

**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**

**Business Proposal Orientation Q&A**

No.	Questions	Responses
421	In what rate cell is a member that is in a nursing facility (NF) for less than one year?	If the member is in a nursing facility when initially enrolled in managed care, then the member is in the nursing facility rate cell. If the member is initially placed in the HCBS or Medical Only rate cell, then is transitioned to nursing facility residence, that client will be placed in the HCBS rate cell for the first 12 months.
422	What is in the rate cell if the member is discharged from the nursing facility?	If the member is discharged from the nursing facility, then that member will be moved to the HCBS or Other rate cell as appropriate.
423	Is the member included in the community rate cell immediately after being discharged from the nursing facility?	The payment for the member will be at the appropriate rate on a monthly basis after being discharged into the community (HCBS or Medical Only); not after one year. Conversely, if the member moves from the community into a nursing facility, the member continues at the community rate for one (1) year before moving into the nursing facility rate.
424	On Bid Form #1 with both duals and non-duals, what should the applicant do with tables 73 to 89?	Tables 73 to 89 give some aggregate data for the applicants and do not directly contribute to the bid form.
425	Will there be changes in the second year of the contract to the rates?	See response to question #319.
426	What is the time frame of data in the bid form #1?	Membership in bid form #1 is based on data from FFY 2006.
427	What will happen to the applicant if the bid rate is higher than the range?	If the composite of all bid rates is higher than the upper bound of the composite rate range, then the applicant will be disqualified. If bid rates for individual rate cells are above the rate-cell-specific rate ranges, then no adjustments will be made to those bid rates during the scoring process. However, those bid rates will be lowered to the midpoint of the rate-cell-specific rate ranges for payment purposes if the applicant is awarded a contract.

**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**

**Business Proposal Orientation Q&A**

No.	Questions	Responses
428	What assumptions is Department of Human Services (DHS) using to define a “well managed health plan”?	DHS will not share specific rating assumptions during the proposal process.
429	Is Milliman aware of the market realities of the QUEST program with health plans having to contract at greater than the Medicaid Fee-For-Service (FFS) rates?	Yes.
430	Will DHS share its trend information?	DHS will not share specific rating assumptions during the proposal process.
431	Is the scoring based on bid form #1 or #2?	Scoring is based on bid form #1.
432	Are the hospital prescription drug costs included in the hospital provider costs?	All prescription drug costs are a separate line item and not included in the hospital costs. Any drugs billed through a hospital revenue code are included in the hospital provider costs line.
433	Are there any Home and Community Based Services (HCBS) that should go anywhere other than the HCBS line item except for case management?	No. Only case management (CM) should be separated out. All other HCBS should be in the HCBS line item.
434	There are categories in the databook with no utilization.	Not all data sources included reliable unit counts to establish utilization rates per 1000 or unit costs in the data book. If the applicant cannot supplement the data book to develop reliable utilization rates and unit costs for specific lines, then leaving these entries blank is acceptable. The applicant may wish to footnote Bid Form #2 in these situations.
435	How many actuarial memorandums does DHS want in the submission?	The actuarial memorandum should summarize the assumptions made in the bid. One memo per applicant that summarizes the information is adequate.
436	Are there any changes that have come out since the databook was published?	Yes. An amendment will be made to the databook showing the changes. See 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**

