

Technical Proposal Question & Answer

Issued on: September 20, 2013

For Request for Proposals RFP-MQD-2014-005

QUEST Integration (QI) Managed Care to Cover Eligible Medicaid and Other Eligible Individuals

Question #	RFP Section #	RFP Page #	Para #	Question	Answer
1	10.400	13	1	For purposes of providing subcontractor information for the technical response, may we limit our discussion to subcontractors with whom we anticipate spending \$25,000 related to the QUEST Integrated contract on an annual basis?	DHS requires that all subcontractors be identified in Section 80.200. DHS does not limit the anticipated spending on the QI contract.
2	20.100	16	Table	When will the DHS release a data book with information on enrollment by program and level of care along with program cost/utilization information?	The data book is considered supporting documentation and will be provided as part of the proposed capitation rates.
3	20.100	16	1	Will there be additional opportunities to submit Technical Proposal questions after the two dates in Section 20.100?	Not at this time.
4	20.100	16	Text Box- Last line	Is the second instance of date to “Request teleconference number for capitation rate orientation” supposed to be “Request teleconference number for capitation rate meeting”? If so, what is the correct date?	See #1 of Amendment #1.
5	20.870	25	2	This paragraph provides that proposals will be considered firm offers binding for 90 days. However, rates will not be	See #2 of Amendment #1. In addition, DHS may request that

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				available prior to submission of the proposals. Will applicants have the opportunity to amend proposals or withdraw, if necessary, after rates are released?	applicants submit a final revised proposal as described in Section 20.870,
6	30.200	66	4, bullet #2	Please clarify that the definition of the term “Subcontractor” does not include parties falling within the definition of “Provider” on page 63 of this section.	See #3 of Amendment #1. Providers are not a subset of subcontractors. Providers’ primary role is to deliver healthcare services defined in this RFP.
7	30.330	68	First paragraph in section	For the Basic Health Option, will an MCO be required to participate in the Health Insurance Exchange?	Not as currently envisioned.
8	30.340	68	3	Please clarify excluded population: -Retroactively eligible only? -Non-medically needy spend-down?	<u>Retroactive eligible only</u> Individuals whose eligibility is only retroactive (i.e., eligibility period ends prior to date of determination). For example, a beneficiary applies on November 15 th and is eligible only through November 30 th with an eligibility determination made on December 15 th . This beneficiary would not be enrolled into a QI health plan and would have received medical services covered in the fee-for-service (FFS) program. <u>Non-ABD medically needy spenddown</u> Individuals whose income is between 133 and 300% of FPL and are not 65 years or

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					older, with a disability, or blind who have incurred medical expenses.
9	30.520	72 and 73	Last (p. 72) and 3 (p. 73)	Please clarify whether members are allowed 15 days or 60 days to change their health plan; Sec. 30.520, page 72, last paragraph says “individuals auto-assigned to a health plan will have 15 days to change their health plan,” Sec. 30.520, pg. 73 paragraph 3 says, “the DHS shall allow members to change health plans without cause for the first 60 days of their enrollment in a health plan regardless of whether enrollment is a result of selection or auto-assignment”	When an individual becomes eligible for QI, they have fifteen (15) days to change/choose their health plan. If a choice is made, the individual will be sent a notice that informs them of their health plan. This notice will give the individual an additional sixty (60) days to change their health plan. Individuals will have two choice periods in the QI program when they are newly eligible.
10	30.520 30.530	72 74	1 1	The exceptions to auto-assignment into a health plan should also include an exception for situations where the health plan has an enrollment cap or limit under Section 30.560.	See #4 of Amendment #1.
11	30.530	74	1	Please provide which year(s) will be considered for the quality measures factored in to the 40% auto assignment algorithm.	CY2016
12	30.530	75	All	The QUEST Integration quality-based component of the auto-assign shall not be implemented until the date indicated in Section 51.800 which is January 1 st , 2016.	No. DHS will enact the algorithm identified in RFP-MQD-2011-002 (current QUEST contract) on July 1, 2014. This algorithm will be revised effective January 1, 2015 for QI.

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				Does this mean that the quality-based algorithm, as described in the current QUEST Contract and in QUEST Memo No. ADM-1220 (December 18, 2012), will not be enacted effective July 1, 2014 because it will be superseded by the algorithm described in the QI RFP?	
13	30.540.1	76	1	Will DHS conduct both an annual APC and the Initial Enrollment 'open enrollment' in 2014?	DHS will only conduct an initial enrollment in CY2014.
14	30.540.2	77	1	Does the addition of '...or commercial plan' refer to HRS 431:10A-115 which provides guidance on coverage of sick and well newborns? If so, can this section reference the HRS requirements? Additional guidance is needed in this area for conformity to Hawaii law.	No. However, we acknowledge that there may be applicable State or Federal law regarding newborn coverage by commercial plans.
15	30.540.3	78	1	Is the "primary insurer" the same as the case name?	Yes.
16	30.540.3	78	1	Can you define 'primary insurer'? What data from the 834 is used to determine 'primary insurer'? Should it be 'primary insured' instead of 'primary insurer' since the health plan/primary carrier is the 'primary insurer'?	See #5 of Amendment #1.
17	30.560	80	3	The RFP notes that "The DHS may	See #19 and #20 of Amendment #1.

