Summary of QUEST Request for Information (RFI)
RFI-MQD-2011-002

This document is a summary of Request for Information (RFI) responses for QUEST that was posted on January 21, 2011 with responses provided on February 11, 2011. 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 primarily from health plans. In addition to health plans, DHS received a response from one advocacy organization. DHS has reviewed all the RFI comments and is analyzing the responses for consideration in the development of the QUEST RFP.

The QUEST RFI posed the following questions:

1. The following are approximate numbers of QUEST, QUEST-Net, QUEST-ACE and BHH eligible clients on each island:

Oahu:	134,475	Kauai:	12,885
Hawaii:	46,581	Maui:	23,237
Molokai:	2,508	Lanai:	541

   Based on these numbers, and assuming that only plans currently licensed in Hawaii with an established provider network were able to bid, would you recommend any limitations on the number of plans per island? If so, how many plans on each island and why.

2. The DHS is considering permitting all health plans that pass the technical scoring threshold to participate in the program. In addition, DHS would have actuarially sound capitation rates determined that would be the same for all health plans. In other words, health plans that pass the technical proposal would essentially be paid the same amount for the same services. Would this encourage or discourage your plan from bidding? Why?

3. The DHS is considering implementing the use of co-payments that are closely regulated by CMS and may have a monthly limit based on an individual's monthly income. Co-payments for what services would be most likely to decrease inappropriate utilization while being less likely to negatively impact health outcomes?

4. Should the DHS pursue the use of quality measures in the auto-assignment process, how much weight do you think the DHS should give to quality versus price? Why?

5. The DHS is concerned about continuity of care for members transitioning from QUEST to QExA health plans. What would you suggest the DHS does to assure that members are not precluded from continuing to receive treatment from their established physician? How should the DHS assure that health plans are not actively precluding physicians from continuing to care for their patients who are moving to another program, as in the event of becoming disabled?

6. What role should the health plan have in assisting members with maintaining eligibility?

7. DHS is starting to plan for the implementation of the Affordable Care Act (ACA). What models of care delivery should DHS consider having its health plans pilot and/or support to improve quality and efficiency of care? What should DHS require of its health plans regarding ability to incentivize meaningful use of electronic health records, to receive, analyze, and make payment based on clinical data transmitted through EHR/HIE, and to provide a patient health record?

8. All health plans in the current QUEST program must be accredited by one of several different organizations. The National Committee for Quality Assurance (NCQA) has committed significant resources to not only accrediting health plans, but also setting standards for managed care nationwide. DHS utilizes the guidelines established by NCQA for its quality program. Would DHS requiring that all health plans in the QUEST program achieve NCQA accreditation encourage or discourage your health plan from bidding on this contract? Why?

The following summaries the responses received from the QUEST RFI.

Health Plan A

Question #1
Suggest the following minimum number of contract awards per island:

Island	QUEST Residents	Number of Health Plan Contracts
Oahu	134,475	4
Hawaii	46,581	3
Maui	23,237	3
Kauai	12,885	3
Molokai	2,508	2**
Lanai	541	2**

They would recommend that in order to be awarded a contract on Oahu, a bidder must also bid and be awarded at least one neighbor island. They would also suggest that Molokai and Lanai be a combined bid so that the health plans awarded contracts are on both islands.

Question #2
A set rate for all bidders would neither encourage nor discourage this health plan from bidding.

However, set rates should be fair, equitable, and to avoid plans attempting to "cherry pick", the common base rates must be fairly risk adjusted. In addition, set rate only cover medical costs and plans be allowed to competitively bid the retention portion (taxes, administrative costs, and profit). The final rates (medical and retention) could then be used in conjunction with the technical score to determine auto-assignment.

Question #3
If copayments are found necessary, they would advocate a tiered program to ensure that they do not put too much of a burden on their neediest populations. Perhaps establishing copayments for only those adults over 100% FPL, and only on certain benefits, would be best.

