Summary of QUEST Integration Request for Information (RFI)
RFI-MQD-2013-001

This document is a summary of Request for Information (RFI) responses for the QUEST Integration program that was posted on June 5, 2013 with responses provided on June 28, 2013. These summaries do not reflect the position of Department of Human Services (DHS); they are solely a compilation of the responses received.

DHS wrote the RFI to encourage responses from stakeholders to include health plans, advocates, beneficiaries and providers. DHS received responses from all types of stakeholders. DHS has reviewed all the RFI comments and is analyzing the responses for consideration in the development of the QUEST Integration RFP.

The QUEST Integration RFI posed 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?

The following summarizes the responses received from the QUEST RFI.

Health Plan A

Question #1
We view the consolidation of the current programs into a single benefit package as a unique opportunity for DHS to align Medicaid health benefits across the continuum of care and consolidate health plan contracts.

We support the goals of minimizing administrative burden on all affected parties, including DHS, beneficiaries, providers, and health plans, and streamlining access to care while integrating programs and benefits. We also strongly support an emphasis on prevention and quality health care as the right way to care for our members and the best approach to sustain Hawaii's health care system.

This change in program administration would not discourage this health plan from bidding. Our ability to accept a contract would be positively supported by adequate and timely disclosure of data and applied assumptions or health plan specific adjustments, and verification that the capitation rates to health plans will be valid and adequate in relation to the contract requirements. As we do with each contract, we'd review this bid opportunity on its own merits and then decide how to proceed.

Question #2
This would not discourage this health plan from bidding. We support the emphasis on a strong provider network as an important aspect of the care delivery model and agree that this should be a focus of plan readiness.

Question #3
We support the promotion of already established standards such as those related to value-based purchasing and to Hawaii's Healthcare Transformation plan. We support and are encouraged by PCMH criteria and other nationally recognized quality metrics such as HEDIS and CAHPS to incent quality and promote improvement, and the reporting of those measures.

We also support the concept of the primary care provider as the leader of the care team and the focal point for helping the member with important care management activities and decisions with a focus on quality outcomes rather than just encounters and procedures. Based on the response we've received from the provider community to our ongoing PCMH efforts, we believe that the activities and vision described would be supported and even embraced by it.

Since DHS has stated an interest in advancing PCMH, we recommend that DHS ensure that capitation rates are sufficient to promote successful implementation of PCMH concepts such as care coordination capacities and meaningful use of technology in practices through impactful financial incentives.

Question #4
This arrangement would not discourage this health plan from bidding. We support beneficiary choice in health plans. Providing the maximum number of health plan choices allows beneficiaries to select the health plan they believe will offer them access to the best quality care and the provider network they need while focusing on member satisfaction.

At the same time, we consider it important that all Medicaid managed care plans have viable business models that can be adapted to different levels of participating membership. Plans that are unable to do so may decide to exit one or more markets in Hawaii, requiring additional administrative costs for DHS and the remaining health plans, disrupting member care, and creating an additional administrative burden on network providers who may be discouraged from continuing in the QUEST program.

Question #5

We appreciate the opportunity to share our thoughts and input. DHS' outreach through this RFI process and its various other proactive interfaces with health plans and the community demonstrate an interest in and willingness to collaborate with its plan and community partners.

We look forward to a transparent and responsive bid process where we can work closely with DHS to demonstrate how this health plan can effectively serve QUEST Integration members. If we decide to pursue this opportunity and are selected to participate, we believe that this type of cooperative and collaborative approach between government and health plan partners will continue to provide the crucial framework to help us all rally around the needs of Hawaii's most vulnerable citizens.

Health Plan B

Question #1
No, the consolidation will not discourage this health plan from bidding. We are unclear if other health plans will see challenges in bidding on QUEST Integration, especially as it relates to long term care services and serving the medically fragile and those with multiple chronic conditions.

Specifically, this health plan is encouraged by the following in QUEST Integration:

- Ability for members to transition easily within the same health plan to receive additional services as they become eligible, such as long term care services and coordination with Medicare, as currently provided within QExA.
- Improved and consolidated interaction with the State of Hawaii through the combination of two distinct contracts into a single combined Medicaid program.
- Opportunity for the current "smaller plans" to interact with the healthcare delivery system in a more meaningful way through a combined Medicaid program with more members in a combined program.

Our experience has shown placing a greater emphasis on preventive initiatives and quality care cultivates a competitive environment that ultimately benefits the members and the community. Further we believe a comprehensive and coordinated whole health delivery system is more effective in bending the curve in health care costs and improving quality, access and outcomes. Effective population management can assist the State in achieving these goals by making a single program accountable for performance. Selecting experienced health plans can effectively improve the health care system, demonstrate value and quality, reduce costs, drive program integrity, and most importantly, provide better care for the Medicaid beneficiary.

