QUEST Integration
(QI)

Request for Information
RFI-MQD-2013-011

Department of Human Services
Med-QUEST Division
June 5, 2013

INTRODUCTION

The State of Hawai'i, through its Medicaid agency, the Department of Human Services (DHS), Med-QUEST Division (MQD), is issuing this Request for Information (RFI) to seek information to prepare a Request for Proposals (RFP) for a Medicaid managed care program called QUEST Integration (QI) that serves persons eligible for Medicaid and Children's Health Insurance Program (CHIP). The QI program would replace the separate QUEST and QUEST Expanded Access (QExA) programs.

The State of Hawai'i is developing its QI program to improve the health care of members with an emphasis on prevention and quality health care. The DHS will be seeking health plans with the proven ability to provide quality health care services through a managed care system to low-income, Hawai'i residents.

Background

The State of Hawai'i with its Federal partner Centers for Medicare & Medicaid Services (CMS) implemented QUEST on August 1, 1994. QUEST is a statewide section 1115 demonstration project that provides medical and behavioral health services through managed care delivery systems. QUEST stands for:
Quality care
Universal access
Efficient utilization
Stabilizing costs, and
Transforming the way health care is provided to QUEST members.

The program was designed to increase access to health care and control the rate of annual increases in health care expenditures. The State combined its Medicaid program with its then General Medical Assistance Program and its State Children's Health Insurance Program and offered benefits to citizens below 300 percent of the Federal Poverty Level (FPL). Low-income women and children and adults who had been covered by the two state-only programs were enrolled into fully capitated managed care plans throughout the State. This program contributed to substantially closing the coverage gap in the State for low-income individuals. The second phase of the 1115 demonstration waiver enrolled the aged, blind and disabled (ABD) populations into managed care on February 1, 2009.

A class action lawsuit under the Americans with Disabilities Act (ADA) was filed against the State in 1995 alleging that disabled individuals with incomes above 100% FPL were kept out of the program based solely on their disability status. To address this issue, the State reduced its coverage of the uninsured under QUEST to those uninsured adults with incomes at or below 100% FPL. A new program, QUEST-Net, was developed in 1995 for individuals who were no longer eligible for QUEST due to an increase in income or assets.

Since its implementation, the State has made several changes to the QUEST program.

- The first amendment, approved July 11, 1995, allowed the State to consider parental income for tax dependent children up to 21 years of age, prohibit QUEST eligibility for individuals qualifying for employer-sponsored coverage, require some premium sharing for expansion populations, impose a premium for self-employed individuals, and change the fee-for-service window from the date of coverage to the date of enrollment.

- The second amendment, approved on September 14, 1995 allowed the State to cap QUEST enrollment at 125,000 expansion eligible individuals.

- The third amendment, approved on May 10, 1996, allowed the State to reinstate the asset test, establish the QUEST-Net program, and required participants to pay a premium.

- The fourth amendment, approved on March 14, 1997, lowered the income thresholds to the mandatory coverage groups and allowed the State to implement its medically needy option for the AFDC-related coverage groups for individuals who became ineligible for QUEST and QUEST-Net.

- The fifth amendment, approved on July 29, 2001, allowed the State to expand the QUEST-Net program to children who were previously enrolled in SCHIP when their family income exceeded the Title XXI income eligibility limit of 200 percent FPL.

- In January 2006 (with a retroactive start date of July 1, 2005), the federal government approved an extension of the Section 1115 waiver for Hawai'i, QUEST Expanded (QEx) which incorporated the existing QUEST program with some significant changes including:

    - Extension of coverage to all Medicaid-eligible children in the child welfare system;
    - Extension of coverage to adults up to 100% of the FPL who meet Medicaid asset limits (QUEST-ACE);
    - Elimination of premium contributions for children with income at or below 250% of FPL;
    - Elimination of the requirement that children have prior QUEST coverage as a condition to qualifying for QUEST-Net; and
    - Increased SCHIP eligibility from 200% of FPL to 300% of FPL.

