-a-provider' tool accessible on a health plan's web site meet the requirements of a monthly update of a provider directory? Data for the find-a-provider tool would be updated daily.	Yes, provided these tools are updated as described in the question.
232	50.370	196	5 th bullet	Does the member id card have to have TPL information if there is another way for a provider to access the information through the health plan's web site?	Yes, the member ID card must include this information.
233	50.370	196	6 th bullet	Does the member id card have to have an EPSDT eligibility indicator if the member's date of birth is provided on the card and a provider has access to the information through the health plan's web site?	Yes, this information must be provided on the ID card.
234	50.380	197, 198	5	Why are QExA plans allowed to return phone messages by COB the following business day, while QUEST plans required to return messages left within 30 minutes of the time the message is left?	The QExA program has the additional requirement for a 24-hour nurse hotline which is designed to address medical situations at all hours.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
235	50.410	199	2 nd bullet	Would the State please consider raising \$5 member gift incentive/promotional fee? This rate (\$5) has been the same amount since 1994 and limits possible incentives that a Plan could consider to improve member participation in health related interventions and compliance.	No. The rate of \$5 is for prohibited marketing activities (see section 50.410 of the RFP). The amount of money a health plan can spend on improving member participation in health related interventions and compliance is not restricted.
236	50.520	202	2 nd	The RFP states: <i>"The health plan shall execute processes to assess, plan, implement, evaluate and, as mandated, report quality management and performance improvement activities as specified in the Medicaid State Health Plan Manual..."</i> Please provide the specific site in the Medicaid State Health Plan Manual that addresses these quality management and performance improvement activities.	MQD's quality management and performance improvement activities are outlined in the RFP Documentation section of the MQD website at www.med-quest.us . At this time, the Medicaid State Health Plan Manual does not have a quality section, but this manual will be expanded in the near future. See #45 and #46 of Amendment #4.
237	50.520	203	2 nd	The RFP states: <i>"The health plan shall develop a process that, at a minimum, meets the requirements specified in the Medicaid State Health Plan Manual instructions."</i> Please provide a copy of the specific Medicaid State Health Plan Manual instructions that are being referenced or the specific site or page in the manual that addresses these requirements.	The process for monitoring services provided in HCBS will be provided to health plans upon Contract Award date. See #45 and #46 of Amendment #4.
238	50.520	203	Last	The RFP states: <i>"The health plan shall submit a written Quality Assessment and Performance Improvement (QAPI) plan, an evaluation of the previous year's QAPI program and Quarterly QAPI report that addresses its strategies for performance improvement and conducting the quality management activities described in this section."</i> Please provide a description of the Quarterly QAPI report and the due dates, as this report, unlike all other reports, is not described in Sections 51.310 and 51.360.	See #47 of Amendment #4.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
239	50.530	205	2 nd sub-bullet	Is an on-site visit required of the Plans's PBM where the delegation arrangement is for pharmacy network contracting and claims processing (which is based on point of sale)?	No.
240	50.540	205	1 st	The RFP states: " <i>The DHS shall notify the health plan, no later than July 1 of the previous year, of the PIP topics for the up-coming year beginning on January 1.</i> " How many new PIPs will the health plan be expected to implement each year? Will DHS provide the health plan with a broad study topic from which each health plan will develop its own specific study question, or will DHS require the health plan to implement a state-mandated study question?	The DHS has not yet determined the actual number of PIPs. For reference, for the annual reporting period of July 1, 2006 through June 30, 2007, the DHS required a minimum of 2 PIPs for the QUEST health plans. Generally, the DHS provides broad study topics.
241	50.540	206	Last	Please clarify the due date for submittal of the proposed PIPs. In Section 51.310 (page 249), it states that the proposed PIP submission is October 1st, but in Section 50.540 (page 206), it states that the proposed PIP submission is due on November 1st.	The due date is October 1. See #48 of Amendment #4.
242	50.550 & 50.555	207 – 210		What are the DHS established performance standards (i.e., Minimum Performance Standard, Goal and Benchmark) for each of the performance measures outlined in section 50.550?	The performance standards will be provided to those health plans that are awarded a contract. Contract Award
243	50.550	207	1 st	The RFP states: " <i>Complete description of these measures can be found in the most recently published results and analysis of performance measures, or from the DHS upon request.</i> " Please provide a copy of the performance measures along with the most recently published results. Also, please provide the minimum standard the State is currently using for each of the performance measures, along with the performance measure results.	The DHS is not currently utilizing these performance measures for the QExA population under the FFS system. The performance standards will be provided to those health plans that are awarded a contract Award.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
244	50.550	209	2 nd Bullet	We request that DHS engage in dialogue with the health plans to define how clinical measures in section 50.550.1 are measured. In particular, how will DHS define "preventable hospital admissions"? For example, some CHF hospitalizations can be averted when the member is monitoring their weight, notes an increase and contacts their PCP for an adjustment in medication but not all hospitalizations for CHF can be avoided.	DHS is using CMS' definition of preventable hospital admissions as a guide. DHS does not anticipate that all members with diagnoses identified as preventable are avoidable, but will utilize data gathered to develop benchmarks for what is a reasonable percentage of admissions versus an unreasonable percentage of admissions.
245	50.550	209	6 th Bullet	Please specifically define a "chronic hospital admission" in Hawaii's delivery system.	A chronic hospital admission would be a hospital admission with a length of stay for longer than 30 days.
246	50.550	210	1 st Bullet	How will DHS determine the minimum performance standard (MPS) for each of the clinical measures in Section 50.550.1? Please consider defining plan specific MPS as the mix of enrollees may differ for the two QExA plans. At program implementation, we would appreciate if the MPS baseline is set based on FFS experience for each plans' enrolled population. Health plans will then be accountable to achieve improvements from the defined FFS baseline.	DHS will utilize FFS and industry standard data, if available. If not, DHS will utilize data gathered for the first contract year as well as industry standard data to establish benchmarks.
247	50.550.1	207	1 st	Please clarify how the State is defining the "performance measures" as it relates to selecting three performance measures from the listing in Section 50.550.1 (page 207). Is the broad category (e.g., comprehensive diabetes care) considered to be one measure, or the sub-bullet under each broad category (e.g., annual HBA1C testing) or the sub-sub bullet, e.g., annual blood pressure monitoring).	The broad category (e.g., comprehensive diabetes care) is considered to be one measure.
248	50.550.1	209	1 st Main Bullet	The RFP states: " <i>Functional Data (implemented in SFY 2012)</i> " Is this a performance measure that the health plan can opt to measure now, or is it a required measure in SFY 2012?	Both. Health plans can opt to measure it now, but it will be a required measure in SFY 2012.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
249	50.580	213	1 st bullet	The RFP states: "Require that the medical record is maintained by the PCP." It is our experience in working with numerous nursing facilities in managing the ALTCS program in Arizona, that medical records are often housed and maintained at the nursing facility and not in the PCP's office. For individuals who are residing in a nursing facility, can the medical record be maintained by the nursing facility?	Yes. See #49 of Amendment #4.
250	50.580	216	1	The process of requesting medical records between providers is well established and occurs routinely between providers without the involvement of health plans. When necessary, a health plan will facilitate this process but please consider removal of this activity as a health plan requirement.	See #50 of Amendment #4.
251	50.860	233	2 nd major bullet	This bullet states that a notice of termination, suspension or reduction of covered services must be sent "for denial of payment at the time of any action affecting the claim." Please explain this bullet in more detail and provide an example.	This bullet does not refer to the termination and suspension bullet. This bullet requires that the health plan mail the notice of action for denial of payment at the time of any action affecting the claim. See #51 of Amendment #4.
252	51.210	241	1	Which functions and/or positions would DHS would not allow a Plan to move out of State?	As described in Section 51.210, the health plan shall have specific functions and personnel in Hawaii. The health plan may request of the DHS, after Contract Award, that functions be located out of the State.