Question #2
This would not discourage this health plan from bidding. We would acknowledge that it will help facilitate other health plans bidding on QUEST Integration to be allowed to submit LOIs for HCBS providers for proposal submission. We also believe requiring contracts may enable providers, by withholding support for particular MCOs, to influence which MCOs are selected, thereby usurping the role of the DHS. Also, such an approach will likely pre-empt new MCOs from entering the market. However, this latter issue is of little consequence as there are an adequate number today.

Question #3
This should not discourage health plans from bidding. This health plan is in full support of this value based purchasing, the patient-centered medical home as evidenced by Accountable Care Model with a focus on quality, measure reporting and increasing engagement by the provider community on case management. This health plan would encourage the DHS, which has been instrumental in providing direction and transformation in Hawaii's Medicaid program, to continue to allow flexibility by health plan in actual execution. This will allow differentiation by health plan, foster competition amongst the QUEST Integration health plans, and provide choice to members and providers.

We agree that aligning program administrative standards is good across the entire system as this alleviates administrative burdens for plans and providers alike. However, it is a delicate balance between not being overly prescriptive so as to squash innovative, unique approaches customized by health plans that incentivizes the network to improve accountability, efficiency, and investment to foster transformative change.

Question #4
This would not discourage this health plan from bidding and would enable the opportunity for continuity from the current QUEST program.

Question #5
This health plan had several suggestions for DHS. Below is a compilation of a few:

- Leverage the work of the Hawai'i Healthcare Project CMMI State Innovation Model in the QI RFP and/or in further development of the QI program including, for example, PCMH model definition and administrative simplification.
- Differentiate or adjust quality factors for health plans with different cohort mix - specifically quality scoring and resulting scores are different between the current QExA and QUEST programs and (3) current QUEST health plans are advantaged by nearly (20) years of opportunity to build such scores and measures.
- Allow the QI health plans the option, with the DHS approval, to conduct collaborative provider training sessions during the (3) months prior to and (6) months after the start of the QI program.
- Allow review and input by health plans, providers and stakeholders in the development/selection of the standardized tool for a HFA.
- An on-going challenge to the service coordination model and associated RFP requirements (such as specific ratios of SCs to population cohorts) are beneficiaries who are "unable to locate." The QI RFP could allow/support the QI health plans and providers to develop innovative programs to reach and better connect with such members.
- Consider including in readiness review a health plan's ICD-10 transition management plan.
- Consider including a provision that would support/enable the QI program to move towards an acuity adjusted capitation rate setting system, such as the Medicare system. This would address the issue of health plans with smaller membership and/or specific challenging cohorts such as medically fragile children. Additionally, this would position the QI program to better compensate providers (especially in a value based purchasing model) to accept and care for more challenging and complex patients.
- To mitigate potential concerns from enrollees and providers, the State can put the following requirements in place with the health plans to ensure continuity of care for members that will be transitioning from QUEST or QExA to QI:
    - ***Prior Authorizations:*** Require health plan(s) to honor all prior authorizations from providers, including pre-authorizations for behavioral health and long-term care services, so that there are no disruptions in services or treatment during transition.

Health Plan C

Question #1

This health plan is committed to serving Hawaii's Medicaid population and intends to bid on the proposed QUEST Integration program. This health plan concurs that when the environment and timing is appropriate, a seamless, holistic and integrated health care system is best for any population. We believe that the health plans should continue to be responsible for all member health care services which promote continuity of care and cost effective care coordination.

This health plan feels, however, that this goal must be achieved with great care and deliberation, given the fragility of the people being served. In prior correspondence, this health plan has expressed specific concerns about the impact of enrollment policy, quality metrics used for auto-assignment, and "carving-out" of members with certain conditions. Those concerns remain as well as additional issues raised by this RFI. Unless these questions are adequately addressed a successful program will be difficult to achieve.

Question #2

This health plan supports the requirement of a fully contracted provider network, and for flexibility in using letters of intent for the HCBS providers. However, to ensure consumers do not experience disruptions in service if changing plans, the RFP should also require health plans to have a complete network of hospitals, specialists and Federally Qualified Health Community Health Centers. We believe that a health plan needs to demonstrate that it is fully prepared to provide the required services to its members prior to the start of the contract. Health plans should also demonstrate experience with the Hawaii Medicaid population and be fully licensed as an HMO in the state.

Question #3

This health plan supports innovation and transformation of the health care system and has actively developed payment and care models that encourage provider quality and technology-based complex care coordination and management programs.

Efforts to "align" plan requirements to standard models, or to those of competing health plans which may not have been developed to serve Medicaid or other vulnerable populations, should be flexible enough to encourage innovation and customization to the specific needs of member populations. Such differences include culture, acuity, economic, educational, demographic and geographic challenges that require creativity and collaboration at the local level to address.

Question #4

Though we would suggest that price is an important factor, we have no concerns about awarding contracts based on the technical proposal nor the option of serving statewide or on Oahu and one other island. This health plan intends to continue operating statewide.

