QUEST Expanded Access (QExA)

Request for Information No. RFI-MQD-2008-006 August 8, 2007

Department of Human Services
Med-QUEST Division

QUEST EXPANDED ACCESS (QExA) RFP SUMMARY

Introduction

The State of Hawaii, through its Medicaid agency, the Department of Human Services (DHS), Med-QUEST Division (MQD), is providing this summary of the Request for Proposals (RFP) for QUEST Expanded Access (QExA) Managed Care to Cover Medicaid Individuals Who Are Aged, Blind or Disabled (ABD) to providers, advocates, members, and interested health plans so that they may better understand the design of the RFP that will form the basis of the QExA program, and submit comments on that design.

This RFP Summary provides information on the RFP as it is drafted as of August 1, 2007. The RFP is undergoing continuous review and discussion both internal to DHS and between the State and Center for Medicare & Medicaid Services (CMS) and, as such, there may be program modifications and changes made prior to the official release of the RFP.

This RFP Summary is organized as follows:

I. Program Goals and Objectives

The RFP lays the groundwork for the future of Hawaii's Medicaid's program for health care for the ABD. The QExA goals and objectives, that influence the design of the RFP, are far-reaching and obtaining all of them will take time; while some of these goals will be achieved immediately, others will be realized incrementally. These goals and objectives were developed because of the importance of achieving sustainable quality of care and provide options for the delivery of care for this vulnerable population. The State anticipates and expects that the program will evolve and improve each year.

Specifically, the goals and objectives of QExA are to create a managed care delivery system for the ABD that will:

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

The means of achieving these goals and objectives is through the MedQUEST Division's (MQD's) contractual relationships with managed care plans. All health plans will be required to have a significant presence in Hawaii. Health plans will not be permitted to operate their business solely from the continental United States.

The provisions of the RFP are therefore designed to reflect these goals and objectives, both in the short-run and in the long-term.

For example, one of the primary goals is to improve the coordination of care for Medicaid members. Currently, in the fragmented Fee-For-Service (FFS) program, there is limited coordination of services. Under QExA, the RFP provides that health plans will be responsible for providing and coordinating all services (including primary, acute, behavioral health and long-term care including services currently received through HCBS waivers[1]). In addition, in order to facilitate this coordination of care, all members will have a service coordinator who will develop a care plan for the member and monitor the delivery of care. Finally, all members, except those also in Medicare, will select or be assigned to a primary care provider (PCP).

Another primary goal is to ensure that members are able to receive the care they need in the setting of their choice. For many members, this means receiving care in their own homes and communities. The RFP thus incorporates several components designed to enhance members' choices, particularly as it relates to expanding the network of providers of HCBS:

1. The State will continue to apply cost effective principles for HCBS. That is, health plans will be required to offer the choice of institutional services or HCBS to members who are nursing facility level of care when a health plan's aggregate cost of serving the eligible populations in the community is not expected to

[1]There is a small subset of services that will not be provided by the health plans. Additional detail on these services is provided in Sections III and IV of this RFP Summary.

exceed the health plan's cost of institutional services for those populations, and when community-based services are suitable for an individual member's needs;

2. The State expects health plans to increase HCBS utilization by a minimum of 5% annually. To encourage this, the State may offer financial incentives to health plans that meet this benchmark and may levy financial sanctions against plans that fail to meet this benchmark. In addition, the State has expectations that the health plans will expand the available services and providers of HCBS in Hawaii; and
3. Institutional services will remain an essential component of the QExA program as they will be an option for those members who need and choose these services.

The following sections summarize the specific provisions of the RFP.

II. Summary of RFP Sections 10 & 20

Sections 10 and 20 include standard language included in many RFPs. This language provides contact information on key individuals involved in the procurement (e.g. the Issuing Officer), the RFP timeline, the process for submitting written questions, a brief overview of the rules of the procurement, information on how to submit proposals, and information about the mechanics of the procurement process.

III Summary of RFP Section 30

RFP Section 30 focuses on two key areas:

1. Program background; and
2. DHS responsibilities.

The program background section includes a comprehensive list of definitions and acronyms used in the RFP and a detailed list of populations that are eligible for QExA.