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				<p>review health plans enrollments at the times identified in Section 51.800 to enact health plan enrollment cap(s)." However, on page 411 of Section 51.800, it references enrollment "limits" and not "caps".</p> <p>Should the “Enrollment limit for auto-assignment” in the table on page 411 be updated to read 'Enrollment cap for auto-assignment' so that there is consistency in the use of the reference to 'enrollment cap'?</p>	
18	30.560	80	Table	Will a plan that reaches the 60% cap on Oahu still be unavailable for member selection in the KOLEA electronic enrollment process?	Yes.
19	30.560	81	6	Will members who have lost eligibility for more than six months but less than 12 months qualify as an exception under #2 if they have a PCP or behavioral health provider that is exclusive to a capped or limited health plan?	Yes.
20	30.560	82	1	The RFP states “In a health plan with a waiting list for HCBS or “at risk” services when another health plan in the same service area open to new members does not have a waitlist for these services shall be able to enroll in a capped or limited	Being on a HCBS or “at risk” services waitlist allows an individual to request a health plan change at any time to a health plan operating in the same service area without a waitlist. Such a change is exempt from a health plan’s enrollment

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				health plan.” If a member is on a waitlist with their current health plan, can they switch to another health plan during the APC period if the other health plan does not have a waitlist, but has an enrollment cap or membership limit in place?	limit or cap.
21	30.710	88	2	<p>The 2nd sentence of paragraph reads “If the DHS and the SHOTT Program contractor determine that the individual meets the transplant criteria, the individual shall be disenrolled from the health plan and transferred to the SHOTT program.”</p> <p>Can information regarding the timeline for disenrollment from the health plan and enrollment into the SHOTT program for those determined to meet transplant criteria be included in this paragraph?</p>	The timeframe for members to be transferred from a QI health plan to SHOTT varies based upon needs of the member. DHS will not make this change to the RFP.
22	30.750	94	1 st paragraph, 1 st bullet	<p>The clinical criteria to end or suspend additional BH services for SMI/SPMI members include, “The member is unable to engage or demonstrate benefit or maintenance of benefit from additional services despite maximum intervention for at least 6 months.”</p> <p>Does suspension of benefits include intensive case management?</p>	<p>If the Community Care Services (CCS) member benefits from intensive case management then they would not be discharged from CCS. If a member has not benefited from efforts of intensive case management, then suspension of benefits would include intensive case management.</p> <p>If someone requires intensive case</p>

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				<p>If a member is released from the SMI/SPMI (CCS) program because of the above criteria, is the health plan to which the member is assigned responsible for assuming BH –related care/service coordination activities for this member?</p>	<p>management (i.e., BH related care/service coordination), then the health plan should refer their member to CCS for provision of services.</p> <p>Health plan members with a SMI/SPMI diagnosis not receiving services from CCS may have other special health care needs (SHCN) that the health plan would need to address through their service coordination system.</p>
23	30.750	95	7	<p>This paragraph references performance incentives. Will they be included in P4P, described in Section 60.200?</p>	<p>Not at this time.</p>
24	30.820.1 40.720.1	96 167	1 1	<p>Section 30.820.1 applies to children and adolescents ages three through twenty. However, Section 40.720.1 requires DOH to provide these services to children/youth less than 21 years of age. Please clarify the age discrepancy.</p>	<p>Ages three through twenty is consistent with less than 21 years of age (or up to the age of 21). Both of these statements refer to the Child and Adolescent Mental Health Division (CAMHD) providing additional behavioral health services. Health plans are not responsible for provision of additional behavioral health services if a child or adolescent is accepted into the CAMHD Support for Emotional and Behavioral Development (SEBD) program. If a child or adolescent is NOT accepted into the CAMHD SEBD program and requires medically necessary behavioral health services, than this would</p>

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					be the responsibility of the health plan under Early and Periodic Screening, Diagnostic, and Treatment (ESPD) identified in Section 41.100.
25	30.900	102-103	2	<p>Currently, members who meet ADRC criteria are dis-enrolled on the 1st day of the 2nd month following the State's determination. In the first paragraph of this section, it states that members who have supporting documentation of SSI eligibility (copy of SSA letter, payment stub, etc.) should be changed to disability status without having to undergo the ADRC process. What is the timeline for this change after a health plan submits all the appropriate documentation to DHS?</p> <p>Regarding disenrollment to SHOTT, there was no indication of disenrollment timeframes for members determined to meet SHOTT criteria.</p> <p>Could you please include this information?</p>	<p>In QUEST Integration, individuals who have a change in their status from non-disabled to disabled will stay in their same health plan. The change in disability status will be effective on the first day of the following month of submission of information from the health plan.</p> <p>The timeframe for members to be transferred from a QI health plan to SHOTT varies based upon needs of the member. DHS will not include a specific timeframe in the QI RFP.</p>
26	31.130	107	1	The RFP notes that "The DHS or its designee may conduct case study interviews. These could require that key individuals involved with the programs (including representatives of the health	The DHS may conduct case studies during readiness reviews and as part of ongoing operational monitoring and may at times use an external quality review organization to perform these reviews.