Experience Serving the Hawaii Medicaid Population Should be Required

With five health plans currently serving the Hawaii Medicaid population, members have ample choice of experienced health plans on every island. That will continue to be true even if one of the current contractors chooses not to participate in the QI RFP. The QUEST program's expansion to five plans has been in effect for only a single year, with newer plans still relying on auto-assignment to build market share sufficient to succeed and provide required service to members. Additional plans entering

the market through the QI RFP could seriously impair current plans' financial sustainability. Maintaining a Medicaid managed care program that allows health plans potential growth is essential to the success of the program.

Question #5

Quality Metrics in Auto Assignment and Pay for Performance

This health plan is concerned about complete reliance on HEDIS, CAHPS and EPSDT as absolute measures for apportioning auto-enrollment as a quality incentive. Such an experimental scheme will punish health plans which have historically chosen the mission of working with essential community providers to serve the most vulnerable, disengaged and often most ill populations.

Member Choice for Electronic Enrollment

This health plan is supportive of administrative advancements using technology such as the proposed electronic enrollment for beneficiaries. However, offering plan choice only to members who use electronic enrollment could significantly impact the size and composition of the auto-assigned pool of membership.

Enrollment Cap

This health plan appreciates the acknowledgement in the RFI that an enrollment cap on potentially dominant plans may be necessary. Measures to ensure a reasonable balance among health plans are extremely important to the overall stability of the program and in effective delivery of health care services.

Ineligibility and Churn

The current rate of members becoming ineligible remains a barrier to continuity of care, prevention services, disease management, quality improvement and financial stability for plans. Based on our own data, this health plan believes many people, including children, are being disqualified despite being eligible for services.

End Open Enrollment Periods

Current Annual Enrollment Periods (AEP) are inefficient and costly for the state and health plans and confusing and stressful for members and some providers. This health plan suggests that member households be given their opportunity to choose a plan annually in conjunction with their enrollment renewal date. The plans and the state are already engaged with these households in order to facilitate renewal. Adding the plan change opportunity at renewal would give members an annual opportunity to choose a new plan without the cost and administrative burden of the open enrollment. A member choice at this stage will be based on their actual satisfaction with the plan, and less based on plan marketing or provider steering.

Rates Must Cover Additional Mandates to Health Plans

Since awards will be based on the technical proposal only, with no financial bid, the DHS needs to assure bidders that capitation rates will be adequately set to cover program health care and administrative costs. We believe new policies and contract requirements, like the ones listed below, will impact health plan costs.

- Requirement for director positions for service coordination, LTSS and non-LTSS
- Requirement for a health plan office on each island where membership exceeds 5,000 members
- Requirement to have all members assigned to a service coordinator
- Requirement for assessments every 6 months

Health Plan D

Question #1

This health plan looks forward to participating in the QUEST Integration RFP and continuing our partnership with the Department of Human Services, stakeholders, and especially our members and their families across our islands. The proposed changes in program administration do not discourage us from bidding, and we are thankful for the opportunity to comment on the changes and the impact we believe they might have on the program.

Should the State choose to proceed with QUEST Integration, we ask the Department of Human Services (DHS) to consider the following potentially impactful issues:

- the availability and design of future benefits packages;
- actuarially sound rates (particularly for members "at risk" who will have access to enhanced benefits); and
- the extent to which the Hawai‘i Healthcare Project/State Plan Amendment activities will result in changes to the program.

Given the level of uncertainty as to benefit design and changes resulting from the State's potential award of a SIM grant, we do not believe that stakeholders such as advocates, beneficiaries and providers can adequately assess potential concerns with QUEST Integration as many of the fundamentals of the program remain unknown.

Based on these factors, we respectfully suggest delaying the RFP process until DHS is able to gather specific input from all stakeholders as to elements of QUEST Integration's proposed benefit design and program administration.

Question #2

Due to the unique nature of most HCBS providers, we caution the State against assuming that LOIs will necessarily result in the delivery of the same HCBS network on a timely basis after a contract is signed with a health plan.

HCBS providers are not typical medical practitioners who have routine business hours and practices common among standard types of health care providers. Any health plan that chooses to create an HCBS network must be cognizant of these fundamental differences when pursuing contracting and credentialing of this type of network.

One of the most challenging areas involving LOIs and the ultimate provision of an HCBS network involves liability insurance. Unlike traditional providers, who often take advantage of group or employer rates and policies, HCBS providers must produce individual liability policies as adequate proof of insurance.

Question #3

This health plan supports the State of Hawai‘i's and DHS's efforts to ensure that Hawai‘i residents have access to high quality care, and improved health outcomes, while increasing the economic value and affordability of care.

We offer a number of suggestions below to DHS as to both PCMHs and VBP initiatives currently being discussed as part of Hawaii healthcare transformation efforts and the State's upcoming SIM grant proposal.