They suggest looking at copayments for unnecessary emergency services and for the use of name brand drugs when there is generic availability. However, in order to support our provider partners, we suggest that if copayments are implemented that the provider community be given ample time and support through the process.

Question #4
This health plan stands behind quality of care as an imperative for any health plan providing for our most fragile populations. They suggest that the use of quality measures in the auto assignment process will be difficult to administer fairly. All of the potential measures are extremely subjective. Not all health plans serve equivalent populations in regard to social and healthcare risk factors. Unfortunately, it is very difficult to compare

quality measures across health plans in a way that accounts for these factors. They would recommend that the DHS continue to use the current auto-assignment process which is comprised of the bidder's technical and business proposal scores.

Question #5
It is this health plan's policy to assist members during health plan or program transition to prevent interruption of care, which includes allowing a member to continue treatment with an established provider. It has never been the practice of this health plan to preclude physicians from continuing to care for members who may be transitioning to another program.

Based on this health plan's experience transitioning members amongst QUEST programs and health plans, the simplest transition is one that is in-house. They would suggest that the best option for ensuring continuity of care for members transitioning from a QUEST to a QExA program would be to re-bid the QExA program. Allowing the QUEST health plans to also participate in the QExA program would ensure that members were able to continue receiving care, no matter their program designation.

Question #6
This health plan believes that the health plans should have an active role in assisting members with maintaining eligibility. They currently support the maintenance of eligibility information through provider and member communications, through the processing and reconciliation of daily eligibility files, through the consistent use of DHS Form 1179 and through timely newborn notifications. This health plan would be willing to assist members with maintaining eligibility through other means as well. They would also be willing to support DHS in determining continued eligibility by working with or following-up with providers to help determine eligibility status of our members.

Question #7
This health plan suggests that the DHS consider strongly encouraging health plans to implement innovative, collaborative programs in response to Health Care Reform rather than mandating certain programs or initiatives on all of the plans. This allows plans to remain creative in experimenting with new care delivery models and payment reform. As Health Care Reform continues to develop and change through the coming months, we would appreciate the flexibility to find reform models that work best for our members and our providers.

Question #8
Requiring NCQA accreditation would neither encourage nor discourage this health plan from bidding on this contract; however, this health plan would strongly discourage the DHS from requiring that health plans obtain NCQA accreditation. If DHS determines to mandate NCQA health plan accreditation, they would suggest that any health plan currently holding health plan accreditation in Hawaii be grandfathered in until their current accreditation expires.

Health Plan B

Question #1
This health plan supports 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 as well as encourage member satisfaction. At the same time, they consider it important that all Medicaid managed care plans, especially those administering a PCMH (patient centered medical home) model of delivery, have viable business models which can be adapted to varying 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, disruption of member care, and create additional administrative burden on network providers who may be discouraged from continuing in the QUEST program. For these reasons, the goals of continuing with high performing health plans and reducing unnecessary health plan turnover in addition to beneficiary choice of health plans should be part of the decision making process DHS uses when deciding if plan participation should be limited by island.

Question #2
One benefit of a competitive bidding process is that it provides DHS a means of determining the reliability of a health plan's proposed operations as described in its technical proposal. With the QUEST program, set capitation rates would presumably preclude DHS the benefit of seeing the range of health plan bids, and another means of evaluating the value a health plan provides to QUEST members and DHS. This health plan's acceptance of a QUEST contract under the scenario DHS described above would depend on the capitation rate's adequacy considering the scope of the contract. This health plan recommends that DHS ensure that the capitation rates appropriately recognize the added-value of implementing PCMH concepts.

Question #3
Co-payments can have a significant impact on low-income populations as well as providers, and this health plan has carefully considered these impacts while recognizing that appropriate cost containment is critical to the QUEST program. In the past this health plan has specifically discussed co-payments for emergency room (ER) utilization and selected pharmaceuticals with DHS. They have also received feedback from providers in their network who are concerned about members who fail to meet appointments. Perhaps in these situations, DHS could consider allowing providers to charge the member a fee to discourage this type of member behavior. When considering each of these options, CMS guidelines and potential negative side-effects on health outcomes must be considered.

