

REQUEST FOR INFORMATION

DEPARTMENT OF HUMAN SERVICES MED-QUEST DIVISION

No. RFI-MQD-2013-005

QUEST Expanded Access (QExA)

The State of Hawaii, through its Medicaid agency, the Department of Human Services (DHS), Med-QUEST Division (MQD), is issuing this Request for Information (RFI) to seek information from a wide variety of stakeholders primarily health plans, advocates, Medicaid clients, and providers. The information received through this RFI will be used to assist DHS in preparing a possible Request for Proposal (RFP) for health plan coverage for its QUEST Expanded Access (QExA) program. The QExA program is a capitated managed care program for individuals 65 years and older or with a qualifying disability at any age. The total statewide ABD client count is approximately 44,900.

The DHS may engage in informal discussions, but, neither the purchasing agency nor interested parties responding have any obligation under the RFI. Participation is optional, and it is not required to respond to any subsequent DHS procurement.

Copies of the scope of services may be downloaded at:

<http://spo3.hawaii.gov/notices/notices>

To receive a copy of the RFI by mail, fax, or email, please contact Patti Bazin at (808) 692-8099 or rfiresponse@medicaid.dhs.state.hi.us.

Responses to this RFI are due on August 10, 2012, 2:00 p.m., Hawaii Standard Time (HST). Please mail or deliver one hard copy response with an electronic version stored in Microsoft Word 2010 or lower and, if applicable, one (1) attachment of existing documents saved in adobe.pdf format on CD-Rom to:

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

OR

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

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

The DHS reserves the right to incorporate or not incorporate any suggestions in the development of a Request for Proposals.

Patricia McManaman
Director

**QUEST Expanded Access
(QExA)**

**Request for Information
RFI-MQD-2013-005
July 20, 2012**

**Department of Human Services
Med-QUEST Division**

INTRODUCTION

The State of Hawaii, 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 possible Request for Proposals (RFP) for health plan coverage for its QUEST Expanded Access (QExA) program. The QExA program is a capitated managed care program for individuals 65 years and older or with a qualifying disability at any age. 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, Hawaii residents.

Background

The State of Hawaii 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. 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.

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 Hawaii, 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, 2008, an additional amendment was approved. The waiver amendment increased the eligibility level from 100 to 200% of the FPL for QUEST-ACE and included terms and conditions related to the newly implemented QUEST Expanded Access (QExA) program.
- 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.
- The current waiver period runs through June 30, 2013. A request for an 1115 demonstration waiver extension was submitted to the Centers for Medicare & Medicaid Services (CMS) on June 29, 2012.

The current goals of the QExA program are to:

- Improve the health status of the member population;
- Establish a “provider home” for members through the use of assigned primary care providers (PCPs);

- Establish contractual accountability among the State, the health plans and healthcare providers;
- Expand and strengthen a sense of member responsibility and promote independence and choice among members;
- Assure access to high quality, cost-effective care that is provided, whenever possible, in a member's home and/or community;
- Coordinate care for the members across the benefit continuum, including primary, acute and long-term care benefits;
- Provide home and community based services (HCBS) to persons with neurotrauma;
- Develop a program that is fiscally predictable, stable and sustainable over time; and
- Develop a program that places maximum emphasis on the efficacy of services and offers health plans not only incentives for providing quality care but also sanctions for failure to meet measurable performance goals.

As with all Medicaid managed care contracts, CMS approval is required prior to its implementation. The contracts must follow all federal statutory and regulatory guidelines pursuant to laws established under the Balanced Budget Act of 1997. As such, the State is seeking to assure that health plans participating in the QExA program are able to demonstrate their ability to:

- Provide high quality care at a competitive price for Medicaid and low-income populations;
- Achieve better health outcomes for their enrollees;
- Offer effective disease management programs relevant to the health needs of Hawaii's low-income populations;
- Document encounters, pay timely claims, and work in partnership with the State to meet measurable performance goals;
- Respond timely to member and provider grievances and appeals;
- Attract and retain membership in their plan;
- Offer long term supports and services (LTSS) in the member's home and community;
- Coordinate care to QExA members who receive some services outside of the managed care system. These services include:
 - The population with a Developmental Disability or Intellectual Disability (DD/ID) that receive their home and community based services under a DD/ID 1915(c) home and community-based services waiver. Case management, HCBS, and intermediate care facility/mental retardation (ICF/MR) benefits for this group are provided through the fee-for-service (FFS) system and are carved out of the QExA health plans capitated benefit package. The QExA health plans coordinate primary and acute health care benefits provided for the DD/ID population. These beneficiaries are ineligible to receive their HCBS under the 1115 demonstration waiver and receive their HCBS that are provided on a FFS basis through the Department of Health's

(DOH) Developmental Disabilities Division. Services in an ICF/MR facility are carved out and provided on a FFS basis as well.