Question #4

The design of the benefit package for QUEST Integration beneficiaries will greatly impact this response. This health plan assumes that the current level of benefits and the eligibility determination for QExA members will remain the same under QUEST Integration. Given this assumption, 'this health plan recommends limiting the number of contracted health plans and/or imposing enrollment caps on health plans as it will be essential to the financial stability of the individual health plans, and the program as a whole, that health plans garner sufficient enrollment to operate efficiently.

We based our answer to this question on our internal actuarial analysis, analysis published by The Urban Institute in July 2012 (Medicaid and CHIP Risk-Based Managed Care in 20 States Experiences Over the Past Decade and Lessons for the Future, Final Report to the Office of the Assistant Secretary for Planning and Evaluation U.S. Department of Health and Human Services, The Urban Institute, July 2012) and operational concerns raised by increasing the number of health plans serving this population.

Question #5

Quality Factors for Auto Assignment

This health plan supports the State's decision to utilize quality factors for auto assignment. We recommend that DHS identify specific HEDIS measures that would apply to members with special health care needs (SHCN) and long term services and supports (LTSS) members, separate from the HEDIS measures that would apply to the rest of the population. Plans with a higher percentage of behavioral health members will have additional challenges with some of the HEDIS measures.

Service Coordination System

We are in agreement that a face-to-face assessment must be performed for any SHCN and LTSS member at least twice a year. While we agree that a set of same/similar assessment questions should be collected from each member and similar measurable collected by each health plan, using a standardized tool provided by DHS may not lend itself to a seamless coordinated care. These same issues would apply to a standardized service plan.

We recommend that a minimal assessment (standardized questions provided by DHS) be performed telephonically for all members not identified above. This would screen potential members for referral to Case Management and/or Disease Management, assist members with assignment of PCP and transition of care providers, and welcome members to the health plan.

Health Plan Personnel

With regard to the proposed health plan personnel, this health plan would suggest that DHS re-evaluate the need for two executive director positions based upon the two clinical tracks: membership participation in LTSS or not participating in LTSS. This health plan recommends that DHS have a single executive-level health plan associate to be fully accountable for the operations and outcomes of the QUEST Integrated Program.

Health Plan E

Question #1
This health plan supports the consolidation of the two programs as it should enable beneficiary's access to additional benefits more expeditiously.

Question #2
We support allowing health plans to submit letters of intent (LOI) for home and community-based service (HCBS) providers rather than requiring executed contracts with the technical proposal. This will not only encourage more health plans to bid for the QI contract, but will allow current QUEST health plans adequate time to exercise due diligence in the HCBS provider selection process.

Question #3
We agree that it is preferable both for the health plans and providers to align requirements with established standards. We encourage alignment with national well-established programs for PCMH or quality reporting with which most health plans and providers already participate, e.g., NCQA, CMS/Medicare.

Question #4
We support allowing health plans to participate on the islands where they have capability and have an established provider network to provide services. This may encourage more health plans to bid knowing that they can elect to participate on just a few islands, and then branch out to other islands in the future.

Question #5
Enrollment Activities:
New members: We support the plan to promote electronic applications. At the same time, individuals who submit paper applications should not be penalized with auto-assignment because they cannot or will not access a computer. The grace period does allow auto-assigned individuals the opportunity to change health plans; however auto-assignment for the sole reason of paper application submission causes unnecessary administrative burden for both MQD and the health plan, delays for the member, and disruption of care continuity for a beneficiary already established with a health plan.

Auto-Assign Algorithm: Health Plans should be allowed to opt out of the auto-assignment algorithm as is currently allowed in the QUEST contract. This would allow plans to better manage their capacity and resources, and ensure adequate access for beneficiaries.

Service Coordination System:
To streamline processes for dual eligible members, we recommend allowing health plans the ability to use Health and Functional Assessment (HFAs) that may already be in place for their Medicare members to avoid duplication of work and to provide a more seamless experience for members. Having a common assessment will minimize confusion and simplify the process for members who will have to complete an HFA at least twice a year.

Health Plan Personnel:
Health plans with smaller enrollments may not require separate executive directors. Although services and benefits may differ, most of the operational requirements are the same. We recommend allowing the health plan to submit waivers from this requirement.

Beneficiaries A

Question #1
No response

Question #2
No response

Question #3
No response

Question #4
No response

Question #5

- We know that the program had plenty of choice with the three non-profit plans available to the members. We do not think there is any reason to let mainland profit making companies participate in the bidding process. We should not be allowing mainland companies to be making a profit from the most vulnerable people in Hawaii.

- We have been looking at the HEDIS scores and have come to the conclusion that they are not the right tool to be used to measure health plans and providers. They were not developed for the population that Medicaid and the community health centers serve. These patients are much more likely to have numerous problems accessing preventive care and this will decrease the ability of their provider to meet the criteria for good HEDIS scores.

- The way the proposal is written it will not take into consideration that people who are homeless and chronically ill and substance abusers need more care and it will cost more to provide services to these patients. Providers who care for these patients need to be paid a higher rate. There needs to be a risk adjustment for the providers that serve a high percentage of patients who will need more care.

