

Amendment # 5
 Issued on: November 16, 2007

For Requests for Proposals RFP-MQD-2008-006
 QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

#	RFP Section #	RFP Language	Amendment
1	Table of Contents, 50.180 and 60.250	Items read: Collection of Spend-Down Amounts	Items amended to read: Collection of Spend-Down Cost Sharing Amounts
2	30.200 Definitions/Acronyms		New Definition: Cost Sharing- Spenddown, cost share, or premium obligation of member
3	30.300, Nursing Facility Level of Care (NF LOC) Definitions & Acronyms	Definition reads: The determination that a member requires the services of licensed nurses in an institutional setting to carry out the physician's planned regimen for total care. These services can be provided in the home or in community-based programs as a cost-neutral, least restrictive alternative to institutional care in a hospital or nursing home.	Definition is amended to read: The determination that a member requires the services of licensed nurses (as defined in HAR § 16-89) in an institutional setting to carry out the physician's planned regimen for total care. These services can be provided in the home or in community-based programs as a cost-neutral, least restrictive alternative to institutional care in a hospital or nursing home.
4	40.750.3.q Private Duty Nursing	Section reads: Private duty nursing is a service provided to individuals requiring ongoing nursing care (in contrast to part time, intermittent skilled nursing services under the Medicaid State Plan) listed in the care plan. The service is provided by licensed nurses within the scope of State law.	Section is amended to read: Private duty nursing is a service provided to individuals requiring ongoing nursing care (in contrast to part time, intermittent skilled nursing services under the Medicaid State Plan) listed in the care plan. The service is provided by licensed nurses (as defined in HAR § 16-89) within the scope of State law.

Amendment # 5
 Issued on: November 16, 2007

For Requests for Proposals RFP-MQD-2008-006

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

#	RFP Section #	RFP Language	Amendment
5	40.810, 2 nd sentence in the last paragraph on p. 157 Service Coordination System	Section as amended by Amendment #4 reads: At a minimum, service coordinators working with members who meet a NF LOC must meet all State certification and licensure requirements for a social worker, licensed nurse, or other healthcare professional with a minimum of three (3) years of relevant healthcare (preferably in long-term care) experience.	Section is further amended to read: At a minimum, service coordinators working with members who meet a NF LOC must meet all State certification and licensure requirements for a social worker, licensed nurse (as defined in HAR § 16-89), or other healthcare professional with a minimum of one (1) year of relevant healthcare (preferably in long-term care) experience. Service coordinators for members working with non-NF LOC members must have, at a minimum, a high school diploma or GED equivalent and one (1) year of relevant healthcare (preferably in long-term care) experience.
6	50.180 Collection of Spend-Down Amounts	Section reads: <u>Collection of Spend-Down Amounts</u> The health plan shall be responsible for collecting all spend-down amounts as described in Section 60.250.	Section is amended to read: <u>Collection of Spend-Down Cost Sharing Amounts</u> The health plan shall be responsible for collecting all spend-down cost sharing amounts as described in Section 60.250.
7	60.110, last paragraph p. 278	Paragraph reads: The DHS will provide member spend-down amounts to health plans monthly. The DHS will pay the health plan the capitation payment less the spend-down amount for members who are Medically Needy with spend-down.	Paragraph is amended to read: The DHS will provide member spend-down cost sharing amounts to health plans monthly. The DHS will pay the health plan the capitation payment less the spend-down cost sharing amount for members who are Medically Needy with spenddown.