**Business Proposal Orientation Q&A**

No.	Questions	Responses
437	How will age/gender factors affect the projection?	Age/gender factors will be applied to the final base rates and may have an impact on the applicants bid rates. While the age/gender factors will composite to 1.000 for each rating category, the age/gender factors will not aggregate to 1.000 for each rate cell (island/rate category combination). Bid rates submitted on Bid Form #1 and documented on Bid Form #2 should reflect a 1.000 age/gender factor to avoid double counting the effect of age/gender on payment rates.
438	What is the risk adjustment factor based upon?	The medical component of the risk adjustment factors will be based on diagnosis coding in the claims data. The HCBS risk adjustment will be based on assessment data maintained by DHS.
439	Will a risk adjustment be done for all 72 categories?	No. For example, there is no risk adjustment done for Lanai and Molokai. Similarly, there is no risk adjustment applied to the medical components of Medicare eligible rate cells. HCBS risk adjustment does not apply to Nursing Home or Medical Only rate cells.
440	When will the risk adjustment be applied? What data will we use?	The risk adjustment is targeted to be done for the first payments under the contract; but may be delayed until the second month should data issues arise following the initial enrollment period. If the initial application of risk adjustment is delayed, DHS will not do a retroactive risk adjustment. We will use the FFS claims data and historical assessment data to make the risk adjustments.
441	Can Milliman use encounter data for the July 2009 rates?	Yes, if we have good encounter data from both plans, then that data will contribute to the risk adjustment process. If not, then we will continue to use rely only on the FFS claims data for risk adjustment.
442	Will the risk score affect only the medical portion of the HCBS and NF rates?	The diagnosis based risk score will apply to the medical portion of all non-Medicare rate cells. The functionality based risk score will apply to the long-term care portion of all HCBS rate cells.

**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**

**Business Proposal Orientation Q&A**

No.	Questions	Responses
443	Will the risk adjustment factor be update through the first eight month period of the contract?	Risk adjustment factors are to be initially applied within the first two months of the eight-month contract period. The first update of those risk adjustment factors is scheduled for June 2009, with application to the July 1, 2009 capitation rates.
444	Does the CM line apply to risk adjustment?	No. Risk adjustment is not applied to the CM component of the capitation rate.
445	Is CM part of administrative or medical expenses?	Medical expenses.
446	There are costs to keeping someone in their own home (i.e., pest control or environmental modifications such as a ramp). Are these costs administrative or medical expenses?	Medical expenses.
447	Do both health plans need to be at a loss for the Risk Sharing program to kick in?	The financial results for both plans combined needs to exceed the specified threshold (either a loss or a gain) for the Risk Sharing program to be implemented. If the aggregate loss threshold is exceeded, but only one plan has incurred a loss, then only that plan will participate in the loss share contribution from the state. Similarly, if the aggregate gain threshold is exceeded, but only one plan has achieved a gain, then only that plan will share a portion of that gain with the State.
448	How does the payment of pre/post tax go forward?	The pre-tax rate is used for scoring the bid. The post-tax rate would be paid to the health plan and includes funding to cover the General Excise Tax (GET).

**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**

**Business Proposal Orientation Q&A**

No.	Questions	Responses
449	Are there any PACE clients in QExA?	The PACE program has ceased operations. Approximately 75 PACE clients were excluded from the compilation of the data book because only partial expenses were included in the data source for these members.
450	Are prescription drugs for the SMI population in or out of the data?	The prescription drugs for the SMI population are included in the data book.
451	Is there any CM in rate cell #1?	CM is primarily in rate cell #2 with maybe a little in the NF rate cell.
452	Is it the health plan's responsibility to pay for Medicaid Cost Based reimbursement?	For certain providers, rates need to be cost-based reimbursement at a minimum. In these situations, it is the health plan's responsibility to pay for these reimbursements.
453	How will Milliman allocate rate reconciliation payments in the rate setting?	Milliman is still working to determine the best approach to allocate these costs.
454	Have rate reconciliation dollars been consistent over the years?	No. Additional data will be provided.
455	How will rate reconciliation be conducted after QExA implementation? Will health plans be expected to do this?	The health plans are expected to conduct the reconciliations. Additional guidance will be forthcoming from DHS.
456	Is rate reconciliation done by island or by provider? What does it include?	Rate reconciliation is done by provider. There are defined rules that outline the rate reconciliation process. The process also includes a capital improvement expenditure component.
457	How will Milliman apply the rate reconsideration payments?	Milliman is still working to determine the best approach to allocate these costs.
458	Are LTC costs excluded from the catastrophic claims program?	Yes.
459	Are outpatient services in the direct line item being added to the cost subtotal?	No. These outpatient services are not being added to the pmpm subtotal in the original data book. The revised data book will correct this issue.
460	Are the prescription drug costs in the data book correct?	No. The utilization per 1000 on the hospital Rx line relied on total member months instead of the 9-month member from figure that it should