The DHS responsibilities portion provides information about specific activities which are the responsibility of the DHS. As examples, the DHS is responsible for:

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

Enrollment Activities

This section also provides a significant amount of detail regarding activities related to enrollment into a health plan. Initially, during the first wave of ABD individuals transitioning from FFS to managed care, members will have sixty days to choose their health plan. This sixty-day period will occur prior to the date upon which the health plans begin providing services to QExA members. The member will have the support of enrollment counselors to provide information that will help the member make a health plan selection decision. Enrollment counselors will contact members directly, be available at outreach events, and be available for the member to contact directly. Enrollment counselors will discuss with the member his/her health conditions, any other health issues that would guide them in making a decision about a health plan and share information on physicians and providers in the health plans' networks. Enrollment counselors will provide information that will assist the member in making the right choice based upon his/her health care needs. When initial enrollment has ended, all members who have not made a selection will be auto-assigned according to a pre-determined algorithm that considers factors such as long-term care facility residence and PCP presence in the networks.

Members who become eligible for QExA after the initial enrollment period will be given 15 days to select a health plan before they are auto-assigned by the DHS. As with members enrolling during the initial enrollment period, enrollment counselors will be available to provide assistance.

All members (those who enroll during the initial enrollment period, those who become eligible after the initial enrollment period, those who select a health plan, and those who are auto-assigned) will be allowed to change health plans without cause for a 90-day period that starts with the first day of their enrollment in the health plan. After that, members will be able to change health plans for cause and during the annual plan change period.

The DHS will implement enrollment caps on any health plan that reaches a specified percent of membership. A capped plan will not receive any additional members, whether by selection or auto-assignment. The RFP does allow for exceptions to this policy when, for example, a QExA eligible newborn is born to a mother in a capped plan.

Additional DHS Responsibilities

Section 30 also provides information about benefits and services that will be provided by the DHS or other designated entity. Examples include:

- For the Mental Retardation/Developmental Disabilities (MR/DD) population, case management, HCBS, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR) benefits to include 1915(c) waiver services for MR/DD members;
- For individuals under age 21: dental services;
- School health services;
- Department of Health (DOH) programs such as the Vaccines for Children Program; and
- For adults with SMI and children who are SED: behavioral health services.

Finally, this section provides a synopsis of the DHS's monitoring activities. The DHS will regularly asses the quality and appropriateness of care provided by the health plans, review reports, review the health plans' quality assessment and performance improvement (QAPI) program, work with the external quality review organization (EQRO) to monitor health plan activities and conduct a comprehensive readiness review of all health plans prior to enrolling members. This readiness review will encompass both on-site and desk review activities and will cover areas such as member services, network adequacy and information systems capabilities.

IV. Summary of RFP Section 40

RFP Section 40 covers three primary areas:

1. Provider network requirements;
2. Requirements for provider agreements, provider manuals and provider services; and
3. Covered benefits and services to be provided by the health plan.

Provider Network

The health plans will be required to develop a provider network for QExA. This provider network will include providers for all services (as described later in Section 40) in the program. The RFP has specific requirements about:

- The types of providers that must be included in the network (e.g. physician specialists, pharmacies, emergency and non-emergency transportation providers, behavioral health providers, HCBS providers, nursing facilities, hospitals and adult day care facilities);
- The number of acute care hospitals;
- The number of PCPs per member that the health plan must have;
- Acceptable wait times for appointments which are as follows

- Immediate care (24 hours a day, seven days a week) and without prior authorization for emergency medical situations;
- Appointments within 24 hours for urgent care and for PCP pediatric sick visits;
- Appointments within 72 hours for PCP adult sick visits;
- Appointments within 21 days for PCPs (routine visits for adults and children); and
- Appointments within six weeks for visits with a specialist or for non-emergency hospital stays; and

- Geographic access of providers (see table below).

	Urban*	**Rural**
PCPs	30 minute driving time	60 minute driving time
Specialists	30 minute driving time	60 minute driving time
Hospitals	30 minute driving time	60 minute driving time
Emergency Services Facility	30 minute driving time	60 minute driving time
Mental Health Providers	30 minute driving time	60 minute driving time
Pharmacies	15 minute driving time	60 minute driving time
24-Hour Pharmacy	60 minute driving time	N/A

Health plans will submit initially and thereafter, annually, a Network Development and Management Plan that will describe the health plan's ability to develop provider networks that are diverse, flexible and able to meet a variety of member issues both in the immediate as well as on a long range basis. The Network Development and Management Plan will assist the State in understanding the components of the health plans' networks.