253	51.210	242	Table	Are all member services staff and provider services staff required to be located in Hawaii?	Yes. However, as is outlined in Section 51.210, the health plan may request, after Contract Award, to move functions outside the State of Hawaii.
254	51.210	244	5	Please provide the rationale for the requirement that a service coordinator manager must be an RN. Please explain why you would consider LSW and Masters level professional as not having appropriate experience or incapable of performing this function?	See #54 of Amendment #4.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
255	51.210	244	3	We have a Medical Director who functions as the Quality Officer and provides guidance and oversight for quality activities. Given this, does the coordinator role need to be an RN?	Because the QExA program is focused on quality, we anticipate that the quality management coordinator be either a physician or a registered nurse.
256	51.220	245	3	This Provider Network section references responsibility of "UM line." Should this requirement be placed under the last paragraph on the previous page?	Yes. See #55 and #56 of Amendment #4.
257	51.220	245	3	The last sentence references 'member services function.' Should it be changed to 'provider services function'?	Yes, see #56 of Amendment #4.
258	51.310	249	Table	When is the due date for performance measures (the row below "proposed performance measure description" and referenced as RFP Section 51.360.7) and who is the recipient?	See #57 of Amendment #4.
259	51.320.2	251	Bullets	Should the 2nd through 5th bullets be included in requirement 51.320.3? GEO Access reports usually present a picture of where a health plan's providers (PCPs) are located on top of where the plan's members are located.	No.
260	51.350.1	258	Last Bullet	Please provide examples of 'type of call'.	Examples of different types of calls include: benefits questions, provider network questions and grievance and appeals issues.
261	51.360.9	261	1	Please clarify HEDIS reporting period. Will the reporting period be based on calendar year to correspond with the QUEST Program HEDIS reporting period?	Yes, the reporting period will be based on calendar year.
262	51.370.2	262	1; 1 st two bullets	Would you provide an example of the criteria use to evaluate the appropriate, safe and effective pharmaceutical use, and the outcomes/results of these evaluations?	Example: Gastrointestinal Drug Use Evaluation The purpose of this intervention is to promote safe, cost-effective use of anti-secretory and promotility agents in the management of gastrointestinal disorders, including peptic ulcer disease (PUD) and gastroesophageal reflux disease (GERD).

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
					<p><i>Drug-Drug Interactions</i> Overall, a reduction in the clinical indicators of 44.2% was achieved during the post-intervention period.</p> <p><i>Long Duration of Therapy</i> Overall, a reduction of 53.6% was achieved during the post-intervention period.</p> <p><i>Duplicate Therapy</i> Overall, a reduction in duplicate therapy clinical indicators of 66.7% was achieved during the post-intervention period.</p> <p><i>Increased Risk of ADE</i> Overall, a reduction in the increased risk of ADE clinical indicator of 65.0% was achieved during the post-intervention period.</p> <p>Per patient per month (PPPM) drug amount paid for intervention-related drugs was calculated for the target group for the six-month baseline and six-month post-intervention periods. The post-period PPPM amount paid for the target group was subtracted from the baseline PPPM amount paid to obtain the estimated PPPM savings. The PPPM savings was then multiplied by the number of intervention months and number of target patients.</p> <p>The amount paid for total drugs decreased \$15.66 in the post-intervention period. This yielded an overall estimated savings of \$94,710 in intervention-related drug expenditures during the six-month post-intervention period.</p>

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
263	51.395	268	3	Will the state accept encounter data in the standard 837 format?	No, the State utilizes a proprietary format which will be provided to the health plans after Contract Award.
264	60.110	278	Last paragraph	Please clarify this paragraph. How will this process occur?	DHS will communicate spend-down amounts for their members to health plans monthly. The capitation payment will be less the spend-down amount.
265	60.120	279	2	The state has three incentive programs (Diabetes mgt, movement of 5%+ to HCBS, and increase of Personal Assistance); which combined may equal an additional 5% premium. How will success in any/all of these three programs impact the 5% premium? (i.e. does success in 2 of 3 = some percent greater than 1 but less than 5%)	The DHS is finalizing its incentive programs and final information will be provided at a later date. It is known, however, that, success in some but not all will translate into an incentive payment of less than 5% but greater than 1%.
266	60.120.3	281	Sub-Bullets	Do the 5% increases represent a 5% incremental increase from the previous year's percentage? Is the formula $50\% * 1.05 = 52.5\%$ or $50\% + 5\% = 55\%$?	The 5% increase represents a 5% increase over the previous year's actual number of members served.
267	60.130	283	1	Are any subrogation benefits recovered by the State returned to the health plan?	No, all subrogation benefits recovered by the State are retained by the State.
268	60.140	283		If the case doesn't reach the catastrophic threshold for the re-insurance by the end of the benefit year, does the dollar amount reset to zero and then re-calculate cost for the next benefit year?	Yes the catastrophic thresholds are based on dates of services within the benefit year. All amounts are reset to zero at the beginning of each benefit year.
269	60.150/ Appendix B	283	5	As described the Risk Share Program exposes more downside risk to carriers than upside profit (up to 5% losses before risk sharing relief, but a 4% cap on profits). Would the State consider a symmetrical risk sharing program?	No.
270	60.220	284	Last	This paragraph appears to limit the plan's reimbursement for its network providers to Medicaid minimum of Medicaid FFS rates – is that correct?	This is the minimum reimbursement; the health plan is not limited in terms of reimbursing providers at higher rates.
271	60.220	284	2	Regarding the requirement that Plans pay Provider at the rates comparable to Medicaid FFS rates in place. Is there any flexibility in this? It may be possible to get discounted	No to both questions.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
				FFS rates in some cases. For example, in exchange for an exclusive contract some Providers might give rates better than Medicaid. This provision does not allow for that type of negotiation which would save the health plan and the tax payers money. Can any exception be made?	
272	60.220	285 – 286	Last paragraph	Please ascertain if the claims processing requirements in this section meets the Hawaii State statutory requirement for payment of clean claims.	To the extent that the question refers to HRS 431:13-108, the DHS believes that this statute is more stringent than section 60.220 of the RFP. Section 60.220 describes standards set by federal regulation, 42 CFR 447.46, which requires that managed care organizations timely process claims to the same extent as the Medicaid agency pays claims under FFS. To the extent that Hawaii statute is more stringent than the federal regulations, a QExA health plan would be required to comply with the stricter requirement.
273	60.220	285	1	Per this section, the FQHC payment report is due quarterly. Per 51.320.5, the report is due annually. Please clarify reporting requirements.	See #61 of Amendment #4.
274	60.220	286	1	What is the current interest rate prescribed by DHS?	The interest rate is updated each quarter and is calculated by prime rate plus 2%. The interest rate for the quarter ending 12/31/07 is 10.25%.
275	60.220	286	2	The health plan shall require that providers use the CMS 1500 and UB-04 forms.' Does this mean all providers including HCBS providers?	Yes.
276	60.240	288	5	The first paragraph of this section indicates that the health plan may collect fees directly from members for non-covered services or services received from unauthorized non-plan providers. Is the plan permitted to deny payment for these services at the time the claim is submitted by the provider, or is the plan required to pay the provider and collect from the member?	The health plan shall use whatever method works for them and the providers.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
277	60.250	289	1	Will the state provide a report of all members who have spend-down requirements to the health plans? If so, when would we receive this report?	Yes. At the end of the month for the next month.
278	60.250	289		How many members are affected by spend-down in FFS? And what dollars need to be tracked in the spend-down (i.e. premiums). What may not be included in the spend-down?	In the Community, 276, In HCBS programs, 338, In Nursing Facilities 1342 Total of 1,956. DHS will provide the spend-down amounts to the health plans monthly. The health plans will be responsible for collection of the spend-down amount and not the determination of its value.
279	60.250	289		Are there any member costs associated with dental that need to be tracked in the spend-down by a Plan?	No.