- The community health centers have been working hard to become patient centered medical homes and to provide coordinated care. Separating the behavioral health services from the medical services is not coordinated care.

- Doctors are already turning away difficult and non-compliant patients because they lower the doctor's chances of getting the financial incentive offered by the insurers. This allows them to make their scores higher and the patients who are the most vulnerable are left without care.

- We know that one of the QExA health plans made a profit of $66,300,000 from the QExA program in fy 2012. We would rather have the money go to a non-profit health plan because they are reinvesting their profits in improving quality and services to the community health centers.

As the only group that seems to be representing actual patients that is responding to these issues we would like to be included in any further information or meetings that will be held on these issues as they relate to this RFP.

Provider A

Question #1
I strongly support the purpose of the QI program to replace the separate QUEST and QUEST Expanded Access (QExA) programs.

Question #2
No response

Question #3
No response

Question #4
No response

Question #5
I would however urge the DHS to strengthen measures required to be taken by health plans and DHS to enforce provider compliance with their contracts with the health plans. Frequently, providers do not adhere to the specific requirements DHS has listed on page 9 of the RFI and suffer no consequences as a result of their non-compliance. This and the health plans' ability to present, with impunity, provider listings to consumers that are filled with substantial inaccuracies seriously erode access to quality health care that the program embraces. It is apparent from page 6 of the RFI that the DHS does plan to establish contractual accountability among the State, the health plans and health care providers, and I would hope that measures established to address existing problems in this area will be strongly assertive.

Provider B

Question #1
This plan may not discourage plans from bidding, however, there is a concern that the population of the aged, blind and disabled may not be served as well unless the plan has had experience with serving this group of people with special needs.

Question #2
A provider network sounds like a good idea. I don't think it would discourage health plans from bidding but it would put an extra burden since so many services must be addressed as part of the proposal submission.

Question #3
Requirements that are already established shouldn't cause much of a problem, however, PCMH is still evolving and some providers are not fully educated on what this involves or are resisting it. I don't know if new practices will encourage or discourage bidders. In the long run, I think these new practices will benefit the patients.

Question #4
Even if an applicant passes the technical provisions, there are cautions that an out-of-state for-profit plan may not have the same cultural sensitivities along with the profit motive that may result in them backing out or leaving after being awarded a contract.

Question #5
One of the QUEST health plans serves the Medicaid population, and many of these patients who are assigned to community health centers cost more to support than patients without complex health issues. One of the QUEST health plans helps support community health centers and should be receiving more equitable compensation for the more complex patients.

Advocacy Organization A

Question #1
No response

Question #2
No response

Question #3
No response

Question #4
No response

Question #5
We are troubled that the latest program details contained in the QI-RFI do not adequately address numerous concerns we addressed previously; in particular, we draw your attention to plan assessment, auto-assignment, and risk adjustment. We re-emphasize the following:

- Plan assessment tools such as HEDIS and CAHPS are limited when evaluating health outcomes of the vulnerable populations that community health centers serve. These measurement tools do not take into account the social factors and medical/behavioral complexities that many of these individuals are faced with such as homelessness and access to care.

- Community health centers are not on a level playing field with other health care providers. Government regulations in Medicaid, including plan assessment, should aim to level the playing field being measured rather than tipping the scale further out of balance. Health centers are placed at a disadvantage by the State when any shared savings that may trickle down to providers flow from health insurance plans and are based largely on these limited measurement tools.

- Quality outcomes, while critical, will take time to demonstrate improvement. A stronger emphasis must be placed on community investment on the front end. Instead of using an equal-division algorithm, plans should be rewarded for investing in the communities they serve. In doing so, communities would be strengthened and healthy market competition in Medicaid will be fostered.

- Social determinants of health must be included into risk adjustment considerations. These determinants include things such as co-morbidities, early onset of chronic disease, education, income, and homelessness into computing capitation rates.

We request a continued dialogue about these and other topics that arise throughout the upcoming bid process for the DHS QI. It is our "collective responsibility" to find ways to work together to achieve better results and improved efficiency.

Advocacy Organization B

Question #1

Our organization encourages this department to place strong emphasis on prevention and quality health care. All health centers must transform to the Patient Centered Medical Home model and move into the more cost savings ways of prevention and patient based health care. If a health plan is discouraged from bidding because of these requirements, perhaps they do not belong in the State of Hawaii. Integration and streamlining the enrollment process and acknowledging the special and changing needs of this population are applauded.

Question #2

Our organization understands that when you are developing a relationship with another entity that could become a partner or in this case a provider, allowing for an LOI allows the plans to file their proposals using the potential providers LOI as part of their plan. By allow this mechanism for plans, it could allow for more plans to expand their potential provider network and programs after the award since they have LOIs in place. But the DHS must have assurances that these LOI are in fact developed into a provider contract as we have seen many health plans state in their web sites that they have a certain provider relationships only for the beneficiary find out later that the beneficiary is non-participating.