- In February 2007, the State requested to renew the QUEST demonstration, and the State reaffirmed its 2005 request to CMS to amend the Demonstration to advance the State's goals of:

    - Developing a managed care delivery system for the Aged, Blind, and Disabled (ABD) population that would assure access to high quality, cost-effective care.
    - Coordinating care for the ABD population across the care continuum (from primary care through long-term care).
    - Increasing access to a health care benefit for low-income children.
    - Developing a program design that is fiscally sustainable over time.
    - Developing a program that places emphasis on the efficacy of services and performance.

- The waiver renewal included terms and conditions related to the QUEST Expanded Access (QExA) program and also increased the QUEST-ACE eligibility level from 100 to 200% of the FPL. The renewal was approved in February 2008.

- On February 18, 2010 the State of Hawai'i submitted an amendment to provide a 12 month subsidy to eligible employers for approximately half of the employer's share for eligible employees newly hired between May 1, 2010 and April 30, 2011. On July 28, 2010, the State of Hawai'i submitted an amendment to eliminate the unemployment insurance eligibility requirement for the Hawai'i Premium Plus (HPP) program. A subsequent amendment was approved which ended the HPP program effective April 2012.

- On July 7, 2011, Hawai'i submitted an amendment proposal to reduce QUEST-Net and QUEST-ACE eligibility for adults with income above 133 percent of FPL, including the elimination of the grandfathered group in QUEST-Net with income between 200 and 300 percent of the FPL. On July 8, 2011, Hawai'i filed a coordinating budget deficit certification, in accordance with CMS' February 25, 2011, State Medicaid Director's Letter. This certification was approved by CMS on September 22, 2011. CMS approved the amendment effective April 5, 2012.

- In the July 7, 2011 amendment, Hawai'i also requested to increase the benefits provided to QUEST-Net and QUEST-ACE under the Demonstration; eliminate the QUEST enrollment limit for childless adults; provide QUEST Expanded Access (QExA) individuals with expanded primary and acute care benefits; remove the Hawai'i Premium Plus program, a premium assistance program, due to a lack of Legislative appropriation to continue the program, and allow uncompensated cost of care payments (UCC) to be paid to government-owned nursing facilities.

- In June 2012, the State requested to extend the QUEST demonstration under 1115(e) of the Social Security Act. Because the extension only allows for limited changes, revisions were made to the waiver and expenditure authorities to update the authorization period of the demonstration, along with a technical correction clarifying that the freedom of choice waiver is necessary to permit the state to mandate managed care, and updates to the budget neutrality trend rates.

- In December 2012, the state requested to amend the demonstration to provide full Medicaid benefits to former foster children under age 26 with income up to 300 percent FPL. The state will not impose an asset limit on this population.

- In April 2012, an additional amendment was approved that reduced the eligibility level from 200% to 133% of the FPL for QUEST-ACE and QUEST-Net adults.

- In March 2013, an additional amendment was approved to provide full Medicaid benefits to former foster children under age 26 with income up to 300 percent FPL.

- The current waiver period runs through December 31, 2013.DHS submitted a Section 1115(a) renewal application to align its current demonstration with provisions in the Affordable Care Act (ACA). This renewal application is the basis for the QUEST Integration program.

QUEST Integration (QI) RFP Summary

As the Department starts the procurement process, DHS is seeking guidance from its stakeholders. The DHS is providing information on the framework of the RFP and will continue to adapt it based upon ongoing review and discussion as well as stakeholder input. This RFP Summary provides information on the RFP as it is drafted as of June 1, 2013. DHS shall make changes prior to the official release of the RFP based upon additional input.

This RFP Summary is organized as follows:

I. Summary of RFP Sections 10 & 20
II. Summary of RFP Section 30
III. Summary of RFP Section 40
IV. Summary of RFP Section 50
V. Summary of RFP Section 60
VI. Summary of RFP Section 70
VII. Summary of RFP Section 80
VIII. Summary of RFP Section 90
IX. Summary of RFP Section 100
X. Comment Submissions

I. Summary of RFP Sections 10 & 20

Sections 10 and 20 include standard language found 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.