280	60.250	289		If the benefit year is to start on 11/1/08 and benefits will be prorated - will this impact the Plan's ability to track spend-down amounts? If not, how will Plans track the spend-down if the benefit starts during an off cycle time?	The 11/1/08 start date should not impact the ability to track spend-down amounts; the collection of spend-down amounts is a monthly activity and is not tied to the benefit year.
281	60.270	291		Are the reinsurance recoveries reflected in the cost models based on the same catastrophic criteria in section 60.270?	Yes.
282	60.130	283	3 rd bullet	Relative to the TPL audits DHS will conduct every 6 months, please specify the health plan's requirements, responsibilities, reporting specifications, and accountabilities for TPL coordination and recovery.	The RFP outlines basic health plan responsibilities. Detailed information on TPL reporting to DHS will be provided to health plans after contract award.
283	70.200	295	1	If the initial term of the contract is from 11/1/08 to 6/30/09, should annual benefit limits be prorated to an 8 month period instead of using the full 12 month benefit limits for the initial period?	Yes.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
284	70.200	296	2	How will health plans be notified of legislative/program changes and any resulting capitation adjustments? Will health plans be allowed to appeal capitation adjustments if they feel that they are inequitable?	The health plans will be notified in writing regarding any legislative/program changes that affect the QExA program. Capitated rates are established by contract. Amendments to the contract terms, including rates, may be accomplished by mutual agreement as provided in the contract general conditions, with rates further subject to a determination that they are actuarially sound.
285	70.710	301	1	It is outlined that a health plan can be run under 431HRS, which provides for licensure of Indemnity companies. Does the RFP allow the Medicaid Managed Care program to be run under an Indemnity company?	The DHS cannot advise a health plan as to the legal requirements for operating as a health plan in the state of Hawaii. It is the responsibility of the health plan to comply with applicable legal requirements related to the provision of health plan services in the State of Hawaii, including applicable provisions of HRS chapters 431, 432 and/or 432D, and ensuring that it is appropriately established and structured to provide the specific services identified in the RFP. Licensure of health plans in the State of Hawaii is administered by the State of Hawaii, Department of Commerce and Consumer Affairs, Insurance Division.
286	71.100	304	1	Does this apply to prescription records?	Yes.
287	71.320	309	Table	For 11-14 in the table, the sanctions are identified on a "per occurrence" basis. Does "occurrence" = each individual failure? (e.g. for each claim that is paid beyond the claims processing standards, \$5000 sanction is imposed, for each HFA that is provided outside the timeframe, a \$5000 sanction is imposed?)	Yes, these do reference each determination of failure. However, these are the maximum amounts and will be applied only when there have been repeated failures to comply.
288	72.100	314	3	Does the health plan have any opportunity to terminate the contract outside of the contract expiration or renewal process? There appears to be a clause in the "General Conditions for HHS Contracts" but nothing appears in the base contract.	We are not clear as to what the "base contract" references. The General Conditions are part of the contract that will be entered into between the State and the health plan. Termination of the contract by the provider (the health plan) is governed by section 4.4, which states that the provider "may withdraw from this Contract after obtaining the written consent

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
					of the State. The State, upon the provider's withdrawal, shall determine whether payment is due to the provider, and the amount that is due. If the State consents to a termination under this paragraph, the provider shall cooperate with the State to effect an orderly transition of services to clients."
289	72.400	320	3	A health plan has absolutely no control or involvement over who a FQHC/CHC/RHC contracts with. CHC's are a totally separate business entity and make their own business decisions. In addition, we understand the issues of reimbursement is only one of several major business requirements that the CHCs consider when contracting. This provision was originally included in the more recent QUEST RFP and subsequently, substantially modified when the State realized the a Plan would not be able to bid because of this provision. Would the DHS agree to amend this RFP provision to reflect the language as it exists in the current QUEST RFP?	See #67 of Amendment #4.
290	80.100	324	2 nd	The recitation of the question, in some cases, takes ½ page or more of space. Given the page limits for the proposal, does the repetition of the question count towards the page limit for a response?	Yes.
291	80.230	326	Item A	At the bottom of the Proposal Application Identification Form, #4 is titled "Funding Request". We will complete this section with the following statement: "Funding determined by sealed competitive bid". Is this an appropriate response for this form?	Yes that would be an appropriate response.
292	80.230R(1)	326-327	R	With regard to requirement 80.230 R (1) - Proof of License to Serve as Health Plan in State of Hawaii: If a bidder has an HMO license application pending with the Department of Insurance on the proposal due date, does the Department of Human Services Med-QUEST Division	Please incorporate a copy of the application with the other required documentation; do not cross-reference to a separate binder.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
				prefer that the copy of such application, as filed with the Department of Insurance, be incorporated into the bidder's proposal with the other required documentation? Or may the DOI application be considered acceptably incorporated in the bidder's proposal if the bidder notes the original submission date and status of the DOI application in the proposal and provides a cross-reference to a separate binder that includes the complete copy of the application as filed with the Department of Insurance?	
293	80.310	329	Item B	The RFP states that the applicant shall provide "contacts for all Medicaid program clients (including those served by an affiliated company or a company with the same parent company as the applicant), past and present." We request that DHS limit this requirement to contacts for States where the applicant or affiliated company is operating as a Medicaid managed care organization, past and present. UHG has many products with State Medicaid customers that do not involve the delivery of Medicaid managed care services. We would like to focus our submission on our experience as a Medicaid health plan for LTC, ABD and TANF populations.	See #70 of Amendment #4.
294	80.310	329	Item B	For the Experience and References submission, can we limit our submission to States where we have full-risk, capitated Medicaid managed care programs? Or does DHS also want plans to submit any administrative service arrangements that we have in place with State customers?	Yes, see #70 of Amendment #4.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
295	80.310	329	B	Please clarify whether the term "applicant" in this paragraph is intended to cover only the "prime applicant" (as the term "prime applicant" is used in Section 10.400 applicable to Subcontracting) or is "applicant" also intended to cover subcontractor applicants? In other words, will a listing of a subcontractor's contact for all Medicaid program clients be considered as part of the response to Section 80.310?	The term "applicant" is intended to cover subcontractor applicants provided these subcontractors are providing direct services (that is, do not include contact information for subcontractors who will be conducting credentialing work). See #70 of Amendment #4.
296	80.310	329	C	We suggest that information should be gathered in terms of whether the potential contractor failed to complete a full contract term or self-terminated mid-contract and if so, why?	See #71 of Amendment #4.
297	80.310	329	(D) & (E)	Can the applicant use evaluations and measures, respectively, from affiliates that are owned by the same parent company for these sections?	Yes, see #72 of Amendment #4.
298	80.310	330	A	Section A indicates experience providing services to a large number of Medicaid ABD enrollees (15,000 or more) will be worth more than experience providing services to a smaller number of ABD enrollees or to TANF enrollees. Is this experience per single health plan or corporate-wide? Will experience in providing Medicaid services in Hawaii be worth more than experience in other Medicaid markets?	Corporate-wide. If a health plan has more experience providing services to the ABD population in Hawaii than in other Medicaid markets, this would count as relevant experience.