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				<p>plans, association groups and consumer groups) identify what was expected of the program, changes needed to be made, effectiveness of outreach and enrollment, and adequacy of the health plans in meeting the needs of the populations served."</p> <p>Can DHS provide more information about "case study interviews"?</p> <p>Is this part of ongoing operational reviews or would this only apply during readiness review?</p>	
27	40.210	113-114	1	Does DHS have any guidelines or minimum standards for an "adequate" LTSS provider network?	Health plans need providers for all services identified in Section 40.700 on all islands that they are offering healthcare services. As described in paragraph two of Section 40.210, "If the health plan's network is unable to provide medically necessary covered services to a particular member within its network or on the island of residence, the health plan shall adequately, and in a timely manner, provide these services out-of-network or transport the member to another island or out-of-state to access the covered services for as long as the health plan's network is unable to provide the member with

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					medically necessary covered services on their island of residence as described in Section 41.500.”
28	40.210	113	2	Should the first referenced section in this paragraph (Section 40.230) instead be Section 40.230?	See #6 of Amendment #1.
29	40.210	113	2	"The health plan is responsible for assuring that members have access to providers listed in Section 40.230." Is this the correct reference, or should the reference instead be 40.220 (as it was in the prior RFP) since this is the section with the list of providers. Do we assess this requirement against 40.220 or 40.230?	See #6 of Amendment #1.
30	40.210	113-114	Last sentence on page	<p>Please provide clarification for this sentence: “The health plan is prohibited from charging the member more than it would have if the covered services were furnished within the network.”</p> <p>Is this sentence meant for a staff-model HMO that provides health care services directly to its members? Or is it related to the first sentence in section 60.320, Non-Covered Services?</p> <p>How does this sentence relate to the rest of the paragraph which requires that out-</p>	<p>This sentence is a requirement of Centers for Medicare & Medicaid Services (CMS) as part of its checklist to fulfill requirements identified in 42 CFR 438.206(b)(5).</p> <p>In addition, if the member sees an “out of network” provider for a medically necessary service (as described in paragraph two of this section), then that provider shall not “balance bill” the member. This statement meets requirements identified in 42 CFR 438.106(c).</p>

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				of-network providers cannot “balance bill” members for covered services and that the health plan’s payment is considered as “payment in full”?	
31	40.210	115	2	All providers that submit claims must have an NPI#; will CCFH/E-ARCH providers be required to submit claims with an NPI#?	DHS is in the process of receiving confirmation from Centers for Medicare & Medicaid Services (CMS) regarding the requirement for NPI in accordance with 42 CFR 455.440. This policy will be resolved outside of the QUEST Integration procurement.
32	40.210	115-116	8	<p>Per the RFP, "The health plan shall immediately terminate any provider(s) whose agents or managing employees are found to be excluded. "</p> <p>Since the ‘provider’ can be considered the individual and the group/clinic/hospital that the excluded individual works for, can the DHS provide additional guidance regarding termination.</p> <p>If after discussing the issue with the provider (clinic, hospital, etc.) the excluded individual (e.g. individual doctor, agent, or employee) who works for the provider decides to terminate his/her employment with the provider, would the health plan still be required to</p>	<p>If an agent or managing employee is found to be excluded from participation in Medicare, Medicaid, or another government agency, then the provider shall be terminated from providing services to Medicaid beneficiaries until that agent or managing employee is no longer affiliated with their organization.</p> <p>Providers such as a group/clinic/hospital may remain a health plan provider if the agent or managing employee is no longer affiliated with the organization. If the group/clinic/hospital continues to remain affiliated with the individual, then the group/clinic/hospital would not be able to be a health plan provider for Medicaid beneficiaries.</p>

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				terminate its contract with the provider (clinic, hospital, etc.)?	
33	40.220	118	7 th bullet, 1 st and 2 nd sub-bullets	<p>Within the “Specific Minimum Requirements’ section, the requirements for “Behavioral health providers” have standards that are based on SMI/SMPI members.</p> <ul style="list-style-type: none"> • "Psychiatrists (1 per 150 members with a SMI or SPMI diagnosis)” • “Advance Practice Nurse (APRN) - behavioral health (1 to 100 members with a SMI or SPMI diagnosis)” <p>Are health plans required to adhere to this standard given that SMI/SPMI members are under the CCS carve-out program for BH services?</p> <p>Is this requirement limited to the provision of medication management services?</p>	<p>Not all individuals with a SMI/SPMI diagnosis will be in the CCS program; only those who meet eligibility criteria identified in Section 30.750 that also have a functional impairment. QI health plans will still have responsibility for provision of standard behavioral health services (as described in Section 40.740.2.a) to individuals that may have a SMI/SPMI diagnosis without a functional impairment. The ratios as stated will still apply and are not limited to medication management or the CCS carve-out.</p>
34	40.220	118	7 th bullet, 3 rd sub-bullets	<p>Within the ‘Specific Minimum Requirements’ section, the requirements for “Behavioral health providers” has “Certified substance abuse counselors” listed.</p> <p>Is a health plan required to contract with</p>	<p>Health plans may use certified substance abuse counselors (CSAC). These providers will be eligible Medicaid providers in the QI program. Though health plans are not required to use CSACs, they shall have adequate substance abuse providers in their</p>

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				certified substance abuse counselors or is contracting at the discretion of the health plan?	network.
35	40.230	122	1	The fifth bullet refers to acceptable wait times for specialist or non-emergency hospital stays as being of sufficient timeliness to meet medical necessity. How will sufficient timeliness to meet medical necessity be determined?	DHS will monitor health plans access to specialist and non-emergency hospital stays within four (4) weeks. However, through the grievance and appeals report, DHS will identify if there are indications related to medical necessity that health plans are not fulfilling.
36	40.230	122	1 st bullet	Due to the provisions of the federal BH parity law, should there be a separate bullet for routine BH services? Example: "Behavioral Health (routine visits for adults and children) - Appointments within twenty-one (21) days"	See #7 of Amendment #1.
37	40.240	123	2 (chart)	The chart in section 80.315.4 refers to "Acute Care Hospitals" and the chart in section 40.240 refers to "Hospitals". Are these the same thing for the purpose of these charts, or is there a difference between the two that is important for accurate completion of these charges?	Hospitals in Section 40.240 and Acute Care Hospitals in Section 80.315.4 are the same.
38	40.250	124	1	Please clarify this sentence: "Individuals who are enrolled in a Medicare Advantage plan are not required to have a PCP. However, members with fee-for-service Medicare shall choose a PCP."	Individuals in a MA plan will have a PCP with their MA plan, not their QUEST Integration health plan. Since the MA plan provides most of the member's primary and acute care services, requiring that individuals in a MA plan have two