II. Summary of RFP Section 30

RFP Section 30 focuses on three key areas:

1. Program background;
2. Participating individuals;
3. Enrollment activities; and
4. Additional DHS responsibilities.

Program Background

The program background section identifies the goals of the QUEST Integration program that are listed below:

- Improve the health care status of the member population;
- Minimize administrative burdens, streamline access to care for enrollees with changing health status, and improve health outcomes by integrating programs and benefits;
- Align the program with the Affordable Care Act (ACA);
- Improve care coordination by assuring members have access to a "provider home" through the use of assigned primary care providers (PCPs);
- Expand access to home and community based services (HCBS) and allow members to have a choice between institutional services and HCBS;
- Maintain a managed care delivery system that assures access to high quality, cost-effective care that is provided whenever possible, in the members' community, for all covered populations;
- Establish contractual accountability among the State, the health plans and health care providers;
- Continue the predictable and slower rate of expenditure growth associated with managed care; and
- Expand and strengthen a sense of member responsibility and promote independence and choice among members that leads to a more appropriate utilization of the health care system.

In addition, the program background section includes a comprehensive list of definitions and acronyms used in the RFP.

This section provides information about specific activities that are the responsibility of the DHS. As examples, the DHS is responsible for:

- Reviewing and approving all health plan materials that are distributed to their 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;
- Reviewing and approving all health plan marketing materials;
- Conducting on-going monitoring of the health plans; and
- Making all eligibility determinations.

Participating Individuals

Individuals who otherwise would have been eligible to enroll in either the QUEST or QExA programs would instead enroll in the QI program. Nearly all Medicaid and CHIP beneficiaries would be required to enroll in the QI program. However, certain individuals are excluded from participation in the QI program and include those who are:

- Medicare Savings Programs Members;
- Enrolled in the State of Hawai'i Organ and Tissue Transplant Program (SHOTT);
- Retroactively eligible only; and
- Eligible under non-ABD medically needy spenddown.

Enrollment Activities

New members

Upon notification of application approval, eligible individuals who submitted their applications electronically shall be provided the opportunity to select a participating health plan on the date of notification. Individuals who make a health plan selection upon eligibility notification will be enrolled in that health plan retroactively to date of eligibility as applicable and prospectively. Individuals who do not make a choice of health plans when notified of eligibility, and those who do not submit an application electronically, will be auto-assigned to a health plan retroactively to date of eligibility as applicable and prospectively.

Individuals who are auto-assigned to a health plan will have fifteen (15) days to change their health plan (including mail time). Their changes shall be effective prospectively beginning the first day of the following month.

In addition, the DHS shall allow all members to change health plans without cause for the first sixty (60) days of their enrollment in a health plan regardless of whether enrollment is a result of selection or auto-assignment. Members have only one (1) change of health plan during the sixty (60) day grace period. Health plan change requests received during the sixty (60) day period shall be effective prospectively beginning the first day of the following month in which the health plan change request was received by DHS.

Initial Enrollment Period for Existing QI Program Members

Members receiving services in the current QUEST or QExA programs will have sixty-days to make a choice of a new QUEST Integration health plan. This process will be called the initial enrollment period for existing members. For individuals that do not select a health plan:

- If enrolled in a health plan from the previous QUEST or QExA procurement that has been awarded a contract in this procurement, the individual shall remain in their current health plan in order to promote continuity of care; and
- If enrolled in a health plan that is not participating in the QI program, the individual shall be auto-assigned into a QI health plan according to the auto-assign algorithm.

Auto-Assign Algorithm
The following provides some of the factors utilized in the auto-assign algorithm:

- Sixty (60%) of the auto-assign algorithm shall be split equally amongst each of health plans;
- Forty (40%) of the auto-assign algorithm shall be based upon quality factors that may include but not be limited to the following quality measures:
  - CAHPS scores;
  - HEDIS measures; and
  - EPSDT measures;
- The DHS may include (as part of the quality-based component of the auto-assign algorithm) other quality measures where the health plans demonstrate improvement; and
- For each contract year following the first year in which the quality-based component is implemented, the quality-based component shall increase by 10% and the non quality-based component shall decrease by 10%.

Member Enrollment Limits/Caps
The DHS may implement enrollment caps on any health plan that reaches a specified percent of membership. The enrollment cap would apply only to the island of Oahu. A health plan may request to have an enrollment limit; however, the request needs to be approved by DHS and requires that at least two other health plans are open to new members in each service area in which the requesting health plan operates. Enrollment limits would be Statewide. The RFP does allow for exceptions to this policy when, for example, a QI eligible newborn is born to a mother in a health plan that is capped or has a limit.