- Adults with serious mental illness (SMI) and/or severe and persistent mental illness (SPMI) are enrolled in a QExA health plan for the delivery of the primary and acute health care services. These beneficiaries' behavioral health services are provided primarily through the DHS' Community Care Services (CCS) program. Some Medicaid Rehabilitation Option (MRO) behavioral health services are currently provided through the Department of Health (DOH), Adult Mental Health Division (AMHD). The AMHD provides these services through a FFS structure through a Memorandum of Agreement (MOA) between the DOH and DHS.
- Children who are in need of Support for Emotional and Behavioral Development (SEBD) will continue to be enrolled in a QExA health plan for their primary and acute health care services. These children will receive behavioral health and substance abuse services as they do currently, through a carved-out, non-risk, capitated plan offered by the Child and Adolescent Mental Health Division (CAMHD) in DOH. However, all inpatient psychiatric hospitalizations shall continue to be the responsibility of the QExA health plan.

The QExA program has been operational since February 1, 2009. As the Department begins to start the re-procurement process, DHS is seeking guidance from stakeholders.

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. Feel free to respond to any /all of the questions posed in this RFI.

Assuming that DHS pursues a Request for Proposal (RFP) to provide health care through a managed care delivery system for QExA, the State is seeking responses to the following questions.

1. As of May 31, 2012, the QExA program is providing services to 44,900 members. The breakout on each island is as follows:

Oahu:	29,769	Kauai:	2,163
Hawaii:	8,960	Maui:	3,556
Molokai:	374	Lanai:	78

Based on these numbers, and assuming that only plans currently licensed in Hawaii with an established provider network for all services are able to bid, would you recommend any limitations on the number of contracted health plans

overall and per island? If so, how many plans and rationale why.

2. DHS intends to determine actuarially sound base capitation rates that would be the same for all health plans with a health plan specific acuity-adjustment. 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 a health plan from bidding? Why?
3. DHS has implemented in its QUEST program financial incentives for performance on HEDIS and CAHPS measures as well as using quality measures in its auto-assignment process. In QExA, how should the DHS incentivize quality?
4. Another factor that DHS implemented in its most recent contract for the QUEST program was the use of outreach services to help members maintain their Medicaid eligibility. What role should the QExA health plans have in assisting members with maintaining eligibility?
5. DHS is planning to participate in the dual eligible demonstration that CMS is offering for beneficiaries with both Medicare and Medicaid health insurance. Beneficiaries enrolled in both programs currently receive only their Medicaid-covered services through the QExA program. Under an integrated demonstration, Medicaid covered services will be combined with Medicare services, and delivered through the QExA health plans. The integrated program creates a single, inclusive package of preventive, acute, pharmacy and long term supports and services (LTSS) that are otherwise covered by Medicare or Medicaid to offer a simplified experience for both patients and providers. To what extent should DHS consider a health plan's ability to participate in an integration demonstration in the QExA procurement?
6. DHS is considering combining both their QUEST and QExA programs into one program Statewide for all Medicaid beneficiaries. The change in practice would allow someone who starts in the QUEST program to continue to be able to receive services from the same health plan when they turn 65 years of age or if they develop a qualifying disabling condition. What factors should DHS consider in making this decision? Would this encourage or discourage your health plan from bidding? Why?

7. There are many goals to the QExA program. One of the goals is to offer long term supports and services (LTSS) in the member's home and community whenever possible. Another goal of the QExA program is to assure that LTSS is offered in a way that supports the social model for provision of healthcare¹ instead of the medical model. Given these goals:
 - a. How do you think health plans should coordinate with non-medical community resources such as housing?
 - b. How do you see DHS assuring coordination between the health plans and community resources?
 - c. What community resources are critical?
 - d. What factors should be built into the program to assure access to services?
 - e. What system should DHS require to be in place to assure its beneficiaries receiving LTSS are assessed using a social model (or holistically) instead of an assessment based solely upon the medical model?

8. Service coordination is a critical component of the QExA program. Service coordinators are responsible for coordinating the primary, acute and LTSS for all QExA members and ensuring the continuity of care. Service coordinators should use a patient-centered, holistic, service delivery approach to coordinating member benefits across all providers and settings. In designing the service coordinator functions of the RFP:
 - a. What activities should the service coordinator be responsible for in working with their members?
 - b. How much time should service coordinators spend with their members? What frequency?
 - c. Should the same service coordinators providing services to members receiving LTSS also be able to provide services for those not receiving LTSS?
 - d. Should all service coordinators meet with their members face-to-face or should DHS allow for telephonic service coordination?
 - e. How should medical care be coordinated with carved-out behavioral health care services?

¹ The medical model focuses on the physical or medical needs of the patient (i.e., quality of care). The social model focuses on the patient as a whole human being including physical or medical needs (i.e., quality of care) as well as the social and emotional needs (i.e., quality of life).

9. The State seeks to improve the quality of care, cost of care, and population health through transformation efforts.
 - a. How can health plans incentivize meaningful use of health information technology?
 - b. What payment reform can health plans implement with the ABD population to encourage effective innovation in healthcare organization and delivery, e.g. group practices, medical homes, accountable care organizations?
 - c. How can the responsibility for care coordination be delegated to providers that are capable of performing that function and how would financial risk accompany it?
 - d. How can health plans be a resource to providers?
10. Are there other thoughts or ideas that you think should be considered?

RESPONSE SUBMISSION

Responses to this RFI are due by 2:00 pm on August 10, 2012, Hawaii Standard Time (HST). Please submit your response 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 clients 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.

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.

If there are any questions or clarifications to this RFI, please contact Ms. Patti Bazin at (808) 692-8099 or at rfiresponse@medicaid.dhs.state.hi.us.