Question #4
This health plan believes auto-assignment should be based on quality. Developing a quality-based auto-assignment algorithm will align provider and health plan incentives around providing high quality care. This would benefit both QUEST beneficiaries and the program as a whole. They also recommend verifying that capitation rates support

potential financial risks associated with auto-assigned members such that members continue to have access to the best available care.

Question #5
This health plan is committed to continuity of care for all of our QUEST members, including those transitioning to QExA health plans. They suggest physician education as a key element in improving physician support of disability referrals. Providers must be convinced that their patient's care will not be compromised during or post-transfer to a QExA plan, and that the additional benefits and services available to members of QExA plans will be valuable to their eligible patients. This provider education should be coordinated by DHS in collaboration with QUEST health plans, QExA health plans, and Hawaii physician organizations.

Question #6
Helping members maintain their health plan eligibility is crucial to promoting timely access to quality health care. Loss of eligibility introduces barriers to care and also burdens providers with the potential for more uncompensated care. This health plan is interested in participating in discussions to explore how health plans can assist DHS in helping members maintain their eligibility with the resources we have available and without duplicating efforts.

Question #7
This health plan supports the DHS goal of advancing the concept of patient-centered medical home (PCMH) for the purpose of improving access to appropriate health services throughout the full continuum of care as described in the report, *Hawaii Med-QUEST Quality Strategy 2010.*

This health plan recommends a phased approach in which all QUEST plans are required to implement medical home for a small percentage of their enrollees according to a specific timeline and defined PCMH goals. This would allow participating providers to learn from each other in a controlled environment and lead further practice change throughout the provider community in Hawaii.

On behalf of our provider network, this health plan proposes working with the State to finalize the formal written plans (including the Health Information Technology Planning Advance Planning Document) necessary for Hawaii to qualify for 90% federal matching funds for meaningful electronic health record (EHR) use. These initiatives support the DHS goal of using clinical data to improve overall population health and individual QUEST member experience.

Question #8
This health plan supports the value of NCQA's accreditation process and would welcome its introduction as a contract requirement. If all QUEST health plans will be required to achieve NCQA accreditation we would suggest allowing currently participating health plans to align their currently allowed accreditation termination date with any new NCQA mandate.

Health Plan C

Question #1
This health plan's mission is to provide affordable, quality health care services and to improve the health of our members and the communities we serve. They want to continue providing comprehensive care to QUEST members and appreciate the opportunity to respond to the state's concerns and interests.

They support that all qualified health plans interested in participating in the QUEST program be allowed to provide services to this population.

Question #2
This health plan fully supports additional health plan participation in the QUEST program and all health plans that pass the technical scoring threshold should be allowed to participate.

The bidding and procurement process should allow for a range of rates to enable more health plans to serve this vulnerable population. There should also be an additional pay for performance (P4P) reward based on quality and satisfaction measures.

This P4P reward should not be a with-hold from capitation; but instead, set-up as a separate pool of funds that is fully distributed to the plans that meet the thresholds. The P4P must be sizable enough to encourage health plans to improve their performance.

Question #3
The administration of co-payment limits on a member-level basis would be cost and administratively prohibitive to administer for the providers, health plans, and DHS. This health plan believes in coverage that supports preventive services, early screening, chronic disease management, and appropriate care at the appropriate time. Benefits design must be carefully considered so as not to create barriers to care. However, they believe there are some ways to introduce patient responsibility through the use of co-payments that are also consistent with recently published federal guidelines.

Shifting the burden of co-payment collection and the potential for increased bad debt to the provider community may discourage providers from participating in Medicaid. However, meaningful co-payments for services such as emergency department (ED) use would likely curb inappropriate utilization of a high cost service and minimizes the number of providers affected by co-payment billing and collection issues. Co-payment amounts could also be tiered based on the type of setting. For example, a visit to an urgent care facility would have a lesser co-pay than at an emergency department. Should an ED co-payment be instituted, this health plan supports waiving this charge if the patient is admitted into the hospital.

