

Kansas Healthy Choices
RFI Responses

	Summary	Potential structure for RFP
Minimum level of benefits	Many respondents recommend a strong slate of required benefits, with an emphasis on prevention. Some bidders also encouraged flexibility in the area of dental, vision, chiropractic, or a more direct relationship with state employee benefits..	CMS requires a number of services be provided, and will not allow more than nominal copays below the poverty line. State does have flexibility in the area of prescription drugs, oral and behavioral health, and vision for expansion population. Issue merits continued discussion with stakeholders.
Different plan types	Nearly all respondents recommend offering only one plan type, and suggest that it be a managed care product.	Likely to recommend a managed product.
HOA pilot	Limited acceptance of concept, would like to see focus on healthy behaviors as incentives.	Expect to request bids for an urban/rural HOA pilot. Will accept, and may encourage, behavioral incentives as part of basic benefits for expansion population or all adults.
Number of plans	Consensus view of multiple plans: 3 at most	Commitment to offer choice to consumers, not likely to exceed three basic plans, plus a small HOA pilot (with CMS approval).
Selection criteria	Bidders generally supportive of suggested criteria but also suggested taking into account the impact on beneficiaries and providers, administrative proficiency, and other criteria.	Working list of rating factors includes strength of network, breadth of benefits, added value and choice for consumers, overall impact on consumers, strength of prevention and wellness, quality of services, transparency and communication with members, expected impact on provider community, and administrative costs.
Coverage areas	Most potential bidders recommend a statewide approach.	Expect to require plans to offer statewide coverage.
Measurement of adequate provider network	Recommended use of GeoAccess tool with certain minimum requirements by caseload and specialty type.	Likelihood that a network will meet or exceed standard geographic access requirements for Medicaid MCOs.

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Lock in period/enrollment process	Most potential bidders suggest a one-month selection period with a lock-in for one year.	KHPA is interested in reducing turnover within and across health plans. This requires an emphasis on maintaining eligibility for a year at time and requiring health plan enrollment for a year at a time. Still investigating administrative and regulatory barriers.
Self-insuring plans	Lots of variation in these responses. General, but not uniform, support for some kind of stop-loss or risk adjustment.	Need for risk-adjustment may depend on final decisions regarding benefits offered, number of plans, and default assignment mechanism. Need further discussion regarding specific mechanisms for additional risk adjustment or stop-loss.
Premium paying/billing	State collection is preferred.	Premiums will not be charged to currently authorized populations. For future populations, the default would be state collection of premiums, as with the HealthWave program.
Billing clearinghouse	Clearinghouse concept acceptable but would need more details before proceeding.	Still exploring the clearinghouse concept, but expect to implement Healthy Choices under existing billing mechanisms.
COB/wrap-around services	Most bidders recommend following current industry standard of provider billing primary, then secondary payor.	CMS' limitation on cost-sharing for under-poverty population limits application of this issue. Wraparound likely to consist of services, rather than cost-sharing. For example, the expansion population could receive a managed, off-the-shelf drug benefit, rather than the current Medicaid/HealthWave product.
Eligibility	Continuous eligibility	KHPA is committed to work towards full-year eligibility.
RHC/FQHC	Some concern about whether community clinics would be encouraged to be part of managed care networks.	CMS requires inclusion of clinics in DRA benefit packages under existing payment arrangements.
Reimbursement	Proposal that capitation rates be adjusted for specific diseases and for this population.	KHPA did not request additional funding for increased rates for services provided to existing beneficiaries. Actuarial value of state employee plan may allow for additional reimbursement, balanced against additional benefits for the expansion population. Issue merits continued discussion with stakeholders.

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Other comments	Concern about moving children from existing plans but encouragement to keep families together. Simplicity is strongly urged. Encouraged to pay higher than "Medicaid" rates.	