Amendment # 5
 Issued on: November 16, 2007

For Requests for Proposals RFP-MQD-2008-006
 QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

#	RFP Section #	RFP Language	Amendment
8	60.250 Collection of Spend-Down Amounts	Section reads: <u>Collection of Spend-Down Amounts</u> 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.	Section is amended to read: <u>Collection of Spend-Down Cost Sharing Amounts</u> The health plan shall collect all spend-down cost sharing amounts from members who have spend-down cost sharing requirements. The health plan may delegate spend-down cost sharing collections to the providers, but shall be ultimately responsible for their collection.
9	80.315.2, between 2 nd and 3rd paragraph Provider Network Attachment: Letters of Intent (LOIs)		Section is amended to insert, after the 2 nd paragraph, the following paragraph: If the health plan is submitting an LOI for a group practice, the health plan may complete one (1) form and attach a spreadsheet containing the names of all providers in the group practice. A group practice LOI shall count as only one (1) submitted LOI. That is, a group practice with seven (7) providers will count as one (1) LOI and not seven (7).
10	80.315.2, 3rd paragraph Provider Network Attachment: Letters of Intent (LOIs)	Paragraph reads: If a representative signs an LOI on behalf of a provider, evidence of authority for the representative must be available to the DHS upon request.	Paragraph is amended to read: If a representative signs an LOI on behalf of a provider, evidence of authority for the representative must be available to the DHS upon request. Evidence of authority is proof/verification that the representative has

Amendment # 5
 Issued on: November 16, 2007

For Requests for Proposals RFP-MQD-2008-006
 QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

#	RFP Section #	RFP Language	Amendment
			the authority to sign on behalf of other providers. For example, a business license indicating the names of all providers is considered evidence of authority.
11	80.315.2, table Provider Network Attachment: Letters of Intent (LOIs)	2 nd paragraph for the PCPs reads: 10 on all other islands (there must be PCPs from East Hawaii, West Hawaii, Kauai and Maui County; the 10 cannot all be from 1 island/geographic area of the island) – applicant must have LOIs from 2 PCPs in each of the 4 categories (the other 2 may be from any category)	2 nd paragraph for the PCPs is amended to read: 10 on all other islands (there must be PCPs from at least one (1) PCP from each of the following areas: East Hawaii, West Hawaii, Kauai and Maui County; the 10 cannot all be from 1 island/geographic area of the island). In addition, – the applicant must have LOIs from 2 PCPs in each of the 4 categories listed (the other 2 may be from any category).
12	80.315.2, table Provider Network Attachment: Letters of Intent (LOIs)	2 nd paragraph for the specialists reads: 10 on all other islands (there must be PCPs from East Hawaii, West Hawaii, Kauai and Maui County; the 10 cannot all be from 1 island/geographic area of the island) – applicant must have LOIs from 2 PCPs in each of the 4 categories (the other 2 may be from any category)	2 nd paragraph for the specialists is amended to read: 10 on all other islands (there must be PCPs from at least one (1) specialist from each of the following areas: East Hawaii, West Hawaii, Kauai and Maui County; the 10 cannot all be from 1 island/geographic area of the island). In addition, – the applicant must have LOIs from 2 specialists in each of the 4 categories listed (the other 2 may be from any category).

Amendment # 5
 Issued on: November 16, 2007

For Requests for Proposals RFP-MQD-2008-006
 QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

#	RFP Section #	RFP Language	Amendment
13	80.370.1 Financial Responsibilities Narrative- Collection of Spend-Down Amounts	Section reads: <i>Financial Responsibilities Narrative - Collection of Spend-Down Amounts</i> The applicant shall describe how it will ensure that all spend-down amounts are collected as required in Section 60.250.	Section is amended to read: <i>Financial Responsibilities Narrative - Collection of Spend-Down Cost Sharing Amounts</i> The applicant shall describe how it will ensure that all spend-down cost sharing amounts are collected as required in Section 60.250.
14	Appendix B, Last sentence in the 1 st paragraph of the Conceptual Framework section	Sentence, as amended by Amendment #4, reads: Note that service coordination costs are reported as healthcare services and not as administrative costs for this computation.	Section is amended to read: Note that service coordination costs (defined as expenses associated with the direct management of a member's care, such as case management and disease management) are reported as healthcare services and not as administrative costs for this computation.