299	80.310	330	A	Please clarify whether scoring as to experience in providing the stated services will take into account and evaluate the experience of only "prime applicants" (as that term is used in Section 10.400) or will the experience of subcontractor applicants also be considered as part of the scoring?	Experience of subcontractor applicants will be considered in the scoring. See #70 and #71 of Amendment #4.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
300	80.310	330	A	<p>The Hawaii QExA RFP is in its first bid cycle. The DHS has historically been responsible for this program. Given the reality that Hawaii-based plans have not had the opportunity to care for the ABD population in Hawaii, the relevant experience that is stipulated in the RFP (that is primarily based on number ABD lives) appears to predispose awarding of the bid to non-Hawaii based Plans. Additionally, the Medicare Advantage numbers, given the recent implementation of these programs (about 2 years) appear inflated. Would the DHS reconsider the requirements or give equal consideration to plans that do not have the same experience with number of lives but have significant Hawaii-based, local experience? It would seem that equal consideration should be given to a Plan that have established Medicare (especially SNP) and Medicaid-based programs in Hawaii because of our unique cultural and environment considerations that are usually best understood by doing business here. This would be a fair counter balance to the 15,000 requirement.</p>	<p>No, the DHS believes that the needs of the ABD population are unique and require experience of a health plan that has experience serving the ABD population.</p> <p>We do not agree that the 15,000 threshold for Medicare Advantage is high; Hawaii has several Medicare Advantage plans with more than 15, 000 members and the Medicare Advantage program (under a different name) is well developed with its inception as early as 1982.</p>
301	80.315.1	330	Provider Network	<p>A provider network that is able to meet the accessibility and availability standards to ensure the provision of timely, medically necessary care to ABD members (who have complex care needs) is an integral component of this RFP. This would be of particular concern given that that RFP proposes the selection of only two winning plans. Not to require the description and availability of a full and complete Provider Network necessary to treat the 32,000 ABD non-institutional eligible patients that are among Hawaii's most medically fragile citizens seems to be a major omission in the RFP and seems to fall short of the State's goal to secure a fully integrated provider network</p>	<p>No, the State will not reconsider this requirement. The State believes the current requirement is in the best interest of the QExA program.</p>

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
				to care for this population. Would the DHS reconsider the RFP requirements to more fully reflect a bidder's ability to contract with a Provider network that will be able to meet the needs of this population?	
302	80.315.2	331	1	To encourage the involvement of new MCOs into the program, is there any leniency on the requirement to have a completed provider network prior to submission for a COA?	The DHS does not have the authority to make changes to provider network requirements enforced by the Department of Commerce and Consumer Affairs to become a licensed health plan in the State of Hawaii. However, a completed provider network is not required for submission of a proposal under this procurement. The Letter of Intent requirement is minimal and assures DHS of communication between interested health plans and health care providers. Health plans will be subject to a continuing Readiness Reviews after contract execution to ensure that the health plan is developing an appropriate provider network.
303	80.315.3	334	1 st	RFP section 80.315.3 of the Technical Proposal states that <i>"The applicant shall attach its PCP policies and procedures that address all responsibilities required in Section 40.260."</i> However, section 40.260 states that <i>"The health plan shall submit the PCP policies and procedures to the DHS for review and approval by the date identified in Section 51.600, Readiness Review." The date identified in Section 51.600 to provide PCP policies is "30 days after Contract Award".</i> Please clarify whether applicants should submit PCP policies with the proposal's due date or at 30 days after Contract Award?	Both. The applicant is required to submit these policies and procedures with their proposal in order that they may be evaluated. Health plans that are awarded a contract will be required to submit the policies and procedures for review and prior approval 30 days after Contract Award.
304	80.345.2	339	Bullet D	The RFP states: <i>"D. How it will monitor compliance with performance standards outlined in Section 50.555 and what it will do in the event they are not being met."</i> Could the State confirm that the reference to 50.555 is correct? The current reference refers to QAPI measures, not member services measures.	See #77 of Amendment #4.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
305	80.350.3	340	B	We have EQRO validation data for only one state, however we have NCQA auditor reports for reportable data in all states that we operate. Would the state like us to submit these reports as an attachment?	See #79 of Amendment #4.
306	80.350.3b	340	B	The RFP states: " <i>B. Provide HEDIS measures for the last two (2), twelve (12) month periods for all Medicaid programs the applicant (or an affiliated company or a company with the same parent company as the applicant) was serving during that time period. Provide reference to population reporting on to include geographic location and member demographics. The applicant shall indicate which measures were validated by an EQRO and provide the EQRO validation reports. Note: the EQRO validation reports do not count towards the page limit.</i> " For health plans with multiple Medicaid programs, repeating HEDIS measures could take up 8 to 10 pages. Can the State consider not counting the provision of HEDIS measure results as part of the 20 page limit for QAPI section as they did for the EQRO evaluations?	See #79 of Amendment #4.
307	80.365.3	344	1	Section 80.365.3 includes a reference to Section 51.310. However, it appears that 51.210 may be a more logical cross-reference. Would you please confirm the accuracy of the cross-reference in Section 80.365.3?	The reference should be 51.210. See #81 of Amendment #4.
308	80.370.2	345	Last	The RFP states: " <i>The applicant shall describe how it will coordinate health care benefits with other coverages, its methods for obtaining reimbursement from other liable third parties, and how it will fulfill all requirements as detailed in Section 60.260.</i> " When the State refers to 3rd party liability, is it referring to coordination of benefits?	Yes.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
309	80.370.1 60.250	345 289	1 st	The RFP states: <i>"The applicant shall describe how it will ensure that all spend-down amounts are collected as required in Section 60.250."...</i> <i>"The health plan shall collect all spend-down amounts from members who have spend-down requirements. The health plan may delegate spend-down collections to the providers, but shall be ultimately responsible for their collection."</i> How does the State define "spend down" amounts? How will the health plan be notified of spend down amounts to be collected? Can the State provide a detailed description of the process currently employed for collecting spend-down amounts?	<p>The spend-down amount is the amount of money that the member must spend monthly on medical expenses in order to qualify for Medicaid.</p> <p>The members' spend-down amounts will be communicated to the health plans monthly via a report from DHS.</p> <p>Currently, the member's cost share is determined based upon the spend-down amount calculated by the eligibility worker. The cost share is communicated to DHS' providers monthly via a Share of Cost report. The providers collect the cost share from the Medicaid member.</p>
310	80.375	346	1	What is the recommended format for the oral presentations? PowerPoint? Can other documents be distributed?	The applicant may use the format it feels is most appropriate. Other documents can be distributed.
311	90.200	349		Many QExA members are fragile and require complex care. The program is also undergoing changes that will be new to members, their caregivers and providers. Winning health plans will have to work with the DHS to get members into the correct rate classes. Could the risk share program be deferred until the 3rd year of the contract to allow plans the opportunity to work with, educate and stabilize its member population under the new managed care delivery system?	No.
312	90.200	349	2	The RFP states "Age/gender factors by aid category will be provided in advance of the business proposal submission date." At what date can plans expect to receive the age/gender factors?	The age/gender factors are expected to be released during the week of November 12.
313	90.200	350	1	When will the DHS provide additional information regarding the diagnosis and functionality based risk adjustment process?	Details of the risk adjustment methodology will be finalized after the award of the QExA contract, but prior to its implementation. Comprehensive descriptions of the models and data sources will occur with the awarded health plans.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
314	90.200	350	1	What risk adjustment model and process will be used with diagnosis data and functional assessments?	The diagnosis based risk adjustment is expected to use the CDPS model with national coefficients. The functional risk adjustment model will be created by DHS using Hawaii specific assessment data.
315	90.200	350	2	Overview of the Rate Structure pg 350, 3 rd paragraph. Please provide an explanation/rationale for why "Risk adjustment will not be applied to Molokai and Lanai." Additionally, the RFP states: "Risk Adjustment factors will be applied as early as possible at program startup with the exception of being no later than the second month of enrollment. If the risk adjust is delayed beyond the initial month of enrollment, no retroactive adjustments will be made." Can plans share their data/findings when they refresh the risk adjustments in June that may not have been initially considered?	Part 1: Risk adjustment will not occur for Molokai and Lanai because only one health plan will participate on those islands. The risk adjustment is budget neutral for the state, and results only in a transfer of funding between the two health plans on the other islands. Part 2: Reasonable efforts will be made by DHS and their actuaries to incorporate the health plan encounter data into the risk adjustment in June.
316	90.200	350	2	Will interest income be paid to plans when DHS fails to make timely monthly capitation payments to plans?	DHS intends to make every reasonable effort to pay capitation payments on time, but will not pay interest in the event that capitation payments are delayed.