The RFP requires that the health plan ensure that all members have a primary care provider (PCP) who will be responsible for supervising, coordinating and providing all

primary care and for initiating referrals, and maintaining continuity of care. PCPs are most often general practitioners (e.g., family practitioners, internists, pediatricians) but the RFP also requires that the health plan allow specialists to serve as PCPs provided specific requirements are met. Members must be allowed to change PCPs at any time. Members will have 15 days to make a PCP selection. If no selection is made during that 15-day period, the health plan will auto-assign a member to a PCP.

Provider Agreements, Provider Manual and Provider Services

The RFP requires that health plans set up contractual relationships with providers, and describes the specific requirements and clauses that must be included in the provider agreements. The health plan will be prohibited from seeking and obtaining signed provider agreements until a template has been reviewed and approved by the DHS. The RFP requires that health plans utilize current National Committee for Quality Assurance (NCQA) standards and guidelines for the credentialing and recredentialing of providers.

In addition, the DHS will require that all providers are given a provider manual which outlines the responsibilities of both the health plan and provider in the QExA program. As with the provider agreements, the provider manual cannot be made available to providers until the DHS has reviewed and approved it. This provider manual must be updated regularly and made available on the provider portal section of the health plans' web-sites.

The RFP requires that health plans provide education to its providers. During the beginning of the contract, health plans will provide initial education for providers. Thereafter, health plans will provide ongoing education throughout the year (at a minimum semi-annually). Health plans must provide one-on-one education to providers who are having difficulty meeting contract requirements.

As part of its provider services, the RFP requires that the health plans:

- Have a provider complaint, grievance and appeals process that provides for the timely and effective resolution of any disputes between the health plan and provider(s);
- Have a provider portal on its web-site; and
- Have a provider call center that is operational during business hours and staffed by competent, trained individuals able to answer provider questions about all aspects of the QExA program.

Covered Benefits and Services

The RFP requires that the health plan provide all medically necessary primary, acute, and long-term care services to all eligible members. This includes all current services offered in the Medicaid State Plan and in the 1915(c) waivers (except for benefits for the MR/DD population, case management, HCBS, and ICF/MR benefits to include 1915(c) waiver services for MR/DD members). The RFP provides a complete list of all QExA services. The following is not an inclusive list but rather provides a general overview of the types of services offered:

Primary and Acute Care Services

- Acute inpatient hospital services
- Behavioral health services (except for those services provided to individuals determined to be SPMI or SED)
- Durable medical equipment and medical supplies
- Emergency services
- Home health services
- Hospice services
- Physician services
- Prescribed drugs
- Transportation (emergency and non-emergency)

Long-Term Care Services (HCBS)

- Adult Day Care
- Adult Day Health
- Community Care Management Agencies
- Personal Care Assistance
- Residential living (Assisted Living Facility, Continuing Care Foster Family Home, Expanded Adult Residential Care Home)
- Respite Care
- Specialized Medical Equipment and Supplies

Long-Term Care Services (Institutional)

- Nursing Facility services

The QExA program RFP requires that health plans provide members, assessed to need personal assistance and respite services, with the opportunity to self-direct these services. Members choosing to self-direct their services will have decision-making authority over providers of allowable services. The RFP requires that service coordinators (described in greater detail below) provide assistance to members in facilitating self-direction opportunities.

Service Coordination System

Service coordination is the heart of the QExA program. As such, the RFP outlines specific requirements for the service coordination system and requires that the health plan submit details describing this system to the DHS for review and approval during the readiness review period (as described in Sections III and V). The RFP requires that health plans use patient-centered, holistic, service delivery approaches to coordinating member benefits across all providers and settings.

As part of this service coordination system, the health plan is required to have service coordinators who are health plan employees/contractors and are responsible for:

- Conducting a Health and Functional Assessment (HFA) for each member at least once per year and in person (unless the member requests a telephonic assessment). The RFP specifies the amount of time the health plans have to provide the initial assessment to newly enrolled members;
- Developing a plan of care through collaboration with the member and his/her family, which describes the health care services the member needs and chooses. For members who are nursing facility level of care, the service coordinator will create a team of decision-makers to develop the plan of care. This team will include the PCP (who may be a specialist), the eligible member, family members (when appropriate) and other providers relevant to the member's needs. This plan of care shall be based upon the needs and choices of the member but shall, at a minimum:
    - Include goals and objectives for the member;
    - Offer needed services and service parameters;
    - Use a member centered approach; and
    - Develop back-up plans in the event providers are unavailable.
- Arranging for health care services based upon the assessment, plan of care, and collaboration from the members' PCP;
- Referring any member appearing to need a nursing facility level of care to the State for a functional eligibility review (DHS' 1147 process);
- Providing options counseling regarding institutional placement and HCBS alternatives for members at nursing facility level of care;
- Assisting members in the transition to and from nursing facilities/residential facilities;
- Coordinating services with other providers such as Medicare fee-for-service and MCO providers, mental health providers at DOH, and DD/MR providers;
- Facilitating access to services; and
- Seeking to resolve any concerns about care delivery or providers.