**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**

**Business Proposal Orientation Q&A**

No.	Questions	Responses
		be using. The prescription drug utilization per 1000, unit cost and PMPM have been adjusted to exclude the period prior to the implementation of Medicare Part D. We will make an amendment to the databook to adjust for these changes and include the 9-month member month count on the cost models.
461	Are spend-down and cost sharing costs in or out of the data?	Both are out of the data. Since neither is paid for under the FFS program, nor will be for with health plan funds, these costs are excluded.
462	Could a well baby be in QExA?	Section 50.150 of the RFP describes a scenario where a well baby could be in QExA.
463	Are there any significant claims outstanding from the data?	Provider reconciliation and capital expenses are not included in the data book. All other historical expenses covered under QExA are included.
464	Is there a list of who can move from rate cell 2 to rate cell 3?	There is no specific list. If an individual fails to meet the Rate Cell 2 conditions for eligibility, they are moved to Rate Cell 3.
465	Is there an increase in cap rate for prior period coverage as is in Arizona?	No. The costs that would affect prior period coverage are included in the data.
466	When Milliman develops the rates, will they take into account that providers may see this as an opportunity to obtain fee schedule increases since fees have been held down over the past few years?	DHS expects to achieve savings through the QExA program and does not expect that significant enhancements to provider reimbursement are feasible in the short term. However, each applicant must assess their own situation regarding provider contracting when constructing their bid.
467	What are the turnover rates (due to death or disenrollment) in each AID category and rate cell?	This data is not available at this time.
468	Please define which services/procedures are included in the Outpatient Cardiovascular line. Also, what services/ procedures are in the Professional Cardiovascular line?	Details will be provided as a separate exhibit in the revised data book.

**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**

**Business Proposal Orientation Q&A**

No.	Questions	Responses
469	<p>Should the following services fall into the Case Management section of the bid forms:</p> <ul style="list-style-type: none"> <li>- Case management</li> <li>- Care management</li> <li>- Personal Assistance Service Costs</li> <li>- Disease Management</li> <li>- Drug Case Management</li> </ul>	<p>Case, Care, Disease and Drug Case Management should all fall into the Case Management section on Bid Form #2. Personal Assistance service costs should fall in the HCBS line.</p>
470	<p>With no information on trend, managed care savings, or assumptions for your rate build up, could you give us some indication of the overall budget dollars the State is expecting from the implementation of this program?</p>	<p>DHS desires for each applicant to bid based on their best estimate of achievable savings in their managed care program. DHS prefers a competitive procurement rather than a budget driven process, so this information will not be shared.</p>
471	<p>Could you describe in more detail the categories of services that was subject to the “fill-in” of cost and utilization due to lack of data?</p>	<p>The detail that is available is provided in the data book as a separate line item.</p>
472	<p>Can the State provide the risk scores (based on prior experience) for all new members entering the plan? Other States provide this and FFS experience for transition of care coordination.</p>	<p>This is a reasonable request that will be discussed further with the contracted health plans.</p>
473	<p>Will the plans have the opportunity to ask questions about the revised databook and other additional data provided next week?</p>	<p>Yes. Questions must be submitted using the process outlined in amendment #4, #2 and #3.</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**