317	90.200	350	2	How should the risk adjustment factors be considered when establishing the base rates in the bid forms as they will impact the actual capitation rates paid to plans? Will the risk factors be provided before the bid forms are due?	Risk adjustment factors are budget neutral for DHS and will depend on actual enrollment by health plan. Risk factors will not be provided prior to the due date of the bid forms.
318	90.200	350	2	If risk adjustment is intended to be budget neutral, and two different contractors have different base rates, then the risk adjustment factors will not be symmetric (unless base rate for risk adjustment calculation is blended). Do you intend to blend rates for risk adjustment impact and then calculate dollar amount?	The dollar impact will be based on the rates of the lower cost health plan by rate cell (island and aid category).
319	90.300	350	3	Does the price bid process apply only to the time period November 2008 through June 2009? How will capitation rates be established beyond June 2009?	The bid price process will establish rates for the November 2008 through June 2009 period. It is the intent of DHS to maintain the relationship between health plans for those rates

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
					in the following rating periods. DHS and their actuaries will establish rates for each state fiscal year beginning with July 1, 2009. They will incorporate historical fee for service data, local and national trend data, health plan experience, updated diagnosis and assessment data, and other sources of information, as necessary. Health plans will be given the opportunity for input during the rate setting process.
320	90.300/ 90.600	351/ 352	#3 on page 351 and all paragraphs in 90.600	Section 90.300 states that documentation must be maintained, but not submitted with the proposal. However, Section 90.600 states that documentation must be included with the actuarial certification that accompanies the rate bid. If these two documentations are different, we need more specificity about what each includes. Would you more clearly define the actuarial information that must be provided with the rates?	The documentation described in Section 90.600 requests a summary of assumptions, but does not require an explanation of the development or sources of those assumptions. The documentation that should be maintained as described in Section 90.300 would be the justification and derivation of these assumptions. In the event that bid rates fall below the actuarially sound rate range as computed by DHS, it may be necessary to produce this additional information.
321	90.400	351	1	Will the State publish the bid range prior to submission of proposal?	No.
322	90.500	352	1	How are plans to evaluate future rates and plan viability if DHS “does not commit to any particular methodology or formula or to any particular benchmark or objective, for rate revisions”?	DHS intends to rely upon an actuarially sound process to develop rates for future periods. See question #319 for a brief discussion of considerations.
323	90.600	352	All	Is the documentation supporting the actuarial certification limited to the values used for assumptions; or can / should bidders also provide justification for the values?	See response to question #320.
324	100.400	356	1	Provider Network seems under valued given the very fragile health status of this population and their many acute and chronic needs.	Thank you for the comment. The point allocation will not be adjusted.
325	100.600	357		Only two applicants winning from Oahu seems to create a situation where the member has fewer choices (i.e., plans, benefits and care model) and less competition. Would the DHS consider expanding the number of Plans on Oahu to 3 or 4?	The State has determined that 2 plans is the best number. We will not consider expanding the number.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
326	100.600	357	1	The RFP indicates that the DHS intends to award the contract to two (2) health plans to serve the entire QExA population. What analysis did the DHS undertake to determine that 2 health plans would be sufficient for the QExA program?	The DHS conducted analysis based on enrollment numbers and worked with its actuaries to determine the number of health plans.
327	100.600	357	1	Comment: Based on its experience in similar markets, SCAN Health Plan is concerned that limiting the QExA program to two (2) health plans may limit members' freedom of choice and their accessibility to services. SCAN Health Plan advises that the DHS conduct further analysis to ensure that two (2) health plans are enough to provide sufficient coverage and freedom of choice for this population.	Thank you for your comment. The State will not be selecting more than two health plans.
328	100.600	357	1	If there are an equal number of points between a second and third candidate, what process will the DHS undertake to decide between these two health plans?	DHS will carry out level of precision in the scoring of business proposals until the tie gets broken.
329	100.600	357	3	This section states the DHS will select 2 health plans per island on Oahu, Hawaii, Maui and Kauai and 1 health plan per island on Molokai and Lanai and that the selection will be based on a health plans combined technical and business proposal scores. Since it's possible overall scores for one plan could differ depending on their business proposal by island, please clarify if it's MQD intent to contract with only 2 plans as expressed during the Orientation on October 18, 2007.	It is the State's intent to contract with only 2 health plans.
330	100.700	358	2	If plans can withdraw their bid from some islands, will the 3rd place plan be awarded the remaining island(s)?	Language about withdrawing from some islands has been amended. Please see #83 of Amendment #4.
331	100.700	358	2	The RFP includes the following statement: "If an awarded applicant requests to withdraw its bid from all or specified islands without incurring penalties, it must be requested in writing to the MQD before the close of business (4:30 p.m.	See response to question #330.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
				H.S.T.) on Contract Award date identified in Section 20.100." This implies that a health plan can selectively choose not to insure members on particular islands after their rates on those islands were used to determine their overall score for award purposes (statewide). Is this true?	
332	Data Book	1	4	Data Book Summary pg 1, 4th paragraph- "some of the HCBS costs were paid outside of the claims system; these services include those listed below." Could the MQD provide Plans with utilization data for services utilized by members in ABD/LTC that fall in these categories? Consumer Directed Personal Assistance; CHORE Services; Case management; Non-medical Transportation; Environmental Modification; Home maintenance; Moving assistance; and Specialized medical equipment.	To the extent the data is available it has been provided in the data book.
333	Data Book	Summary		Could the DHS provide a list of Providers used by the FFS program in these service categories?	MQD's provider network is listed on our website in the RFP documentation section listed on the left navigation bar. The MQD website is: www.med-quest.us The provider network does not list providers by service category.
334	Data Book	Summary		Please provide a listing of the categories of expenses not included in the cost models. For each such category, please provide a brief description and if available the total PMPM expenses by Rate Category for FY 2006.	Expenses associated with cognitive rehabilitation and hands-on level 1 personal care is not included in the cost models because these were not covered services in FFY 2006.
335	Data Book	Summary		Please provide details of contractual differences between historic and future contractual periods.	Cognitive rehabilitation and hands-on level 1 personal care are new contractual requirements. We are not aware of any previously covered services that are no longer covered. Exclusions from the managed care contract are spelled out in the RFP.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
336	Data Book	Summary	Item #11	Will plans be required to settle with hospitals on capital improvement costs and rate reconciliation payments? Will guidance on this be released with the cost details to be provided, and will the cost detail include sufficient history for trend adjustment development?	Part 1: MQD is in the process of making this determination. Part 2: Guidance will be released in the future with regards to this process.
337	Data Book			Have you conducted any evaluation of the efficiency of the delivery system used to administer the services summarized in the Data Book. If so, what were the results?	No such analysis has been performed to date.
338	Data Book/40.700			Of the covered benefits listed in section 40.700 are there any benefits not completely reflected in the Data Book cost models? If so, what are they and to what degree are they not reflected in the Data Book cost models?	The data book includes all costs for clients in the period Oct 2005 – Sept. 2006. Except for payments to hospitals for capital improvement and rate reconciliation, these will be included in the updated data book. Also no IBNR factor has been applied, nor has it been calculated at this time.
339	Data Book/40.700			Do the Data Book cost models contain any services not within the scope of the covered services described in section 40.700? If so, what are they and to what degree are these services no longer covered?	The data books are not intended to include any non-covered services.
340	Data Book/40.700	Summary	Item #7	Are mental health services for children diagnosed with SEBD and adults diagnosed with SMI covered under the proposed Covered Benefits and Services? If so, what are the estimated costs of providing these services?	Professional mental health services for these clients are not intended to be covered services and have been removed from the cost models based on criteria provided by the State. We have not summarized the costs of these services separately.
341	Data Book/20.100	Summary	Item #11	When will additional detail be provided regarding costs for hospital CCA rate reconciliation and capital improvement costs be provided?	Additional data has been provided with the release of this Q&A.
342	Data Book	Summary	Item #12	What is the current membership of the PACE population as of August 2007?	As of August 2007 there were no PACE enrollees.