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:

- Individuals with Developmental or Intellectual Disabilities (DD/ID) will continue to receive their 1915(c) waiver or ICF/ID facility services through the Department of Health, Developmental Disabilities Division (DOH/DDD);
- Dental services;
- School health services; and
- Department of Health (DOH) programs such as the Child and Adolescent Mental Health Division (CAMHD), Early Intervention Program, or Vaccines for Children Program.

This section also describes that all comprehensive behavioral health services for adults with a diagnosis of serious mental illness (SMI) or serious and persistent mental illness (SPMI) shall be provided by the DHS' Community Care Services (CCS) program. CCS shall provide to its adult members a full range of specialized behavioral health services including inpatient, outpatient therapy and tests to monitor the member's response to therapy, and intensive case management. Adult members that are receiving services

through CCS that require alcohol and/or drug abuse treatment may also receive these services through CCS.

Finally, this section provides a synopsis of the DHS' monitoring activities. The DHS will regularly assess 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. If the health plan is unable to demonstrate its ability to meet the requirements of the contract, as determined by the DHS, within the time frames specified by the DHS, the DHS may postpone availability for enrollment or terminate the contract.

IV. Summary of RFP Section 40

RFP Section 40 covers five primary areas:

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

Provider Network

The health plan shall have an established provider network that meets the requirements of this RFP at the time of proposal submission for all primary, specialty, and acute care; behavioral health services; and nursing facilities. The DHS shall allow submission of letters of intent (LOI) for home and community-based services (HCBS) providers as part of proposal submission.

The health plans' 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 (i.e., physician specialists, pharmacies, emergency and non-emergency transportation providers, behavioral health providers, HCBS providers, nursing facilities, and hospitals);
- The number of acute care hospitals;
- The number of PCPs per member that the health plan must have (1:300);
- 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 four weeks for visits with a specialist or for non-emergency hospital stays.

- 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

*Urban is defined as the Honolulu metropolitan statistical area (MSA).

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. New members will have ten (10) days to make a PCP selection. If no selection is made during that ten-day period, the health plan shall auto-assign a member to a PCP. Members must be allowed to change PCPs at any time.

Provider Agreements, Provider Manual and Provider Services

The RFP requires that health plans set up contractual relationships with providers and describes the specific requirements that must be included in the provider agreements.

In addition, the DHS will require that all providers are given a provider manual that outlines the responsibilities of both the health plan and provider in the QI 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 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;
- Have a Hawai'i based provider call center that is operational during business hours, staffed by competent, trained individuals able to answer provider questions about all aspects of the QI program and assure that access to prior authorization staff is readily available.

Covered Benefits and Services

The RFP requires that the health plan provide all medically necessary primary, specialty, acute, standard behavioral health and long-term services and supports (LTSS) to all eligible members. This includes all current services offered in the Medicaid State Plan and section 1115 demonstration waiver (i.e. all services currently covered in QUEST and the QExA.) The RFP provides a complete list of all QI 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 in the CCS program or receiving services through CAMHD);
- Durable medical equipment and medical supplies;
- Emergency services;
- Home health services;
- Hospice services;
- Physician services;
- Prescription medications; and
- Transportation (emergency and non-emergency).

Long-Term Services and Supports (HCBS)

- Adult Day Care;
- Adult Day Health;
- Community Care Management Agencies;
- Environmental Accessibility Adaptation;
- Personal Care Assistance;
- Residential living (Assisted Living Facility, Continuing Care Foster Family Home, Expanded Adult Residential Care Home);
- Respite Care.

Long-Term Services and Supports (Institutional)

- Acute waitlisted; and
- Nursing Facility services.

The QI 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

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. The DHS may revise the health plan's responsibilities within the service coordination system to align with implementation of the state healthcare transformation plan or innovation model grant. The RFP requires that health plans use patient-centered, holistic, service delivery approaches to coordinating member benefits across all providers and settings.