All members will be assigned a service coordinator. Members can change their service coordinator at any time.

The RFP specifies the ratio of members to service coordinators. It also requires that service coordinators receive on-going training about their roles and responsibilities at least annually and that the health plans submit all training materials to the DHS for review and prior approval

Additional Services

In addition, the RFP outlines requirements for out-of-state and off-island coverage and requires that health plans have:

- A DHS approved cultural competency plan;
- A DHS approved Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program for all members younger than 21 years of age; and
- DHS approved disease management programs for diabetes mellitus, obesity management, behavioral health and renal disease (that has not yet reached end-stage) and for at least two (2) other programs to be selected from the following: hypertension, drug abuse, or cardiovascular disease.

Finally, the RFP outlines specific requirements health plans must follow as it relates to transition of care of members to and from the health plan. For example, there are requirements for the exchange of information and honoring of prior approved services for members in hospitals or other institutions, for those who are in an on-going course of treatment, and for special populations such as pregnant women and medically fragile children who have a tracheotomy or are ventilator dependent.

V. Summary of RFP Section 50

Section 50 of the RFP outlines the administrative requirements of the health plans. The areas discussed include requirements related to:

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

Additional detail about many of these sections is provided below.

Enrollment

The RFP requires that the health plans send, within 10 days of receipt of their contact information from the State, the following information to all new members:

- Confirmation of enrollment;
- A health plan member number;
- A flyer (or other handout), separate from the member handbook, which describes PCP information;
- A choice form for the member to use to choose their primary care physician;
- A member handbook (information about what must be included in the member handbook is provided below);
- A class schedule for member education classes; and

- An additional flyer (or other handout) which describes where the member can find the following in their member handbook: member rights, member responsibilities, and information about advanced directives.

The RFP includes very specific information about what must be included in the member handbooks. Some of these required elements are:

- Rights and responsibilities of the member;
- The role of the PCP;
- The role of service Coordinators;
- Information that interpreter services and alternative formats are available, free of charge and how to access this information;
- Information on how to access HCBS providers and nursing facilities;
- List of covered services with a basic definition;
- Procedures for disenrollment; and
- Procedures for reporting fraud and abuse, including whistleblower information.

The member handbook must stress to the member two crucial persons/numbers: their PCP and their service coordinator.

The health plans are required to provide assistance to members in selecting their PCPs.

Member Services

Health plans will also be responsible for providing the following:

- An easy to understand member identification card;
- Member education provided in specified areas;
- A toll-free hotline that is accessible 24 hours a day, 7 days a week, and is staffed with a registered nurse who can answer medical questions;
- A toll-free member service call center available during identified business hours. The RFP outlines specific requirements for maximum call waiting times and hold times which the health plan must meet. Staff answering these calls must be

trained and qualified to answer questions about all aspects of the QExA program and the health plan. During non-business hours, members must be able to leave messages for member services call center staff; calls must be returned the next business day;

- An internet presence with an easy-to-use web site that contains accurate, updated information;
- An up-to-date provider directory available through the web site as well as via calls through the health plans customer service line; and
- Oral translation services (and some written,, see below) for languages other than English and for the hearing impaired. These services shall be provided at no cost to the member.

Written materials

In accordance with federal law, the RFP includes very specific requirements about written materials generated by the health plans. The RFP requires that all written health plan materials be translated into, at a minimum, English, Ilocano, Tagalog, Chinese-Mandarin, and Korean. All health plan materials written in English must have a language block in the languages listed above that states that health plan materials are available in alternate languages.

The RFP requires that health plan materials are available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. Finally, the health plans must produce all written documents in language that is written at the sixth grade level (6.9 or lower). The RFP requires that the health plans submit all written materials to be distributed to members to the DHS for review and approval. In addition, the reading level and methodology used to measure it must be included with the submission to DHS for prior review and approval.