Question #4
Auto-assignment should be based on the lowest cost health plan. Cost savings can be achieved through quality improvements and increased efficiencies in care delivery.

Question #5
As patients move from QUEST to QExA, their medical and social needs require heightened coordination as well as an additional breadth of services including a different level and more frequent use of specialty care. The physicians that participate in the QExA health plans are equipped to meet the needs of this population. This health plan does not see continuity of care as an issue since all providers are required to do routine transition of care for patients. As an example, acute trauma patients will be transferred from an acute setting to a rehabilitation setting with physicians collaborating and communicating to ensure a smooth transition for their patients. Also, the majority of patients that become eligible for QExA qualify on a permanent basis; therefore, care going forward should be where they will be receiving care in the long-term.

This health plan would like the flexibility to be able to freeze and unfreeze enrollment to mitigate these capacity issues, with the understanding that newly eligible QUEST members would be allowed to enroll with the QUEST health plan that participates with their physician, regardless of the health plan's freeze status.

Question #6
This health plan is concerned that further requirements would discourage health plans or providers from participating. The administrative burden created by health plans assisting members with maintaining eligibility will increase cost. This process is better served in a centralized administrative department that has the expertise and systems to be able to work with the population, as is currently done by the State.

Question #7
As introduced by health care reform legislation, developing and becoming a certified Patient Centered Medical Home (PCMH) should be considered as a model of care delivery to support improved quality and efficiency. To encourage these pilot programs, they recommend that DHS provide financial incentive through additional payments.

It is unrealistic to require all health plans and providers to implement an EHR in the near-term; however, they support the use of EHR for purposes of patient safety, quality, and continuity of care.

Question #8
NCQA accreditation is a widely recognized symbol of quality. It assures that a health plan continues to achieve and maintain a high standard of excellence.

While this health plan applauds DHS for raising the performance of healthcare organizations, they are concerned that a requirement will discourage plans and providers from participating.

NCQA accreditation is costly and resource intensive, and health plans that achieve and maintain the accreditation should be rewarded financially at different levels in alignment with the different levels of accreditation. Health plans that have not made an attempt to become NCQA accredited would then have an incentive to achieve a higher standard.

Health Plan D

Summary of Quest Program Design Recommendations

QUEST PROGRAM DESIGN		
QUESTION/ DESIGN ELEMENT	**RECOMMENDED**	***ALTERNATIVE*** ***(if competitively procuring)***
1. Number of health plans per island	Do not impose limits by island	
2a. Health plan selection process	Award contracts to currently-licensed plans that meet technical threshold	*Award three or four contracts through competitive procurement*
2b. Capitation Rate Setting	Establish uniform capitation rates for use across plans to ensure financial stability during initial low enrollment period for new entrants	*Permit health plans to competitively bid rates and incorporate results into award decisions*
3. Co-payments to reduce inappropriate utilization	Consider alternative methods to reduce inappropriate ED use, including case/disease management and targeted member and provider interventions	
4. Use of quality measures for auto-assignment algorithm	Incorporate quality measures (HEDIS® and CAHPS) as data becomes available. In the short term, use algorithm to facilitate enrollment growth among new entrants until minimum enrollment threshold is met	*Incorporate cost into algorithm to encourage competitive capitation rate proposals. As new entrants reach minimum enrollment threshold, set at 50 percent quality and 50 percent cost*
5. Assuring physician continuity of care for members transitioning from QUEST to QExA	This health plan supports operating a single network for both programs, allowing members to remain with their physician and other providers	
6. Role of health plan in maintaining eligibility	Health plan assists in outreach activities to aid in recertification	
7. Adopting ACA models of care and encouraging use of electronic health records	Incorporate medical and health home concepts into QUEST design. Collaborate with health plans to develop strategy (including use of incentives) for converting providers to EHR use	
8. Requiring NCQA accreditation	This health plan supports adopting this requirement	

Health Plan E

Question #1
Given the opportunity of potential membership, this health plan would suggest that Oahu could support up to three plans if each of those plans had membership on other islands as well. In the case of Kauai, Hawaii, and Maui, they would suggest that the plan offerings be limited to two. In light of the very small membership on Molokai and Lanai, it would be logical to offer only a single plan.