The Service Coordination system shall be developed to include the health plan's members with Special Health Care Needs (SHCN) and those receiving LTSS. As part of this service coordination system, the health plan is required to assure that the following occurs:

- Conducting a Health and Functional Assessment (HFA) for each members identified with SHCN or receiving LTSS at least two (2) times per year and in person. The HFA shall be a standardized tool provided by the DHS;
- The service plan shall be a person-centered written document that analyzes the assessment, describes the medical and social needs of the member, and identifies all of the services to be utilized to include but not limited to the frequency, quantity and provider furnishing the services. The service plan shall be based upon the HFA. The health plan shall use a standardized service plan developed by the DHS and have a process for completing the service plan. This service plan shall, at a minimum include:
  - Problem identification;
  - Goals, objectives and desired outcomes;
  - Interventions; and
  - Needed services and service parameters.
- Arranging for health care services based upon the assessment, service care, and collaboration from the members' PCP;
- Performing (or delegating) an institutional level of care assessment and referring to the State for approval (DHS' 1147 process);
- Providing options counseling regarding institutional placement and HCBS alternatives for members at institutional 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 CCS or DOH, and DD/ID 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 that DHS shall approve for:

- Out-of-state and off-island coverage;
- Cultural competency plan;
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program for all members younger than 21 years of age; and
- Disease management programs and performance improvement programs.

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 those receiving LTSS.

V. Summary of RFP Section 50

Section 50 of the RFP outlines the administrative requirements of the health plans below. Additional detail about some of these sections (those in bold) is provided as well.

- **Enrollment;**
- **Member services;**
- **Value-based purchasing;**
- Marketing and advertising;
- **Quality improvement programs**;
- **Utilization management program;**
- **Member grievances;**
- Information technology;
- Fraud and abuse;
- **Health plan personnel;**
- **Health plan reporting;**
- **Readiness review;** and
- Timeframes during RFP implementation.

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 membership card;
- A member handbook;
- A flyer (or other handout), separate from the member handbook, that describes PCP information;
- A choice form for the member to use to choose their PCP;
- An additional flyer (or other handout) that describes: member rights, member responsibilities, information about advanced directives, and how to access assistance for those with limited English proficiency (LEP); and
- A provider directory.

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 QI 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 interpretation and written translation services for languages other than English and for the hearing impaired. These services shall be provided at no cost to the member.

Value-Based Purchasing

Value-based purchasing (VBP) links a provider's reimbursement to improved performance or aligning payment with quality and efficiency. This form of payment holds health care providers, both outpatient in inpatient, accountable for both the cost and quality of care that they provide.

Value-based payment methodologies may also include risk-sharing and gain-sharing. Care management fees may be utilized should they be associated with improved patient outcomes and/or reduced cost.

DHS seeks to reduce administrative burden and may require alignment of provider metrics and reporting with a community standard or other standard including federal requirements.

The medical home is an evolving delivery model to facilitate the provision of high quality and highly efficient outpatient care. The health plans shall enable providers that have an accredited or recognized Patient-Centered Medical Home (PCMH) by certain organizations to function as such.

Certain entities may be able to be more accountable for an individual's healthcare, and health plans are encouraged to explore innovative payment methodologies with accountable care organizations.

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.

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.

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 authorized 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 most individuals be physically located in the State of Hawai'i. The health plan shall have an office on each island that they are providing services to at least 5,000 members.Examples of some positions that the health plans are required to have in State:

- An executive director for members not receiving LTSS;
- An executive director for members receiving LTSS;
- A medical director licensed to practice in the State;
- A service coordinator director, 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;
- Member grievance system reports to enable the State to monitor and trend analysis on the number of grievances and appeals that the health plans have processed; and
- Long-term services and supports reports to enable the State to monitor and trend services provided, assessments performed, service plan updates, addition or reduction of services, and authorization of specific services (i.e., environmental adaptations).

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; 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 financial incentive programs; and
- Implementing and managing the health plan gain share program.

The RFP requires the health plans to:

- Reimburse providers and subcontractors as follows:
    - With the exception of eligible services provided by hospice providers, FQHCs, RHCs, hospitals, critical access hospitals (CAHs), and nursing facilities the health plan may reimburse its providers and subcontractors in any manner, subject to Federal rules. (This does not preclude additional payments such as for a health home or financial incentives for performance.); 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);
- Incentivize electronic billing;
- Collect cost-share amounts from members, as necessary;
- Implement co-payments, if determined by DHS; 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 DHS determined capitation rates and future rate setting.

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 that are considered mandatory (i.e., 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.