Quality Improvement Programs

The RFP requires that all health plans provide for the delivery of quality care that is accessible and efficient, provided in the appropriate setting, according to professionally accepted standards, and in a coordinated and continuous rather than episodic manner. The health plan shall provide quality care that includes, but is not limited to:

- Providing adequate capacity and service to ensure members' timely access to appropriate needs, services/care;
- Ensuring coordination and continuity of care;
- Ensuring members are receiving the services they need to maintain their highest functional level;
- Ensuring that members' rights are upheld and services are provided in a manner that is sensitive to the cultural needs of members;
- Encouraging members to participate in decisions regarding their care and educating them on the importance of doing so;
- Placing emphasis on health promotion and prevention as well as early diagnosis, treatment and health maintenance;
- Ensuring appropriate utilization of medically necessary services; and
- Ensuring a continuous quality improvement approach.

In order to achieve these goals, the RFP requires that the health plans, at a minimum:

- Have a DHS approved quality assessment and performance improvement (QAPI) program;
- Establish performance standards that are monitored on an on-going basis. The health plans must show demonstrable and sustained improvements;
- Conduct performance improvement projects (PIPs); and
- Adopt practice guidelines that are based on valid and reliable clinical evidence and disseminated to all affected providers.

In addition, the RFP requires that the health plans comply with specifically identified QExA quality performance measures.

Utilization Management Program (UMP)

The RFP requires that health plans have in place a UMP that is linked with and supports the quality monitoring program. The UMP shall be developed to assist the health plan in objectively and systematically monitoring and evaluating the necessity, appropriateness, efficiency, timeliness and cost-effectiveness of care and services provided to members. The UMP shall be used by the health plan as a tool to determine and continuously improve the quality of clinical care and services and to maximize appropriate use of resources. The RFP specifically prohibits the health plans from requiring prior authorization of emergency services, post-stabilization services, and urgent care services.

Member Grievance System

In accordance with federal regulations, the RFP requires that the health plans have a well-developed and articulated member grievance system that includes a grievance process and an appeals process. The health plans are required to give members, or their representative (an individual who will act on behalf of a member), reasonable assistance in completing forms and taking procedural steps related to the member grievance system. The RFP outlines very specific time-frames with which the health plan must comply in making decisions about the disposition of grievances and appeals.

In addition, grievances and appeals which are not resolved through the health plan can be referred to the State's grievance and appeals systems. Health plans will be required to provide information to their members on how to file grievances and appeals with the State.

Health Plan Personnel

The RFP provides a detailed list of specific personnel that the health plans must have on staff. In addition, the RFP requires that many of these individuals be physically located in the State of Hawaii. As examples, and this list is by no means exhaustive, the health plans are required to have in State:

- A medical director licensed to practice in the State;
- A service coordination manager and service coordination staff;
- A member services director;
- A grievance coordinator; and
- A pharmacist.

Reporting Requirements

In order for the State to monitor the health plans and to determine the extent to which they are in compliance with all RFP requirements, the RFP includes a substantial number of reports that the health plans must provide on a regular basis. Some of these reports must be provided monthly while others require annual submission. A few examples of the required reports are below:

- Provider network adequacy and capacity reports that will enable the State to monitor the health plans' networks and identify any areas where there are provider shortages;
- QAPI reports and other quality related reports to enable the State to monitor the health plans' quality improvement activities;
- Call center reports to enable the State to monitor the number of calls placed and responded to by the member call centers; and
- Member grievance system reports to enable the State to monitor and do trend analysis on the number of grievances and appeals that the health plans have processed.

Readiness Review

The period following contract award and signing and prior to the date upon which the health plans begin providing services is referred to as the readiness review period. The RFP outlines specific activities which the health plans must perform. These activities include:

- Submission of documents requiring review and prior approval on the date identified. Documents include but are not limited to:
    - The member handbook;
    - Other member materials;
    - The provider manual;
    - Templates of provider agreements; and
    - Policies and procedures for health plan activities.
- Preparations for the on-site readiness reviews conducted by the DHS;
- Submission of bi-weekly updates to implementation plans that track all readiness and implementation activities; and
- Submission of bi-weekly updates to the health plans' network.

VI. Summary of RFP Section 60

Section 60 of the RFP addresses the financial requirements of both the DHS and the health plans.

The DHS is responsible for:

- Making monthly capitation payments to the health plans based on the amounts submitted by the health plan as part of the procurement;
- Managing the health plan incentive programs in the following areas:
    - Treatment of diabetes mellitus;
    - Increases in the number of members receiving HCBS; and

    - Additional programs to be determined by the State.
- Managing (through its designee) the catastrophic care program; and
- Implementing and managing the risk share program.