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				<p>Is this requirement accurate? As the managed care alternative to the FFS Medicare program, it appears more appropriate that individuals enrolled in a MA plan would need to choose a PCP.</p> <p>How would a health plan promote a medical home if a PCP is not required?</p>	<p>PCPs (one with the MA plan and one with QI) would cause confusion for the member and potentially disrupt their care.</p> <p>Individuals in Medicare FFS may identify a Medicare provider as their PCP, who is not participating with their QI plan, and the QI health plan must recognize this provider as the member's QI PCP.</p> <p>Whether through their MA plan, Medicare FFS, or only QI, all individuals are expected to have a PCP. The health plan is encouraged to contract with members' Medicare PCPs who are not in the health plan's network.</p>
39	40.270			<p>In the RFP (40.270) it states that if a patient has been assigned to a PCP at an FQHC, they can receive services at any other FQHC w/o prior auth. We are concerned that some patients may receive services (including prescriptions) from their FQHC PCP and then later incur costs (potentially including prescriptions) that are a duplication of services. It presents problems in continuity of care. Can you address the added cost, risk, and quality responsibility in this configuration?</p>	<p>See #8 of Amendment #1.</p> <p>Certain individuals, particularly those who are homeless, may unexpectedly be near a different FQHC than the one that employs their assigned PCP. The intent is not to cause problems with continuity of care, but rather to avoid preventable ER visits and potential hospitalizations. FQHCs are critical providers that may provide increased access to services that are urgent in nature for vulnerable individuals. We will replace the</p>

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					<p>following sentence:</p> <p>If a member is assigned to a FQHC or RHC as their PCP, the health plan shall allow the member to receive covered services at any other FQHC or RHC without prior authorization.</p> <p>with:</p> <p>The health plan shall allow all members to receive covered services that are urgent in nature at any FQHC or RHC without prior authorization.</p> <p>The health plan shall require the FQHC to refer the patient back to and inform the assigned PCP or help the individual select a new PCP.</p>
40	40.400	37	2	<p>Clarification on collection of disclosure information under “The health plan shall obtain disclosures from its providers at the following times:”</p> <p>In an effort to reduce the number of times a provider would need to provide disclosures during the initial contracting and credentialing/recredentialing process could the 2nd and 3rd bullets be modified to include the bolded language?</p>	<p>DHS and its health plans are required to meet Federal regulations for participation in the Medicaid program. The timeframes for health plans to collect disclosures from providers that is included in Section 40.400 is a requirement identified in 42 CFR 455.104(c)(1).</p>

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				<ul style="list-style-type: none"> • Upon execution of the provider agreement if disclosure information has been revised since submission of initial application; • During recredentialing if disclosure information has been revised 	
41	40.500	138	1	<p>Due to provider contract requirements in section 40.500, should a health plan seek DHS approval for changes to its current contract templates prior to use for LTSS provider contracting?</p> <p>If DHS review is required, can the DHS review be fast-tracked so that contracting can be completed prior to proposal submission?</p>	<p>Health plans shall obtain approval for provider contract templates as part of readiness review after contract award. Health plans should not submit any requests for approval of QUEST Integration (QI) contract templates prior to contract award.</p> <p>Health plans may utilize a current provider contract in place for any new contracts or contracts for the QI program. Once QI health plans have their regulatory compliance portion approved during readiness review, they can update their current provider contracts (with signatures) for QI as an amendment to an already existing provider contract.</p> <p>Examples of how health plans can assure that they have an adequate provider network for QI proposal submission include but is not limited to:</p> <ol style="list-style-type: none"> 1. If allowable as part of their provider

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					<p>contract, send out notice to current providers with a specified time frame for response, that their current contract will be expanded for the QI program; or</p> <p>2. If not allowable as part of their contract, have providers sign a one-page agreement that identifies that they will provide services for the QI population.</p>
42	40.500	141	Bullet 25	<p>“Require that the provider submit to the health plan any marketing materials developed and distributed by providers related to the QI program to include the use of either QUEST Integration or Medicaid”</p> <p>How does the DHS define ‘provider marketing materials’ that health plans should be looking for? Can examples be provided?</p> <p>What is the recommended process for handling this type of situation?</p> <p>Are health plans expected to inform the DHS of the materials or submit them for DHS approval on behalf of the provider?</p>	<p>1. Any materials that a provider develops for their practice. Examples include brochures, posters in their waiting rooms, handouts, mailings, advertisements, etc.</p> <p>2. Health plans should have this requirement in their provider contract. If a health plan identifies any materials that a provider is using that include the term QUEST Integration or Medicaid, the health plan shall obtain a copy and submit to MQD for approval.</p> <p>3. Health plans shall include this requirement in each provider contract.</p> <p>4. Health plans are required to hold their providers accountable to their contracts.</p>