Amendment # 5
 Issued on: November 16, 2007

For Requests for Proposals RFP-MQD-2008-006
 QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Clarifications		
1	30.300	<p>While not specifically delineated in the RFP, Transitional Medical Assistance coverage may be provided to a QExA member that has received benefits under the §1931 group (families with income <100% FPL) and lost §1931 eligibility due to increased earnings or collection of child support payments. There is a low occurrence of this happening because a §1931 QExA member cannot receive SSI. After TMA coverage ends, eligibility will be determined for continued medical assistance under the appropriate programs: QUEST-Net, ACE, FFS (with spend-down).</p>
2	60.250	<p>We have received several questions regarding spend-down for medically needy individuals. The following clarifies the process as it is currently administered in the State under FFS. Currently, medically needy must verify that they have sufficient monthly incurred medical expenses to meet spend-down obligations in order to establish Medicaid eligibility. Medically needy members not receiving long-term care services must provide the verification to their eligibility worker (EW). The EW will authorize eligibility for the balance of the month following the date the spend-down obligation was met. Members receiving long-term care services do not have to provide verification to the EW, as the State will assume that the spend-down obligation will be met by the long-term care services. Eligibility for these members is established from the first of the month</p> <p>The determination of cost-sharing requirements for Medicaid member will depend on the need for coverage of long-term care services. Medically needy long-term care members will go through two processes to determine the amount of their cost sharing. Eligibility determination is the first process in which the spenddown obligation must be met. After eligibility is established, the second process will determine level of the member's cost sharing by allowing certain deductions (personal needs allowance, spousal support, etc) from countable income. Cost sharing for medically needy members who do not require long-term care is the amount of the spenddown obligation.</p> <p>The DHS maintains all eligibility requirements in the Hawaii Automated Welfare Information System (HAWI). The amount of the spend-down obligation is determined in HAWI, as well as the date the obligation was met and when eligibility is established. For medically needy long-term care members, the spend-down obligation is considered met by the long-term care services and eligibility established on the first of each month. For medically needy not receiving long-term care services, eligibility is established the day following the day the</p>

Amendment # 5
 Issued on: November 16, 2007

For Requests for Proposals RFP-MQD-2008-006
 QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

Clarifications		
		<p>spend-down requirement is met.</p> <p>It is estimated that approximately 5% of the QExA membership who are medically needy will have a cost sharing requirements. Cost sharing will be either a cost share for members receiving long-term care services, or a spenddown obligation for members who are not receiving long-term care services. The amount of the cost sharing amounts for each member will be provided by the DHS at the end of the month for the next month. The details of how the health plan will fulfill it's responsibility to collect the cost sharing amounts will have to be determined.</p>
3	General	<p>Given the vulnerable nature of many potential QExA members, it is important to clarify who can serve as a representative. Per the requirements of Hawaii Revised Statute (HRS) 327E-5, a representative (referred to as a surrogate in the statute) who assists a member in making health-care decisions must be someone that has a close relationship with the member and who is the most likely person to be currently informed of the member's wishes regarding health-care decisions.</p>
4	General	<p>The DHS would like to clarify the general methodology for risk adjusting the health plan's rates.</p> <p>Budget neutrality from the state perspective means that the same expected cost in terms of paid capitation rates is projected both with and without risk adjustment. This requires that the aggregate dollar increase for one plan is equal to the aggregate dollar decrease for the other. A straightforward application of calculated risk adjustment factors that composite to 1.000 will not result in budget neutrality when applied to rates that differ between the two health plans. Therefore, the risk adjustment must be applied to a common set of rates. Such an application to any set of common rates can achieve budget neutrality. Using the lowest cost plan rates will minimize the amount of funding shift between the two plans, which was deemed to be the fairest approach.</p>

Amendment # 5
Issued on: November 16, 2007

For Requests for Proposals RFP-MQD-2008-006
QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind or Disabled

5	Appendix B	There have been several comments/questions about the Risk Share Program. To be clear, this program will not be based on the performance of an individual health plan but rather on the aggregate performance. 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.
---	------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------