343	Data Book	Summary	Item #12	How many dollars were removed for services provided to the PACE population? Do you think the ongoing costs for providing benefits to the PACE population will be comparable to the past experience?	The partial fee-for-service costs and PACE capitation payments were removed from the cost models, along with the few PACE clients. It is estimated that the PACE population during FFY 2006 was approximately 75 members.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
344	Data Book/ 20.100	Summary	Item #13	When are the Age/Sex factors described in the Data Book Summary going to be released?	Age/gender factors will be released the week of November 12.
345	Data Book			Please provide supporting information for drug rebates per script by Generic and Brand. Also, please provide the distribution of scripts by Generic and Brand for those scripts contained in the Data Book cost models.	This information is not readily available. However, The de-identified data is available to those health plans that make a request to receive it. To make a request to receive this data, the interested health plan should send an e-mail to gexarfp@medicaid.dhs.state.hi.us . Include in the e-mail the contact person who should receive the information requested.
346	Data Book			What are the effective coinsurance provisions for the Prescription Drugs costs contained in the Data Book cost models?	There are not coinsurance provisions for this population.
347	Data Book			Bidding health plans are asked to submit a "pre-tax" bid rate. Previous QUEST RFPs have only asked for a bid rate. "Pre-tax" bid rate is not defined or discussed in the RFP. To ensure that our bid meets the DHS' criteria, could you please clarify/define this term and explain the reason for this language change from previous DHS RFPs? If there is a "pre-tax rate, are we to assume there is also a "post-tax" rate?	This process is consistent with the prior QUEST RFP. The scoring analysis will be performed with pre-tax rates for all bidders. Should the contract be awarded to a bidder subject to the general excise tax, the pre-tax bid rates will be increased to include the cost of the tax.
348	Data Book			There is approximately a three year gap between the midpoint of the incurred twelve month period in the Data Book and the eight month time period the price bids apply to. Can DHS provide information on the trend factors its actuarial consultant is using to develop rate ranges, or on the methodology being used to estimate such trend factors? Please provide information on known unit price changes in Hawaii's Medicaid program during recent years by provider type, including any price changes that are known to go into effect during calendar year 2008.	Part 1: No. Part 2: A preliminary version of the known unit price changes that have been completed in Hawaii's Medicaid program will be posted on November 30, 2007 with official version being posted by December 31, 2007. This document will be posted on the Med-QUEST website in the RFP documentation section located on the left navigation bar. The website is located at: www.med-quest.us .

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
349	Data Book			Can DHS provide any information on the assumptions and/or factors its actuarial consultant is using in "completing" the Data Book's base costs? Please also provide any and any claims lag data tables upon which those completion factor assumptions were (or will be) derived.	No. Lag triangles will be provided during the week of November 12.
350	Data Book			DHS is currently paying the Community Care Management Agencies for services provided in the RAAC Program under FFS Medicaid today. Are all case management services for which the contractors will be responsible captured in the Data Book tables under the "Case Management" row? For example, are Community Care Management Agency (CCMA) services included in this row? If not, where are these costs located in the Data Book tables? Is the funding for CCMA services shown separately from funding included for care management required for individuals who are not in the RAAC program?	Part 1: All historical case management expenses are included in the data book Case Management row. Part 2: CCMA costs are included in this row. Part 3: N/A Part 4: No.
351	Data Book			Can DHS provide any information on the approximate width of the rate ranges the actuarial consultant has derived (or will derive)? For example, will the top end of the range typically be 20 percentage points above the bottom end of the range? Ten percentage points above? Five percentage points above?	This information will not be made available to bidders.
352	Data Book			When were the rate ranges completed (or if they have not yet been completed, what is the expected completion date)?	Rate ranges will be completed prior to the opening of the business proposals.
353	Data Book			Are individuals with neurotrauma currently eligible for Medicaid services in the FFS program today? Is there a line item that includes current FFS Medicaid costs for individuals with neurotrauma in the data book? If not, can the State indicate the categories that include the FFS costs for this population?	Individuals with neurotrauma are included in the cost models. Their costs are not isolated to a specific line item. These clients have not been specifically identified in the cost models at this time.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
354	Data Book			In what respects do the Data Book tables not fully capture all baseline costs for the enrollee benefits for which contractors will be at risk?	See response to question #335. Also, the data book includes no adjustment for IBNR claims nor have the expenses for hospital cost reconciliations and capital improvements.
355	Data Book	1	2	For the claims data in the data book, are the provider reimbursements based on Medicaid and/or Medicare rates? If so, will the rate ranges assume similar reimbursement levels to providers?	Part 1: Historical costs are based on Medicaid reimbursement. Part 2: Rate range assumptions will not be disclosed during the bid process.
356	Data Book	1	2	Does the claims data in the data book include any services covered or paid by Medicare for the dual eligible population?	No.
357	Data Book	1	4	For HCBS costs in the data book, what kinds of reimbursement methods are in place? Are similar reimbursement arrangements expected to be reflected in the rate ranges?	HCBS in the data book have been paid on a FFS basis. We are unsure at this time and therefore, cannot answer this question.
358	Data Book	1	5	For HCBS, why were costs presumed to be uniform across all members? Is this the assumption to be considered in the rate ranges?	The services that were assumed to be uniform were allocated across members in the same HCBS program, not across all members. These dollars were small and we had no additional data to allocate these otherwise.
359	Data Book	1	6	For non-emergency transportation (NET), if the State has no specific use rates for these services, how are plans expected to properly estimate a rate in their bids? What assumptions will be considered for the rate ranges?	NET services are a very small portion of the total rate. Milliman has provided air travel costs as well as assumptions as to the allocation of the NET dollars.
360	Data Book	3	3	The Data Book summary notes in #11 that there are reconciliation payments made to DSH hospitals. Is the health plan responsible for those payments?	Yes.
361	Data Book	3	5	The Data Book summary notes in #13 that age/sex factors by aid category and rate cell will be a later supplement to the data book When will this be released?	Age/gender factors will be released during the week of November 12.
362	Data Book	3	5	Will our base rate be adjusted for risk using an age/sex factor?	Yes.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
363	Data Book Summary	1	6 (2 nd to last on page 1)	Were HCBS paid outside of the claim system included in the values in the Excel cost models?	Yes.
364	Data Book Summary	1	6 (2 nd to last on page 1)	If HCBS was paid outside of the claim system, how were they allocated (utilization, cost per service, etc.)?	Most claims were at the member level of detail and allocated based on the member. Cases where this level of detail was not available were described in the document that accompanied the data book.
365	Data Book	3	8	Considering the Milliman disclaimer that third parties “are to place no reliance upon this data book”, how are plans to adequately bid the rate categories and DHS to properly set rate ranges?	The caveat indicates that plans are to place no reliance on the data book that creates any legal liability for Milliman. When using the data book, plans must rely on their own experts, supplemental data sources, their experience in other states and other programs. DHS will rely on the data book when setting the rate ranges.
366	Data Book Summary	1	4 th paragraph including bullets	<p>The Data Book Summary states: <i>"Some of the HCBS costs were paid outside of the claims system, these services include:</i></p> <ul style="list-style-type: none"> • <i>Consumer Directed Personal Assistance</i> • <i>CHORE Services</i> • <i>Case Management</i> • <i>Non-Medical Transportation</i> • <i>Environmental Modification</i> • <i>Home Maintenance</i> • <i>Moving Assistance</i> • <i>Specialized Medical Equipment"</i> <p>When referring to purchased case management in your data book, is that service coordinators or actual case managers through contracted case management agencies? Also, are the costs for service coordinators included in administrative or medical costs?</p>	Case management in the data book includes service coordinators and contracted case managers. Costs for service coordinators should be considered medical costs.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
367	Bid Forms			Will the rate evaluation be performed based on the pre-tax capitation rate Line 12 or the total capitation rate Line 14 of the bid form?	Scoring of the bids will be based on the pre-tax capitation rates on Line 12 of the Bid Form 2 exhibits, which are the values transferred to Bid Form 1.