Question #3

This organization has better understanding of the State's Transformation plan and especially the value of the Patient-Centered Medical Home (PCMH) criteria. With PCMH as the core, the center will evolve into the quality measures reporting and case management within the center. With the amount of work that has been done by the State, the Hawaii Primary Care Association and the National Association of Community Health Centers, any plan that does not have this as their core plan should be deemed substandard. There is a need to return case management closer to the provider. However, with that being said, DHS should also be involved in and assist in ways to bring the provider into this frame of mind. In our many interviews with providers of all levels, there is not any understanding of this transition and a willingness to conform or change regardless of the plans requirements. When dealing with the rural areas with aged providers, the plans will need State and DHS support in retraining providers to this new concept of the delivery of care and the quality responsibility of the provider. This cannot be just left to the plans. The providers in dealing with this special needs population and now with having as many as five or six different health plans along with different billing and other administrative procedures could discourage doctors and other providers from doing Medicaid.

Question #4

We require further clarification of the statement *"In other words, health plans that pass the technical proposal would …"* The ambiguous nature of this statement creates concern. In looking back in history to the first RFP for the QExA, there was substantial negative public and political reaction as the technical proposal of that prior RFP was created in such a way that no local Hawaii insurer was able to or willing to compete. Only two for-profit corporations were awarded the contract. (Please note that these awardees have shown their ability to engage the population and the community and have now proven themselves as local corporations.) Because of this, we lost years of experience and involvement of physicians and other providers that were currently providing services to the QExA population. Any awardee must be made aware of the history of the process and be required to start to build bridges of relationships of those serving this population.

It is the hope that in the development of this new RFP, the technical proposal will take into account the diversity of healthcare insurers of the QExA population.

The RFP should not only look at the accomplishments of the existing two contractors in creating the new "technical proposal" but do it in such a way that it is fair and has flexibility in addressing the various ways that different insurers approach the "technical" aspect of the delivery of service to this special population. Developing the technical requirements that allow for all qualified insurers to participate would level the playing field, expand the competition and diminish the anxiety of having only two insurers for the QExA population.

Also, in reviewing the responses, this organization would like to see that plans not be evaluated on their size and history in providing services to the employees in the private sector that have employment standards applied to them. This special population has special specific needs that require a special understanding by a health plan. Now that Medicaid will require the integration of both the QUEST and QExA population, bigness may not always be the technical right way of providing proper, quality and complete care and coordination of services.

In response to the question on health plans locations on the outer island, as a state organization we really has a problem with allowing health plans to cherry pick what outer island they want to participate on. This is patently unfair to all the outer islands. The outer islands have as much right to the same quality and availability of insurance plans in the QI as do the beneficiaries on Oahu. Health Plans should not be given a choice. If it is financially infeasible or if requiring presence on all islands, perhaps the RFP could look at the size of the plan and if they have coverage on an island because of their participation on the Prepaid Employee plan, they then must also provide QI coverage as a mandate on each island that they are located. There should also be a ratio of the size of the insurance company and that should determine how many islands they will participate on. The size of the insurance company should be based upon their presence only in Hawaii and the actual insurers that they currently insure. In other words, competition is a factor in government insurance to create competition. The RFP should be creative so that more insurance companies will be able to develop proposals that will bring that competition and perhaps new, efficient ways to deliver quality, high caliber care to their insured's and the population of ALL Hawaii Islands.

Question #5

There are many other concerns and suggestions to make the RFP work holistically with the quality deserved by the beneficiaries. Below are some various thoughts and suggestions:

- Maintaining eligibility is of the utmost importance to keep the delivery and payment/reimbursement system seamless. Providers are overburdened with regulatory paperwork so effort must be made to keep clients insured. Insurers must make certain that clients/members have continuity of their eligibility.

- Health Plans should be required to work with community organizations, community health centers and social support services, including long-term services and supports. They should be involved at the front end in working with community and social support services in providing assistance for clients to obtain and maintain eligibility for not only health care, but also disability benefits, housing, personal need and legal services, and any additional support services that are needed.

- Health Plans should be required to work and coordinate with the Hawaii Health Connector and the

Market Place Assistors that are being contracted to do outreach into the community across the State. This would be a collaboration that would help to reach the vulnerable population while the outreach effort and the public announcements of the health connector are being provided to the public. There will be substantial public awareness and HS and the health plans (regardless of their intention to participate in the exchange) should be required to collaborate with outreach.

Meaningful drug coverage and prior authorization forms.

- There should be a process to require managed care plans' formularies to be developed and reviewed by an independent pharmacy and therapeutics committee. A majority of the members of this committee should be practicing physicians, practicing pharmacists, and administrators from the community health center community.

- Assure that there is a continuity of care for members with chronic conditions. It should be required that members with ongoing medication needs to treat and manage their chronic condition have continued coverage. Continuity of coverage for a maintenance drug prescribed within the last six months, even if the drug would be otherwise non-preferred or subject to a prior authorization requirement, for as long the patient's physician continues to prescribe the medication.