**Business Proposal Orientation Q&A**

No.	Questions	Responses
474	<p>Local providers have told competitors that they expect significant improvements in reimbursement. Have Milliman and DHS taken into account explicitly in the trend assumptions the following factors:</p> <ul style="list-style-type: none"> <li>- Hawaii hospital provider expectations of reimbursement increases above current FFS Medicaid?</li> <li>- Hawaii physician expectations for reimbursement increases above current FFS Medicaid?</li> <li>- If yes, in the aggregate, how much? What percentage?</li> <li>- If you won't reveal a percentage, is your assumed reimbursement level approximately equal to QUEST plans?</li> <li>- FYI. Local hospitals got significantly improved reimbursement from plans in 2006.</li> </ul>	<p>DHS expects to achieve savings through the QExA program and does not expect that significant enhancements to provider reimbursement are feasible in the short term. However, each applicant must assess their own situation regarding provider contracting when constructing their bid.</p>
475	<p>Please provide details of contractual differences between historic and future contractual periods. For each item, please provide a brief description and if available the total pmpm expenses by rate cell for FY 2006.</p>	<p>See response to question #335. No PMPM expenses for FY 2006 are available for these items.</p>
476	<p>Are we correct in assuming that the allowed administrative loss ratio is 7%?</p>	<p>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.</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**

**Business Proposal Orientation Q&A**

No.	Questions	Responses
477	Please provide historical and utilization trend information by hospital inpatient, hospital outpatient, physician, other LTC and HCBS.	This historical data is not available at this time.
478	Please provide claim lag triangles for claims included in databook. Also for claims not included in databook.	Claim lag triangles will be provided during the week of November 12 for most claims included in the data book. No such lag triangles will be constructed for claims not included in the data book.
479	How will you reflect costs associated with recipients currently on waiting lists, for services such as Personal Assistant Services 1? Do you agree that this population might show some pent-up demand for services in this population? Will these members be removed from the denominator when calculating pmpm costs?	DHS expects the plans to manage the amount of Level 1 Personal Assistant Services provided to members. These members will not be removed from the denominator.
480	When will the age/gender factors be released?	These factors will be released during the week of November 12.
481	Please ( <i>illegible wording</i> ) factors of which you are ( <i>illegible wording</i> ) that might affect expected morbidity of members beyond those reflected in cap rates such as eligibility rate changes, people coming of wait lists, etc.	DHS is unclear as to the intent of the question.

**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**

**Business Proposal Orientation Q&A**

No.	Questions	Responses
482	It is my understanding that in calculating the composite rate, you intend to multiply each of the 72 cells by the age-gender factor for that cell. Is this correct?	In the computation of the composite rate for the purpose of scoring the bid, age/gender factors will not be considered. The composite will be a member weighted average based on the membership figures included on Bid Form #1.
483	Which hospitals are reimbursed on cost-based level? (\$8.6 Mil)	All the critical access hospitals are reimbursed on a cost-based reimbursement.
484	Q1 of data set are prior to Part D. What adjustments have been made to the data for this period prior to Part D?	No adjustments have been made to the data reported in the data book. For example, no trend has been applied to account for the difference between the 9-month data collection period for pharmacy and 12-month data collection period for other services.
485	When will additional details be released on the risk adjustment process?	The details regarding the risk adjustment process will not be available until after the procurement is complete.
486	Please release detailed instructions on scoring of each rate cell.	During the scoring process, each bid rate by rate cell is compared to the DHS constructed actuarially sound rate range specific to that rate cell. Any bid rates below the rate range will result in further examination. This may involve discussion with the applicant and a request for additional rate development documentation. Ultimately, DHS will decrease the lower bound of the rate range, increase the applicants bid rate, or both to ensure that the bid rate is within the rate range. Bid rates above the rate range for a specific rate cell will not be adjusted for the purpose of scoring.
487	Will the DHS actuaries use Hawaii FFS data prior to October 2005 to establish their trends?	DHS is unsure whether its actuaries will use data prior to October 2005.
488	How is member share of cost presented/ accounted for in the cost data?	The member share of cost is excluded from the data book.

**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**

**Business Proposal Orientation Q&A**

No.	Questions	Responses
489	Q2 of the data set is during start up of Part D. Were there any adjustments to data due to the CMS start up and beneficiary confusion?	No adjustments have been made to the data contained in the data book for Q2.
490	As described, the risk share program exposes more downside risk to plans 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? Given the uncertainty with the program, would the State consider narrowing the risk corridor for year one and increasing the \$5 million cap on losses?	DHS is not willing to consider changes to the risk sharing program at this time.