The DHS shall select all applicants/health plans that pass the technical proposal for provision of services. The DHS shall allow applicants/health plans to be awarded contracts either on Oahu and one other island, or Statewide.

RFI RESPONSE

The State is actively soliciting the ideas of a wide variety of stakeholders to include health plans, advocates, beneficiaries and providers. Toward that end, it recognizes that not every question will be applicable to each individual or organization responding to this RFI. Please feel free to respond to any /all of the questions posed in this RFI.

The State is seeking responses to the following questions.

1. QUEST Integration will consolidate the current programs and provide all beneficiaries enrolled under the demonstration with access to a single benefit package, of which access to certain services will be based on clinical criteria and medical necessity. Integrating the current programs will ease administrative burdens, streamline the enrollment process, and facilitate access to care for enrollees with changing health status. QI will place an emphasis on prevention and quality health care. Does this change in program administration encourage or discourage a health plan from bidding? Why? Does this cause any concern for stakeholders such as advocates, providers, and beneficiaries?

2. The DHS is proposing to require a complete provider network for primary, specialty, and acute care; behavioral health services; and nursing facilities and allowing health plans to submit letters of intent (LOI) for home and community-based services (HCBS) providers as part of proposal submission. Would this encourage or discourage a health plan from bidding? Why? Would this cause any concern for stakeholders such as advocates, providers, and beneficiaries?

3. The DHS seeks to align health plan requirements with already established standards such as related to value-based purchasing and to Hawai'i's Healthcare Transformation plan. For example, this may include Patient-Centered Medical Home (PCMH) criteria, quality measure reporting, and migration of case management responsibility closer to the provider. Would thisencourage or discourage ahealth plan from bidding? Why? Would this be encouraged or discouraged by providers in the community?

4. The DHS shall select all applicants/health plans that pass the technical proposal for provision of services. The DHS shall allow applicants/health plans to be awarded contracts either on Oahu and one other island, or Statewide. Would this encourage or discourage a health plan from bidding? Why? Would this be encouraged or discouraged by stakeholders such as advocates, providers, and beneficiaries?

5. Are there comments to the QI RFP summary that you think DHS should consider in the further development of this RFP and program?

Note: The DHS will not accept questions or provide responses/answers as part of this RFI. Questions and answers will be included as part of the RFP process.

RESPONSE SUBMISSION

Responses to this RFI are due by 2:00 pm Hawaii Standard Time (HST) on June 28, 2013. Please include in your response your name and organization, if applicable. Please indicate on the cover "QUEST Integration (QI).-RFI-MQD-2013-011" Submit your response typed in Microsoft Word 2010 or lower using Times New Roman, 12 point font with no less than one inch margins on all sides of the page, single line spacing. Please limit your responses to no more than 16 pages. Please mail or deliver one hard copy response with an electronic version stored on CD-Rom to:

Ms. Patricia M. Bazin
Health Care Services Branch Administrator
Med-QUEST Division
Department of Human Services
601 Kamokila Boulevard, Room 506A
Kapolei, HI 96707-2005

OR

E-mail response to rfiresponse@medicaid.dhs.state.hi.us.

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

Confidential Information

If respondents believe that portions of their RFI response should remain confidential, respondents shall clearly identify that portion of their response they wish to maintain as confidential and include a statement detailing the reasons that the information should not be disclosed. (Blanket labeling of the entire document as "proprietary" or "confidential" will result in none of the document being considered proprietary or confidential.)

The detailed reasons shall include the specific harm or perceived prejudice that may arise. The DHS Director, the Med-QUEST Administrator and the Health Care Services Branch Administrator shall determine whether the identified information should remain confidential. A prior notice shall be provided to the respondent if it is determined that any information which was requested to be confidential becomes part of public distribution/information; the respondent requesting confidentiality can choose whether or not to withdraw their submission.

Cost of Response

DHS will not reimburse any respondent for the cost of preparing and submitting a response to this RFI.

Use of Information

The DHS reserves the right to incorporate in a solicitation, if issued, for such a contract, any recommendations presented in responses to this RFI. Please note that participation in this RFI process is optional and is not required in order to respond to any subsequent procurement by the DHS. Neither the DHS nor the responding party has any obligation under this RFI.