- Establish a standard form for plans to provide to physicians seeking authorization for a covered drug, including streamlined process for handling request for expedited review for urgent or medical emergencies. While Medicaid has established a standardized form, DHS must address this n the RFP.

Adequate Network:

A complete provider network for this proposal is a must. This organization still hears that certain plans that are participating the present program, fail to have an adequate provider network and care coordination. While there are many reasons why these plans may not have adequate networks in place, the DHS must continue to make this a mandatory requirement and must have administrative mechanisms in place to make sure this happens and be able to verify that what the plans says is in fact true. Quite often some plans have reputations that preclude physicians from wanting to participate. We find that the few remaining physicians in Wahiawa do not accept any new patients (QUEST and QExA included). In these hard need areas, DHS must do what is necessary to help the providers develop relationships with the plans so that the physicians will understand the need for their services. In our interviews with the physicians many of the problems stem from the many different systems of the plans, and the cumbersome paperwork and preauthorization procedures. Plans need to be held accountable to make sure that they make it as seamless as possible for the providers.

Advocacy Organization C

Question #1
No response

Question #2
No response

Question #3
No response

Question #4
No response

Question #5
As DHS is certainly aware, the aging population of Hawai‘i will double in the years to come. Simply stated, the coiffures of the State will not be large enough to support an influx of frail seniors in the system. Moreover, the value that residents of Hawai‘i place on caring for our Kupuna motivate us to begin finding solutions NOW so that we can avoid a situation in which large numbers of Kupuna have limited personal resources and a system that simply cannot bear the burden of the enormity of need.

Currently, the Area Agencies on Aging (AAA) across the state report that as long as Kupuna are not deemed eligible for Medicaid services (QExA in particular), the AAAs can provide varying levels of supportive services that assist Kupuna to remain in the community for as long as appropriate. However, at the point of Medicaid enrollment (too “poor” for AAA assistance), those same seniors are deemed not “sick enough” for home and community based services according to either the Medicaid State contract or to the contracted service providers. Prior to enrollment in QExA, Kupuna may receive a variety of supportive services from the AAA; upon enrollment, those services for many are stopped.

The provision of as few as four hours per week of PA 1 or PA 2 services could very well make the difference between an elder being able to live independently at home versus slowly decompensating to the point of requiring an institutional level of care.

Again, with the rise in this population, preventative efforts will be far more cost effective than simply waiting until seniors require HCBS and then providing the service.

We are particularly pleased to see in the RFI the following:
- The QI program will have an emphasis on prevention;
- The QI program will expand access to home and community based services and allow members to have a choice between institutional services and HCBS; and
- DHS shall allow submission of letters of intent (LOI) for HCBS providers as part of proposal submission;

We respectfully request that DHS consider the following in the formation of the RFP for the QUEST Integration program:
- Consider that rather than to “cap” the number of individuals across the state who can receive PA 1/PA 2 services, if a “cap” needs to occur, please consider “capping” the units of service. This adjustment would allow those Kupuna who need only limited units of service to receive those units of service;

- Consider to add Case Management as a service for Kupuna who are not able to manage their own care;
- Consider that the QI, especially for Kupuna, should require that contracted providers expand program philosophies to NOT be limited to the "medical" model. Often, limited HCBS can effectively assist elders to remain at home rather than requiring institutional care. These services are far more effective when authorized prior to individuals reaching Nursing Home level of care. When services are withheld until frailty is maximized, the system is losing the opportunity to intervene effectively and realize cost savings;
- Consider encouraging contracted agencies to work closely with the AAA network. The aging network has an existing infrastructure of home and community based services. We would gladly work with health care providers in the areas of case management, options counseling and HCBS service delivery; and
- Consider encouraging contracted service agencies to partner with the aging network for such evidence-based services as Better Choices, Better Health® (a six-week course formerly called Chronic Disease Self-Management designed to increase patient empowerment and activation), EnhanceFitness™ (an on-going exercise program with demonstrated improvement for individuals over the age of 55 in balance, strength, and flexibility shown to reduce medical care utilization costs), and Care Transitions Intervention® (a 30-day post-hospitalization program demonstrated to reduce unnecessary hospital readmission rates). AAAs offers all three of these evidence-based and highly effective programs.

Thank you for the opportunity to provide input into the RFP process.

Stakeholder A

Question #3 and Question #5

This stakeholder specifically requesting that DHS:

1. **include URAC's Health Plan Accreditation Program among the accreditation options necessary for MCO participation in the QI Program;**
2. **permit plans to report URAC or other publicly-available quality measures that are comparable to the currently-required proprietary HEDIS measures; and**
3. **recognize URAC's Provider Integration Programs as part of its Patient-Centered Medical Home (PCMH) requirements.**

Hawai'i Medicaid and URAC Health Plan Accreditation

Per §432E-11(c) of the Hawai'i Statutes, Hawai'i recognizes any nationally recognized accreditor for managed care plans operating in Hawai'i. Pursuant to Insurance Memorandum 2000-15H (October 31, 2000), Hawai'i recognizes URAC as a national accreditation organization that plans may use to comply with state requirements. In the past, QUEST and Quest Expanded Access (QExA) MCOs have obtained accreditation from either the National Committee for Quality Assurance (NCQA) or URAC, but those that had chosen URAC have recently been moving over to NCQA due to Med-QUEST RFP requirements.