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				Are health plans accountable for provider marketing materials?	
43	40.640	159	4, bullet #1	With a 5% allowable for Call Center overflow; will exceptions be made during Disaster Recovery?	During a disaster, health plan contract requirements may be waived temporarily.
44	40.740.1 50.480	175	All	Will DHS consider adding a waiver opportunity to the requirement that health plans operate a toll-free call center in Hawaii if a health plan is able to provide equivalent levels of care and customer service in accordance with Section 50.480 using an after-hours nurse triage line located in the continental United States?	DHS does not have a requirement for the 24-hour nurse line to be located in Hawaii. However, the member call center (identified in Section 50.480) does need to be located in Hawaii. DHS will not make an exception to the member call center being located in Hawaii.
45	40.740.1 e.	179	2	Please clarify what 24 hours a day 7 days a week post stabilization outpatient services mean in practice related to an emergency medical condition	Health plans are responsible for providing post stabilization services related to an emergency medical condition. This includes both inpatient and outpatient services. Outpatient services 24 hours a day, 7 days a week may include but are not limited to observation status in a hospital.
46	40.740.1 p.	186	2	Can physician services be provided via alternate means such as telephonic consultation, web based consultation and/or video chat/conference?	DHS' State Plan does not recognize physician services provided through telephonic consultation, web-based consultation and/or video chat/conference.
47	40.740.1 s.	190	4	Does the DHS anticipate a plan to consider copayments for chronic pain medication that are in excess of what a	If DHS requires that members pay copayments for chronic pain medication, we will notify QI health plans at least three

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				most PCPs are willing to prescribe or what is above recommended dosing/ considered standard practice?	months prior to this change as described in Section 40.740.1.s. Any State Plan required co-payments would be expected to comply with federal regulations.
48	40.740.2. a	200	1	<p>The last sentence of this paragraph states that health plans are responsible for court-ordered diagnostic, treatment or rehabilitative BH services even when determined to be not medically necessary. For example, per this RFP, psychological testing requires prior authorization.</p> <p>If court-ordered, then the health plan cannot require a PA, nor can it apply any utilization control (e.g., limit over number of hours of psych testing) over this service?</p>	This RFP does not require prior authorization (PA) of any services. PAs are determined by the health plan (as described in Section 50.900). However, there are circumstances when courts will determine that behavioral health services are required. Because QI is a Medicaid program funded by the State, DHS is requiring that health plans pay private hospitals for behavioral health services that are court ordered. Health plans may require a notification of hospitalization, but cannot deny payment for behavioral health services that are court ordered.
49	40.740.2. a	201	4	<p>The two sentences in this paragraph appear to be inconsistent with each other. In the first sentence, DOH is responsible for treating the criminally committed. In the second sentence, health plan remains responsible for providing “medical services” to the criminally committed.</p> <p>In the Section 30.200, the term, “medical services”, includes behavioral health services (which is defined as “Services</p>	See #9 of Amendment #1.

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				<p>provided to persons who are emotionally disturbed, mentally ill, or addicted to or abuse alcohol, prescription drugs or other substances.”)</p> <p>Please clarify what DOH and the health plans are responsible for.</p>	
50	40.740.3 n.	212	2	<p>If PA 1 is limited to 10 hours per week “for individuals who do not meet institutional level of care”- does that mean for “at risk” individuals who are not NFLOC (no- 1147) can receive a maximum of 10 hours PA1 service per week? If yes, does an individual with 10 hours personal assistance level 1 “at risk” but does not meet NFLOC LOC still fall into the 1:50 (if agency HCBS) or 1:30 (if self-directed)?</p>	<p>1. Yes.</p> <p>2. Yes.</p>
51	40.740.3 n	214	6 (Letter I)	<p>Please confirm that regardless of provider (agency or self-direct) standby/<i>minimal</i> assistance or supervision of ADLs such as bathing, dressing, grooming, eating, ambulation/mobility and transfer are personal assistance level 1 type of services.</p>	Yes.
52	40.740.3 n	215	6 (Letter F)	<p>Please clarify the meaning of: “assistance with routine or maintenance healthcare services by a personal care provider with specific training, satisfactorily</p>	<p>This is assistance with routine or maintenance healthcare services to include but not limited to blood glucose monitoring (for someone with diabetes</p>

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				documented performance, care coordinator consent and when ordered by a member's physician"	mellitus), recording weight daily (for someone with CHF), or changing a dressing (for someone with a wound that is progressing well).
53	40.740.3 o	217	Letter C	Med-Alert bracelets are in PERS section- is medical alert bracelet a covered benefit in the absence of an actual PERS device or only covered as a supplement to a PERS authorized service?	A Med-alert bracelet is a covered benefit as the PERS or as a supplement depending upon what is appropriate for the member.
54	40.740.3	220	F	In the current QExA program, electricity reimbursement is only covered for children. Is it the intent of DHS to open this benefit up to adults?	In the QExA program, electricity reimbursement is not only for children. In QI (as is currently in QExA), this benefit will be for individuals with high-cost electric-powered equipment such as ventilators and oxygen concentrators who cannot afford the increased cost of electricity.
55	40.800	221	1	Should the personal assistance services section referenced as Section 40.730.3.n instead be Section 40.740.3.n? Should the respite services section referenced as Section 40.730.3.q instead by Section 40.740.3.q?	See #10 of Amendment #1.
56	40.800	230	Last bullet point	Can a member waive the skills check requirement for Skills competency to perform PA II and delegated task if formalized by member in writing?	No.
57	40.910	232	1	The RFP notes that "DHS may revise the	DHS will participate in programs that the