However, given the referral patterns to Oahu, the Straub connection to Lanai and Queen's connection to Molokai, and being able to offer a choice of QUEST plans, two plans for Lanai and Molokai could be feasible.

Question #2
This health plan is comfortable working in markets with either scenario as long as the rates are actuarially sound and there is sufficient transparency in rate development to evaluate our ability to meet any established managed care savings.

That said, the DHS suggestion that any plan meeting the technical requirements would be able to participate would be problematic. This has the potential for allowing more plans per island than was recommended in our response to *Question 1* above. In order to ensure meaningful membership, plan participation should be limited by island. Successful competitive bidding can occur absent cost proposals. Many states with established rates continue to use competitive procurement to ensure the most experienced and highest quality plans serve their Medicaid programs. If cost is eliminated from competitive procurement, the DHS could use criteria such as network adequacy, experience serving the population and demonstrated quality to achieve a competitive procurement.

Question #3
In order to achieve the stated goal of decreasing inappropriate utilization, this health plan would suggest copayments be applied to those services and in such a way as to create a disincentive to using unless absolutely necessary. Most specifically, co-payments applied to emergency rooms meet these criteria and should disincentivize the use of these costly services for conditions that could be easily and safely managed in physician offices or Community Health Centers.

This health plan would discourage the use of co-payments for primary care physician visits. In many instances, emergency and other high cost services are used in lieu of primary care unnecessarily. To encourage an increase in primary care and limit any barriers to individuals seeking primary care, co-payments should not be applied.

Question #4
Following the initial year, this health plan recommends the DHS establish an enrollment algorithm that is focused on quality metrics that demonstrates plan improvement year over year. They would also recommend a forum in which plans would be able to make

recommendations for appropriate and meaningful quality metrics. They would recommend that the quality component of the algorithm be given more weight than price.

Question #5
Continuity of care is an important consideration in any program. 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 to QExA:

- ***Prior Authorizations:*** Require health plan(s) to honor all prior authorizations from QUEST providers.
- ***Out-of-Network Providers:*** Require health plans to authorize an enrollee's existing out-of-network providers for medically necessary or functionally necessary services until the enrollee's records, clinical information and care can be transferred to a network provider.
- ***Medically Necessary Covered Services:*** Require health plans to authorize all medically necessary covered services without any form of prior approval and without regard to whether such services are being provided by contract or non-contract providers and provide for the continuation of these services for the lesser of 90 days or until the enrollee has completed the Health Risk Assessment and/or Comprehensive Health Status Assessment.

Obviously if the current treating provider is contracted with QExA plan then continuing the physician/patient relationship should not be an issue. If the treating provider is not a contracted provider of the QExA plan, the QExA plan should be required to attempt, and document such attempt, to contract with the current provider. In the event the provider is unwilling to contract with the QExA plan, and the plan has a provider meeting the access standards in its contract with DHS, the QExA plan should be allowed the opportunity to transition the beneficiary to a new contracted provider.

Question #6
This health plan believes eligibility processing is a function best performed by an entity independent from health plans and can be efficiently performed by DHS or by a specialized third-party enrollment broker. Health plans can play an important role in reminding members about their renewal dates and requirements.

Question #7
This health plan believes health plan based managed care programs, built upon the foundation of a Medical Home, provide the best model to ensure Medicaid populations receive high quality cost effective care. This health plan supports the fullest possible adoption of EHRs which we believe is crucial to enhancing the quality, safety and cost effective delivery of care.

Question #8
This health plan supports a requirement that health plans be accredited or seeks accreditation consistent with NCQA guidelines.

Advocacy Organization

Question #1
All plans should be required to have a presence on all Islands. We are an island state and plans should not be allowed to cherry pick islands they wish to provide insurance. This is a requirement of our successful Prepaid Health Care Act and our public health plans should be held to the same standard.