368	Bid Forms			How are Medicare covered medical services to be handled on the bid forms? Is the presumption that the plans have been reimbursed by Medicare?	Medicare covered services should not be included on the bid forms. It is assumed that these costs are paid by Medicare.
369	Bid Forms			How are Medicare Part D drugs to be handled on the bid forms? Should plans consider any SPAP in their bid forms? Is the presumption that the plans have been reimbursed by Medicare?	Medicare Part D drugs are to be excluded from the bid forms, as are any SPAP covered expenses.
370	Bid Forms			Where should Personal Assistance Services be reported on the bid forms?	Personal Assistance Services should be reported as Home and Community Based Services.
371	Bid Forms			Where should the administrative services for self-direction providers be reported on the bid forms?	Should be reported as administrative costs.
372	Bid Forms			Are their limitations on administrative costs – either a percent or pmpm?	While there are no direct limitations on administrative loads in the rate build-up, the competitive bid process and the overall rate restriction imposed by the upper bound of the rate range both indirectly limit administrative costs. Administrative costs are also potentially limited as described in the risk sharing program.
373	Appendix B	B-1	3	Is the 94% MLR referenced in Appendix B the actual target MLR, or is for illustration purposes only?	See amendments #1 dated October 22, 2007 and #84 of Amendment #4. This is the target MLR and is not for illustration purposes.
374	Appendix B	B-1	3 rd	According to Appendix B (Risk Share Program), the health services portion of the capitation revenues is assumed to be 93%. Please detail the cost elements that are included within "health services".	Costs associated with direct services to clients can be included in the health services portion of the costs, such as case management and disease management.
375	Appendix B	B-1	3	Are all services listed in the RFP Section 40 considered "health care services" as defined in this section?	Not all requirements contained in Section 40 qualify as health care services. Services described in Sections 40.700 through 40.950 do qualify as health care services.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
376	Appendix B	B-1	3	Will risk adjustment payments come in time to be included within the Risk share calculations, or will they be excluded?	Risk adjustment will be applied to capitation rates on a prospective basis, so those risk adjusted payments will be included in the risk share calculations.
377	Appendix B Amend-ment #2	B-2	4	States "Total Revenue for Health Care is defined as Total Revenue times 94%". Is this meant to be "93%"?	The definition of Total Revenue for Health Care will be corrected to Total Revenue times 93%. See #84 of Amendment #4.
378	Appendix C			Appendix C contains a breakout of Eligible population by age band as of August 2007. Can we get a breakout of this population by the same age/sex categories as are found in the demographics tabs of the bid forms?	This information will not be provided.
379	Appendix C	C-1	Table	Can the state provide detailed information on what the most common chronic conditions specifically affecting the proposed populations are, and how they are distributed across the three rate cells and two Medicare eligibility groupings (Dual or non-Dual)?	This information will not be provided.
380	Appendix D.3	D-19	1	Can DOH AMHD refer Medicaid clients for the SMI carveout?	Yes, if the recipient does not meet the AMHD SMI criteria.
381	Appendix G	G-1 to G-4	Table referenced	Through out the Request for Proposals the significance and importance of community based coordination of care is articulated. The ability to utilize current service providers familiar with consumers and their communities is an asset to the entire program. However, in Appendix G, "QExA-Service coordinator Responsibilities and Ratios", the actual option to delegate certain functions of service coordination is very limited. While there are well established and readily available Licensed Case Management Agencies throughout the state of Hawaii, the option to delegate tasks to these licensed Medicaid providers is withheld. An allowance to delegate certain functions with proper oversight, supervision and	There are certain functions of the service coordinator that can be delegated to a provider through provider contracting. In addition, health plans can subcontract service coordination or any other area that meets the guidelines outlined in Section 70.500 Subcontractor Agreements. Therefore, DHS is not excluding the option of subcontracting service coordination functions to community care providers.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
				accountability will dramatically affect a plan's ability to fully execute the initial and ongoing care coordination in a timely and cost effective manner. Taking into consideration the ongoing labor shortage of licensed social workers and nurses, the full membership of the Case Management Council, requests reconsideration of this exclusion and asks for language that will allow plans to delegate aspects of service coordination with safeguards ensuring quality and consumer protections. Please explain the rationale behind the exclusion of the option to delegate service coordination functions to community care providers.	
382	AppendixH1		Auth Period	Is the 1147 the process to produce a rate change or change in Aid category?	The 1147 process is the process to determine nursing facility level of care which will trigger a rate change to coincide with change in services.
383	H1			Will the State provide training on the 1147 process for Plans?	Yes.
384	H4			How will the State do 1147 during TOC?	Currently, MQD's providers complete 1147's and submit to the State's designee. This process will remain intact during transition of care until the health plans have either assumed this responsibility themselves or delegated this responsibility to their providers via their provider contracts.
385	Appendix H	H-4	11.B	On the 1147 form, it states: "A Registered Nurse (RN) or physician must perform the assessment. The name, title signature, and phone and fax numbers of the assessor should be entered." In performing a similar function in implementing similar forms for the Arizona ALTCS program, we use trained, non-RN eligibility workers. Can the service coordinator perform the assessment and have an RN sign the assessment? The cost and time to have an RN or physician perform and sign the assessment can	A Registered Nurse and a physician need to sign the 1147 assessment. The health plan can determine the method that they use to complete the assessment.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
				be high. Our experience is that program quality is not jeopardized in any way if the service coordinator has the authority to sign the assessment.	
386	Appendix K 1.2.2	K-1	6	This section requires the plan to hold all necessary licenses as of the date of the contract. For new plans currently in the licensure process, the license may not be in place as of the contract's effective date on February 15, 2008. Can this section be revised?	The RFP provides a timeline for health plan licensure in section 80.230.R. As the RFP is a part of the contract, the timeline as described above, would be considered the actual timeline for health plan licensure. The DHS will consider special conditions in the final contract to amend section 1.2.2 of Appendix K accordingly.
387	Appendix L	L-9	Head- ing	The Disclosure Statement Ownership form requests a period beginning and end date. What time periods should we submit for this form?	Disclosure statement should be for the last completed plan year.
388	Appendix L	L-14 thru L-16		This Disclosure form is not part of the list on page 326 and 327, Section 80.230 of Other Documentation. Do we submit these forms and in what order should they be submitted?	See #66 of Amendment #4.
389	Appendix L	L-24; B1		Do the medical loss ratios need to be consistent between Appendix B where 94% is used and Appendix L, page 24, where the net medical costs as a % of capitation revenue should be no more than 88%?	See #85 of Amendment #4.
390	Appendix L	L-26	Whole Form	For the Background Check information, the State requires that the applicant submits information for "key personnel (i.e., CEO, Medical Director, Financial Officer, Consultants, Accountants and Attorneys)". Is it adequate for applicants to submit information for those staff who will be directly responsible for ongoing operations in Hawaii? Is it necessary for plans to submit background check information for corporate executives with oversight of future Hawaii operations? Is it necessary for plans to submit this information for executives of a parent company that do not have day to day oversight of the Hawaii business?	No. Yes. Yes. It is necessary to submit background information for all key personnel for ongoing operations in Hawaii, with oversight of Hawaii, and in the parent company.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
391	Amendment #1	Page 1	#1	Please consider allowing phone participation for the November 9th orientation with DHS' actuaries.	See Amendment #3 released on November 5, 2007.
392	General			How many of the ABD dual eligibles are enrolled in FFS Medicare, Medicare Advantage, or SNP dual plans? Does the Agency expect that the primary provider of care for these beneficiaries will be the FFS Medicare, Medicare Adv, SNP dual plans with the responders to this bid providing wrap around services only?	In Appendix C, DHS provided the distribution of dual eligible members in the Medicaid program; DHS does not have access to the number of dual eligible members that are in FFS Medicare, Medicare Advantage, or SNP dual plans. The DHS expects and requires that the primary provider of Medicare services is Medicare and that the health plan will provide all services outlined in this RFP that are not Medicare covered services.