Past QUEST RFPs (e.g., RFP-MQD-2008-006) have recognized URAC, AAAHC, and Joint Commission health plan accreditation in addition to NCQA accreditation, but other RFPs (e.g., RFP-MQD-2007-002, RFP-MQD-2011-003) have illustrated DHS' inclination to recognize only NCQA accreditation. DHS has provided rationale that it solely requires NCQA accreditation "not only for the benefit of our clients but also because it is consistent with our use of quality measures and with the requirements of the Balanced Budget Act."

This stakeholder believes that this loss of recognition in RFPs and resulting movement in the marketplace may stem from analysis of a past iteration of URAC's Health Plan Accreditation Program, and that Hawai'i's forthcoming QI RFP must reflect URAC's current Program.

DHS must understand that requiring health plans to obtain only NCQA accreditation and to report only their proprietary HEDIS measures undermines healthy competition among accreditors and forces plans to use an outmoded, inflexible approach to measuring plan quality.

This stakeholder encourages DHS to include nationally-endorsed, publicly-available, outcomes-based measures in the new QI program for the following reasons:

1. **Measures used in a public sector program should be nationally endorsed and in the public domain, and not be subject to barriers related to proprietary interests.** While we do not wish to infringe on an entity's intellectual property rights, we believe that when proprietary measures are used in publicly-funded programs, they should be treated as a public good and made open to all interested parties.

2. **All accrediting entities responsible for these measures sets should have a level and competitive playing field.** Because HEDIS measures are copyrighted by NCQA, other accreditors must obtain NCQA permission to use them—not likely, given that NCQA views them as competitors. Should

DHS endorse only HEDIS, this will then effectively grant NCQA a monopoly for the accreditation of Hawai'i's managed care plans. This is counter to public policy interests promoted through HHS's approval of multiple accrediting entities for Exchanges and to its goal of national measures harmonization, and undermines the continuous plan quality improvement that results from a fair and level playing field.

3. **Federal programs' quality reporting requirements need to be aligned.** While HHS is allowing all Health Insurance Exchange plans to use any HHS approved accreditor and that accreditor's measure set, other state/federal programs, such as Medicaid, still require some HEDIS measures to be reported instead of allowing comparable measures that are publicly available. Current dependency on proprietary HEDIS measures for these programs discourages competition among accreditors, critical for encouraging innovation in quality measurement and ratings of health plans.

HHS has made it clear it wants a new approach to health plan quality measures and ratings, which is why it has opened the doors to URAC and other accreditors to help build a harmonized system for nationwide Exchange usage in future.

URAC's Health Plan Accreditation aligns with federal external review regulations.

URAC's Health Plan Accreditation aligns with CMS' Medicaid external quality review (EQR) regulations, including access to care, structure and operations, and measurement and improvement. (*See* 42 CFR 438.204-242.) Per Sec. 4705(a) of the Balanced Budget Act of 1997 and CMS non-duplication regulation (42 CFR 438.360), states are able to incorporate accreditation in their Medicaid quality strategies to partially or wholly replace a Medicaid review by the state or its EQRO. Many states, including Florida, Georgia, Louisiana, Michigan, Minnesota, Nebraska, Ohio, South Carolina, and Wisconsin, recognize URAC Health Plan Accreditation as meeting all or part of the requirements a Medicaid plan must fulfill. URAC is currently working with CMS for official recognition for Medicaid EQR.

URAC's Suite of Provider Integration Accreditation Programs aligns with established value-based purchasing standards and Hawai'i's Healthcare Transformation plan.

Recommendations and Conclusion

This stakeholder believes that quality measures and the information they provide should be a *public good*, and, in a public program such as Medicaid, barriers to their use—particularly proprietary interests—should be eliminated. Further, restricting MCO choice to a single accreditor, especially when multiple accreditors have been approved by HHS, contravenes HHS' intent to create a level playing field for all and to harmonize quality measures.

This stakeholder urges DHS to include URAC's Health Plan Accreditation—and use nationally-approved, publicly available, and outcomes-based measures such as URAC's—in its QI RFP, thus aligning with HHS's policy of allowing plans to choose freely which accreditor and related quality measure set best meet their needs for Health Insurance Exchanges. Hawai'i Medicaid MCOs would then have access to the same HHS-approved accreditors that health plans will be using to participate on the Hawai'i Connector beginning next year.

DHS should not mandate use of HEDIS measures, and consider working with HHS to establish a policy that requires waiver of proprietary interests for measures sets in publicly-funded programs.