The RFP requires the health plans to:

- Reimburse providers and subcontractors as follows:
    - By utilizing the Medicaid FFS schedule as a floor for negotiating rates with providers for the first year the health plan provides services to members; and
    - On a timely basis, meaning that, at a minimum, 90% of clean claims are paid within 30 days of receipt and that 99% of clean claims are paid within 90 days of receipt;
- Utilize current billing forms (UB-04 for institutional and CMS 1500 for ancillary providers);
- Have electronic billing available;
- Collect spend-down amounts from members who have spend-down requirements; and
- Comply with specific third-party liability requirements.

VII. Summary of RFP Section 70

Section 70 of the RFP encompasses the standard terms and conditions for DHS procurements. This section touches on compliance with federal and State law, contract term, requirements for subcontractor agreements, disputes, audit requirements, liquidated damages, sanctions and financial penalties that may be imposed upon the health plans, contract termination requirements, and conflict of interest requirements.

VIII. Summary of RFP Section 80

Section 80 of the RFP outlines the process and requirements for the technical proposal. This is the section that contains the questions to which the health plans must respond in the proposals. There will be questions on most of the sections in the RFP, including but not limited to, provider network development, covered benefits and service delivery, service coordination, member services and quality. The State expects that the health plans will provide information on *how* they will fulfill the responsibilities and requirements outlined elsewhere in the RFP.

IX. Summary of RFP Section 90

Section 90 of the RFP provides information about the requirements and expectations related to the submission of the business proposal (cost) of the RFP. This section will be accompanied by a detailed data book containing utilization data that the health plans can use in developing their business proposals.

X. Summary of RFP Section 100

Section 100 of the RFP provides additional information about how the evaluation and selection process will work. There is a description of those items which are considered mandatory (e.g. proposal was submitted on time). Proposals that do not pass the mandatory evaluation will not be evaluated any further. This section also provides information about how the technical proposals will be evaluated, including a break-down of points allocated to each section of the technical proposal.

Finally, this section contains information about the number of health plans that will be selected and the process for awarding contracts.

XI. Comment Submission

Comment on this QExA RFP Summary must include name, organization (if applicable), and contact information of the person/organization submitting the comments.

Comments are due by August 20, 2007 at 4:30 p.m. Hawaii Standard Time (HST). Please indicate on the cover "QUEST Expanded Access (QExA) RFI Response-RFI-MQD-2008-006" and mail or deliver one hard copy of comments with an electronic version stored in Microsoft Word 2003 or lower and, if applicable, one (1) attachment of existing documents saved in adobe.pdf format on CD-Rom to:

Ms. Patricia M. Bazin
Long-Term Care Assistance Program Officer
Department of Human Services
Med-QUEST Division
601 Kamokila Boulevard, Room 518
Kapolei, HI 96707-2005

OR

E-mail comments to Ms. Bazin at rfiresponse@medicaid.dhs.state.hi.us. E-mailed comments do not need a hard copy mailed/delivered.

Electronic responses are required for submission in RFI process. Only Medicaid members may provide hard copy comments without electronic submission.

Response Format

Utilize the following format for submission:

- Comments must be typed in Microsoft Word 2003 or lower. Only Medicaid members may provide handwritten or manually typed comments.
- Each page must be numbered and contain your name and organization (if applicable).
- If comment submission is e-mailed, assure that e-mail is sent in the following format:
  - E-mail message; and
  - Comments, typed in Microsoft Word 2003 or lower, saved as an attachment.

Confidential Information

The information submitted in your comments to the RFP Summary is not considered confidential. Therefore, any information submitted will be considered a government record under the Hawaii Uniform Information Practice Act (UIPA), and may be disclosed to the extent required under the UIPA.

Cost of Response

DHS will not reimburse for the cost of preparing and submitting any comments to this QExA RFP Summary.

Use of QExA RFP Summary Information

The Department reserves the right to incorporate in a solicitation, if issued, any recommendations presented in comments to this QExA RFP Summary. Please note that participation in this QExA RFP Summary comment process is optional and is not required in order to respond to any subsequent procurement by the Department.

Neither the Department nor the commenting party has any obligation under this QExA RFP Summary.

If there are any questions or clarifications to this QExA RFP Summary, please contact Ms. Patti Bazin at (808) 692-8072 or at pbazin@medicaid.dhs.state.hi.us.