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				<p>health plan's responsibilities within the service coordination system to align with Hawaii's implementation of an innovative delivery system that migrates these functions closer to the provider level...".</p> <p>Please provide an example of a type of an "innovative delivery system".</p> <p>If Hawaii implements a 'delivery system' what consideration would be given to health plans and providers that have already invested extensively in care coordination systems within their organizations, with providers, and within the community?</p>	<p>Hawaii Healthcare Project's State Innovation Model (SIM) develops for Community Care Networks (CCN) in the Medicaid program. Hawaii health plans, providers, and the community has had input into suggestions for changes to Hawaii's delivery system as part of the SIM grant.</p>
58	40.910	235	10	<p>Would DHS consider mixed ratios for services beyond HCBS and those who choose self-direction for health plans with limited membership or smaller geographic locations?</p>	<p>DHS will work with health plans individually based upon enrollment with regards to service coordinator ratios with a low number of HCSB or members with SHCN on an island.</p>
59	40.910	235	3 and 4	<p>The RFP states that service coordinator caseloads may not be mixed for 3 of the 5 categories of the QI population. In the previous RFP, mixed caseloads were permitted.</p> <p>Since health plan flexibility to provide innovative services could be</p>	<p>DHS is making this change to provide better service to its beneficiaries. These changes are made due to problems related to mixed caseloads in the current QExA program.</p>

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				compromised, what is the rationale or intent for this change?	
60	40.910	235	7	<p>The RFP notes that "The health plan shall maintain sufficient service coordinators to meet members' needs."</p> <p>Can we delegate service coordination to 1) FQHCs or other physician groups who may have these service coordinators or 2) other providers who specialize in service coordination as described in Appendix L?</p>	<p>1. Yes.</p> <p>2. Yes.</p>
61	40.910	236	1	<p>For Service Coordinators on smaller Neighbor Islands such as Maui, there may not be enough membership to support a full caseload without mixing populations (i.e.: there may not be 200 SHCN Children at one time with one health plan). Would DHS consider letting Neighbor Island SCs have mixed caseloads of the two SHCN populations?</p>	<p>DHS will work with health plans individually based upon enrollment with regards to service coordinator ratios with a low number of HCSB or members with SHCN on an island.</p>
62	40.900	236	2	<p>Please clarify mixed caseload.</p> <p>1. Can you mix SHCN adults and SHCN children? Can you mix NFLOC with non-NFLOC at risk?</p> <p>2. Can SC with HCBS members mix with any other types if his HCBS caseload is low (under 50)?</p> <p>3. Can caseloads be mixed for family members in the same home, or</p>	<p>1.a. No.</p> <p>1.b. Yes.</p> <p>2. No.</p> <p>3. Only if within the same categories as described in Section 40.910, fifth</p>

Question #	RFP Section #	RFP Page #	Para #	Question	Answer
				related/unrelated members living in the same building?	paragraph.
63	40.910	236	4	<p>The RFP states that service coordinators are required to be a certified social worker, licensed nurse or other healthcare professional.</p> <p>Please define “other healthcare professional.”</p> <p>What is the definition of ‘certified’?</p> <p>Will DHS permit a waiver of this requirement in locations that are designated by the U.S. Health Resources Services Administration as Medically Underserved Areas (MUA) and Healthcare Personnel Shortage Areas (HPSA)?</p> <p>In these areas where there is a shortage or lack of qualified certified social workers or licensed nurses, will DHS permit service coordinators to be individuals that have experience and proven skills serving the QI population with service coordination or related services, and have cultural and linguistic competency skills, if they work in close collaboration with</p>	<ol style="list-style-type: none"> 1. ‘Other healthcare professional’ is other disciplines of healthcare other than social worker or nurse. This may include but not limited to physical therapist, marriage and family therapist, registered dietitian, mental health counselor, certified nurse aide, etc. However, if the State of Hawaii has either certification or licensure requirements for the healthcare profession, the service coordinator must obtain that certification or licensure. 2. Health plans may submit waivers in accordance with requirement identified in Section 72.470. 3. Health plans shall use only individuals for service coordinators that have healthcare experience and is are certified or licensed healthcare professionals.

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				the PCP?	
64	40.910.3	241	1	All members receiving LTSS shall have both a nurse and a SW for each individual receiving LTSS. The ratios for LTSS 1:30, 1:40, or 1:50. Would members be assigned one of them as the primary SC but have access to the other discipline?	Yes. However, both the nurse and the social worker need to be present for the initial assessment and service plan development as described in Appendix L.
65	40.910.3	241	1	<p>The RFP notes that "The health plan shall have both a nurse and a social worker service coordinator for each individual receiving LTSS."</p> <p>What credentials are required for the nurse and the social worker serving as service coordinators?</p> <p>Can the service coordinators be an LPN?</p> <p>Can the service coordinators be an unlicensed social worker?</p> <p>Can the nurse/social worker be augmented by another health staff who may be a CNA or para-professional (assistant service coordinator) working under the supervision of the assigned RN or LCSW service coordinator?</p>	<ol style="list-style-type: none"> 1. Licensed as a nurse or social worker under the Department of Commerce and Consumer Affairs and with at least one-year of experience in service coordination. 2. Yes. 3. No. The QExA program has required licensed social workers since 2009 and DHS does not want to lower its standards for QI. 4. Yes.
66	40.910 and	233-236	-	Will DHS permit service coordinators that specialize in health and functional	No. However, health plans may develop teams that provide services to their