393	General			Can the RFP be provided in Word?	No, the RFP is distributed in PDF or hardcopy only.
394	General			In order to expedite the contracting cycle, can the DHS release a provider contract template review tool with all of the required elements for each provider contract type as soon as possible? (This review tool would be similar to what was used in MQD's review of Health Plans' provider contract templates during the QUEST Readiness Review process).	The DHS will release this tool as soon as possible. All of the required contract elements are provided in the RFP in Section 40.500.
395	General			Please provide a breakdown of health care program expenditures including QUEST, Fee-for Service Medicaid, and any others (i.e. carve out programs) that reconcile to the \$1,062,635,792 health care program expense as stated in the DHS audited financial statements for the year ended June 30, 2006?	This data not available at this time.
396	General			Will plans be required to pay Medicare co-payments and if so, have those costs been included in the cost models?	Yes to both, however, in some cases, Medicaid pays less than the full co-payment due to fee schedule differences. We would expect similar results for managed care.
397	General			What is the administrative loss ratio allowed under the RFP?	7% is the administrative cost assumption in the risk sharing program. DHS has not specified an allowable administrative loss ratio for the construction of bid rates.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
398	General			Please provide historic cost trend information by hospital inpatient, hospital outpatient, physician, other, LTC and HCBS.	This data not available at this time.
399	General			Please provide claims lag triangles for the claims included in the ratebook cost models for IBNR development. If available, please provide similar information for the claims excluded from the cost models.	Claims lag triangles will be provided that include most services contained in the cost models. Similar information will not be provided for claims excluded from the cost models.
400	General			The RFP has a very aggressive timeline for both bidders and the DHS. Getting everything in place for an implementation date in Nov 2008 will require significant collaboration between the DHS and the winning plans. Could you please share your plan to ensure that the DHS has available resources to respond timely to bidder's questions, evaluate the bids and then embark on a comprehensive Readiness Review program which includes numerous components that require the winning plans to submit develop and p&ps, contract, etc. and respond to any identified corrective actions. It will be difficult to meet the aggressive timeline without timely support and feedback from the DHS.	The DHS declines to share the specific plan but understands the need for timely support and feedback. The DHS will have the personnel in place to conduct the Readiness Review activities and provide timely support and feedback to the health plans.
401	General			Would you provide information on "per enrollee spending" (acute versus LTC) in as much detail as possible for historic periods to assess trends?	It is unlikely that this historic period data will be available.
402	Cost Model Spread-sheet	All	All	For prescription drug costs / utilization in the cost models during the experience period, what percentage of scripts were generic versus brand?	This data is not readily available.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
403	Cost Model Spread-Sheet	All	All	Understanding that costs have not been reduced for the impact of rebates; what was the overall rebate percentage on prescription drugs?	DHS has indicated that rebates range from 13% to 18%.
404	Cost Model Spread-sheet	All	All	What was the average discount off of AWP for prescription drugs?	DHS has indicated that the average discount off AWP is 10.5%.
405	Cost Model Spread-sheet	All	All	Prescription drug costs in the cost model only include 9 months (Jan-Sep 06) of the 2005-06 service period (Due to inception of Part D). Hospital Drugs appear to use 12 months of experience. Should we assume that Hospital drugs are not in Part D or will the hospital drugs costs be overstated for Oct-Dec 2005?	PMPM costs on a PMPM basis include only 9 months of experience from January – September 2006. This partial year membership will be included in the updated cost models.
406	Cost Model Spread-sheet	Tab 19 as example (average LOS = about 1 month)	LTC Services lines	If someone is in nursing home for six months without interruption, is that counted as six separate admissions (i.e. reset at the end of each month) in the historic data summary or is it counted as a single 180 day admission?	The data book is constructed in a manner consistent with paid claims. Nursing home claims are typically billed on a monthly basis, so an extended stay would generally be recorded as multiple “admissions”.
407	Cost Model Spread-Sheet	All	All	What portion of expenditures have historically been paid in the Medicaid program after 9 months of runout (LTC versus acute)?	Claims lag triangles will be provided during the week of November 12.
408	Cost Model Spread-sheet	All	All	During the experience period, were there any significant changes to the state reimbursement rates for medical or LTC services?	No.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
409	Cost Model Spread-sheet	All	All	Since the experience period, have there been any significant changes to the state reimbursement rates for medical or LTC services?	No for both medical and LTC services. In July 2005, the nursing facilities started to be reimbursed through an acuity-based system which will be fully implemented in July 2008. Yet, this did not change the overall impact of reimbursement rates for LTC services.
410	Cost Model Spread-Sheet	All	All	For certain rate cells, the implied membership is less than the total membership. Should we assume that the experience period is pro-rated to a different starting point with the same endpoint?	For non-pharmacy services, such differences are expected to be caused by the rounding of utilization rates. For pharmacy, the nine-month membership figures will be provided with the updated data book.
411	Cost Model Spread-Sheet	All	All	Case management services are included in the cost models. This would indicate that case management costs are considered "health care services" as defined in Appendix B paragraph 3. Is this correct? Are disease management services also considered health care services?	Case management and disease management costs are included as health care services in the Appendix B risk sharing program.
412	General			What is the current inpatient hospital reimbursement standard for Medicaid in Hawaii?	DHS has used hospital specific rates based on cost reporting and a market basket index computation.
413	General			Would you provide the last two years of utilization trend information by category of service or by benefit?	This additional data is not available at this time.
414	General			What services are currently included in the RFP, but not the Cost Model?	Please see the response to question #354.
415	General			What services are included in the Cost Models, but not the RFP?	None such services are included in the cost models.
416	General			Is there a detailed list of services associated with the cost models?	The de-identified data is available to those health plans that make a request to receive it. To make a request to receive this data, the interested health plan should send an e-mail to gexarfp@medicaid.dhs.state.hi.us . Include in the e-mail the contact person who should receive the information requested.
417	General			Do the rates have to target a 93% MLR?	No.

RFP-MQD-2008-006

Issued 11/15/07

QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Q&A

No.	RFP Section #	RFP Page #	Para #	Question	Responses
418	Orientation	7	Slide	Are there any Medicaid beneficiaries on the island of Niihau that will be served under the QExA initiative? Are there potential eligibles on Niihau who may apply for coverage and services through QExA? If so, how is the contractor expected to provide these services given the restrictions on travel to this island?	There are no Medicaid beneficiaries on this island nor does the State anticipate that there will be any.
419	Orientation	8	Slide	When referring to case managers in the State's orientation power point presentation (<i>"Case Managers are common to all Medicaid Waiver participants – Case Managers are the gate keepers"</i>), was the State referring to service coordinators?	Yes and No. First, four of the five waiver programs will be ended when QExA starts. Second, in all four of the waiver programs that will be coming into QExA, there are case managers who are the "gate keepers" to the program. The Service Coordinator will assume all of the "gate keeper" functions in QExA. Lastly, in the RACCP program (as described in Section 30.300 of the RFP), the Community Care Foster Family Homes have case managers called Community Care Management Agencies (CCMA). These CCMA's perform functions that are separate from the service coordinator functions as described in Section 40.750.3.e of the RFP.
420	General			What happens to a dual eligible nursing home resident whose physician coverage comes from a Medicare advantage plan and that plan is not a MedQuestX provider. Say for example, a Medicaid nursing home resident is a member of HMSA Senior Plan for Medicare coverage and HMSA does not bid or is not awarded the QuestX contract for Medicaid on Maui. And, furthermore, the physician, for some reason chooses not to be part of the QuestX network which has been awarded coverage on Maui. I assume that the resident can continue to stay with the physician. But, what does that mean for the physician and the resident in terms of the management of that care?	The resident can stay with the physician, but the physician will need to coordinate care with the health plan.