This organization supports the concept that competition will develop a better product. It is imperative that there be at least three, but preferably four health plans that will be selected to provide QUEST and QExA coverage. This organization strongly believes that we need more plans participating. There must be at least four plans to give choice and to create competition.

Question #2
Technical scoring is a valid measurement for those health plans that want to participate in the program. However, Hawaii is a different place to provide health care. Not only are we isolated from the rest of the United States and the way that public health care is provided, we are multi-cultural in our people. Medical care has to incorporate the "Ohana". Fairness in the capitation rates is necessary especially in this time of our budgetary crisis, but the capitation must be based upon the needs of the population that is served by the insurer. Also, different islands may require a different capitation rate. This organization sees that the rural areas on the outer islands need more services and coordination of care, especially getting to care, than does Oahu.

Question #3
This organization feels strongly that there should not be any co-payment. This population is already at the bottom of society and co-payments will be an issue. If this does become necessary, than there should be an identified tier of co-payments, a stop-gap amount and most importantly, the providers and physicians should not be held responsible for the collections of these co-payments. DHS will need to incorporate the collection of the co-payments through some State process. Do not place additional administrative burdens on our already over worked provider and hospital network. A co-payment requirement could force the beneficiaries to choose between other needs or their health care, decrease their health care prevention/maintenance which will in turn have a negative impact on our emergency rooms and hospitals.

Question #4
This organization will always be in support of Quality over price. But with the unknowns of the budget crisis this organization is unable to address this issue at this time. This organization feels the auto assign process should not be used to disqualify beneficiaries or lessen competition by assigning a greater number of members to one health plan. Assignment must be population weighted and fair. DHS qualification requirements must be weighted by population.

Question #5

As in commercial health insurance, a patient's relationship and continuity of care with a patient's established physician is expected. This is especially true with the PCP. This organization understands that in the QExA program, there is still a problem with patients obtaining a PCP and this is of great concern. As there is an assumption that QUEST members will be transitioning into QExA, this continuity must be a requirement. By making the health plans responsible for having a complete physician network on all Islands, the continuity will be available as patients are moved to another program.

Question #6
Assisting members with maintaining eligibility is the right thing to do. With budget cutbacks, it would appear easier for the plans to keep their members covered. However, the plans must be reimbursed for these services if this will be a requirement.

Question #7
This organization agrees that the contract should have a process or pilot program that will make the delivery and quality of care more efficient. However the State (DHS) should not through its contract or requirements on the Health Insurers, transfer this concept onto the backs of the provider without proper funding or assistance. DHS should look at the development of the BEACON Grant process on the Big Island and work with providers and health insurers to develop similar programs on all the islands.

Question #8
This organization feels that NCQA should not be used as a tool to disqualify our existing health insurers or insurers that have the capacity to deliver quality health insurance. As the State agency, DHS should have NCQA as a tool for setting standards as seen in managed care programs nationwide. This organization strongly believes that Hawaii as an isolated location, with multi-cultural needs that are not found any place else in the world, this should be a tool but not a requirement. We have a very static population and do not have the numbers in our population to set these types of requirements. Our pool of potential insurers are limited and we need to make sure that the standard is set, but we also need to make sure that it is not so extreme that we lose competition.

Other Items

1. The Hawaii Insurance Law and the Hawaii Prepaid Health Care Law have qualifications and licensing of health insurers that have worked since 1972. This organization recommends that all insurers must meet the level of assets and other requirements before being allowed to participate in the procurement process.
2. There is no consideration for population or any requirement for community development. In delivering health care to the QUEST and QExA population, there must be a balance in the technical scoring with the population experience. We are an isolated, multi cultural population and understanding our people does not come from just technical experience.
3. This organization strongly believes that the QUEST and QExA contracts should be combined and the RFP should include both. This will help with confusion by the beneficiaries (who should be the important voice in this RFP) and will help with continuity of care.