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	40.920	and 242		assessments (HFA) to conduct the HFAs and development of the care plans, and then transfer the implementation of the care plans and ongoing case work to community case managers? These community case managers will be able to interact more frequently with the member and PCP, be required to have cultural and linguistic skills, and be integrated in the local community network of health and social services.	members. The team may consist of the service coordinator and a 'community case manager' who may have more frequent interaction with the member.
67	40.740.1s, 40.910, and 40.920.2	190, 232 and 244	Last paragraph, 1 st paragraph and 2 nd paragraph	In cases in which the DHS states that they may develop program changes or implement new systems, will there be an opportunity for collaboration between the health plans and DHS in these developments prior to implementation?	DHS will discuss program changes with QI health plans prior to implementation.
68	40.920.1 / 51.800	243, 244, 248, 411	Multiple	Will the standardized form (HFA) and the standardized service plan form, both developed by DHS, be available in an electronic version? We believe that the members' best interests are served when we incorporate these forms into the health plan's clinical information system for timely and accurate use by the health plan and the member's provider(s). Issuance of the forms only 180 days prior to commencement of services is a short timeline to implement an electronic	DHS will provide these forms electronically. Health plans may incorporate these forms into their clinical information system. DHS is planning on issuing the forms 180 days prior to commencement of services as is described in Section 51.800 of the RFP.

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				interface between the forms and the health plan's information system - can the format for both forms be issued earlier?	
69	41.500	264	Last paragraph	<p>The 3rd sentence states that the health plan should cover a member's and one (1) attendant's, transportation, lodging, meal services when referred off-island or out-of-state for needed medical care/services. The sentence is written such that the attendant is a requirement, and not based on any rationale, such as the patient is a minor child or has a medical need for an attendant.</p> <p>Is the sentence as written in the RFP an accurate reflection of what the DHS would like to see?</p>	See #11 of Amendment #1.
70	50.220	273	1	In regard to the Member Survey; will DHS provide a uniform format and specific content for the surveys?	No.
71	50.230	274	1	Can a health plan use a standard of 25 calendar days from the DHS notification of enrollment to assign a member to a PCP if the member has not selected a PCP?	Yes.
72	50.490 and 50.620	296 and 304	2 and item 7	The RFP notes on page 296 that "The section of the web-site relating to QUEST Integration shall comply with the marketing policies and procedures and	Health plans are able to interact in member-specific communication without approval from DHS. A health plan's using technology to improve its members'

Question #	RFP Section #	RFP Page #	Para #	Question	Answer
				<p>requirements for written materials described in this contract and all applicable State and Federal laws." Also, on page 304, the RFP notes that the health plan is prohibited from "Failing to receive DHS approval on all marketing materials;".</p> <p>If a health plan's website has interactive capabilities with members or the general public (as is common with many contemporary websites), how would compliance be maintained to enable such interactions?</p> <p>Similarly, if the health plan engages in other current technology, such as social media, with interactive communication with members and the general public, how would compliance work?</p>	<p>health is encouraged.</p> <p>Communication from a health plan to other than its members is considered marketing. Health plan shall notify DHS of all websites and social media it utilizes. Health plan may submit to DHS common responses for social media (such as Facebook or twitter) for the general public, and DHS reserves the right to review websites and social media and determine what content is allowed, not allowed, and/or requires DHS approval.</p>
73	50.500	301-302	1	<p>Section 50.500 requires health plans to meet the 50% criteria for hospitals with a value driven health care schedule.</p> <p>Since there will be hospitals that do not want to enter into acuity adjusted diagnosis-based reimbursements, what happens if a hospital refuses to accept acuity based reimbursement</p>	<p>Reimbursing hospitals on an other than per diem basis is strongly encouraged, but is not the only option for meeting the hospital value-based contracting requirement at this time. In the future, DHS may require that health plans reimburse all of its participating hospitals on a DRG-based basis.</p>

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				methodologies?	
74	50.500	301-302	Table, 1 st column header	<p>According to section 50.500, the requirement for meeting the 50% criteria for hospitals with a value driven health care schedule is effective with the “beginning of the contract year”.</p> <p>Is the reference to the “beginning of the contract year” equivalent to the commencement of services to members as defined in section 20.100 of the RFP which would mean that this would be effective for hospital contracts beginning January 1, 2015?</p>	Yes.
75	50.540	301	First paragraph in section	Are Vertically Integrated Organizations ACOs or ACO-like?	They can be if accountable for providing at a minimum primary, acute, and chronic care services.
76	50.610	302	1, 3 rd bullet	Are health plans required to submit the activities/events they attend or conduct, such as health fairs or other health education and promotion activities for MQD review and approval?	Yes.
77	50.630	305	2	<p>Per Section 50.630, “In addition, the health plan shall submit to the DHS any marketing materials it has received from a provider or subcontractor for review and prior approval.”</p> <p>Can the DHS give a few examples of</p>	See answer to question #42.

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				<p>provider marketing materials that they would expect health plans should submit for review?</p> <p>Is this requirement for the submission of provider marketing materials specific to materials that mention the health plan in the provider's marketing materials?</p>	
78	51.280	352	1	Does DHS have any specific requirements that can be shared with the health plans with reference to participation in the Health Information Exchange?	No.
79	51.280	352	1	Is there a draft timeline for health plans to start integrating with HIE?	No.
80	51.310 and 51.320	353 and 354	2 and 1	<p>Under 51.320, suspected fraud and abuse should be reported to MQD. Under 51.310, second paragraph, third sentence the reports should be made to the DSH.</p> <p>Can these sections be reviewed for consistency in reporting requirements?</p> <p>Will these requirements replace the guidance provided in MQD Memo ADM-1301, dated February 7, 2013?</p>	See #12 of Amendment #1.
81	51.310, 51.320, 51.340,	353-358	See Question	Please clarify the threshold for reporting fraud allegations to DHS. The RFP contains conflicting references.	<p>See #12 of Amendment #1.</p> <p>Suspected fraud or abuse will remain for</p>

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	51.410			E.g., Section 51.320 ¶1 the RFP states that health plans are required to report “credible allegations of fraud or abuse to the MQD.” However, Section 51.340 ¶2 requires the reporting of “suspected and/or confirmed fraud.” Section 51.410 ¶3 requires reporting of “suspected instances of internal and external fraud.” Section 51.310 ¶1 requires health plans to have internal controls and policies designed to report “known or suspected fraud and abuse activities.”	consistency with the federal regulations.
82	51.320	354	1	Please clarify whether DHS would extend the time frame within which to report fraud referrals following the completion of preliminary investigations. E.g., 120 days?	No. DHS will keep timeframe to thirty (30) days to complete preliminary investigation.
83	51.320	354	2	To be consistent with the language in the first paragraph, should the term “suspected cases” be changed to “credible allegations”?	See #12 of Amendment #1.
84	51.320	356	4	Please clarify whether, once a fraud referral is made following the health plan’s completion of a preliminary investigation, there are any circumstances under which DHS will provide the health plan with authorization to proceed with additional investigation (including further	The DHS investigator or MFCU may request for an additional investigation or information.

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				contact with providers) within a defined timeframe.	
85	51.410	362	3	Must the FTE requirement always be met by just one employee, or can FTE requirements be satisfied by two or more employees who work together on QUEST Integration part time, but their combined QUEST Integration time equals 1.0 FTE?	Health plans may use two (2) employees who work together to satisfy the one (1) FTE requirement. However, health plans will need to notify DHS of the arrangement and meet the contract requirements in the shared responsibilities. If health plan responsibilities are not being met through the arrangement, the health plan would need to revise their staffing plan.
86	51.410	363	Table	Catastrophic Claims Coordinator position in the health plan personnel table. Is this position still required since Catastrophic Reinsurance is not a part of this RFP? If position is required, why is 'business continuity planning' included in the position description of the catastrophic claims coordinator?	See #13 of Amendment #1.
87	51.410	363	Grid	What is the role of the Catastrophic Claims Coordinator if there is no catastrophic reimbursement program?	See #13 of Amendment #1.
88	51.410	363	Service Coordinators	A health plan cannot adequately assess the number of service coordinators it may need based on information provided in	Related to answering proposal question 80.345.3, DHS cannot identify how many individuals in each category will be in a

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				<p>this RFP (staffing ratios and instructions to assume a minimum of 20,000 members).</p> <p>Can DHS provide member counts or estimates for the 5 service coordination categories described on page 235 and the ‘at-risk’ category described in page 244?</p>	<p>health plan. Applicants should include their assumptions of how they determined service coordinator FTEs in their response to question 80.345.3. However, health plans may use the following as guidelines:</p> <ol style="list-style-type: none"> 1. Individuals with SHCN is 5% of the population; 2. Individuals with LTSS is approximately 3% of the population; 3. Of the individuals with LTSS, 65% are in the community and 35% are in an institutional setting; and 4. Of the 65% in the community, half are choosing self-direction.
89	51.420	367	2	<p>“The director and managers should be either a registered nurse or licensed social worker who has experience with serving LTSS members in the community.”</p> <p>Can a health plan obtain qualification waivers for these positions for individuals with comparable experience?</p>	<p>Health plans may submit requests for a waiver as described in Section 72.470.</p>
90	51.520.6	379	2	<p>In the Provider Suspensions and Termination Report, should only providers suspended/terminated for confirmed fraud or abuse be listed on the</p>	<p>See #14 and #15 of Amendment #1.</p> <p>In addition, the health plans shall notify DHS within three (3) business days of any</p>

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				report, or all providers who were suspended and terminated? Also, is there supposed to be more to the last sentence in the paragraph "Denied Credentialing"?	providers that are suspended or terminated for suspected or confirmed fraud or abuse.
91	51.530.2	381	1	<p>The RFP notes "The health plan shall submit to the DHS a Long-Term Services and Supports report. Reports shall be for members that are receiving LTSS as defined in Section 40.730. Reports shall include information on services provided, assessments performed, service plan updates, addition or reduction of services, authorization of services (i.e., environmental adaptations) and any other quality measures that the DHS deems necessary."</p> <p>Is the information in this report aggregate counts of services, assessments, updates, change of services, authorizations, etc. or is more specific case information required?</p> <p>Will DHS provide a report template?</p>	<p>The LTSS Report will include both aggregate and individual member specific information.</p> <p>The health plan shall submit all reports using a format provided by the DHS as described in Section 51.510.</p>
92	51.530.3	382	3	Quality of Life Surveys: does each health plan create our own or will this be provided?	This is a standard report for the Going Home Plus program. The report format is determined by the DHS.
93	51.580.1	400	Referenc e entire	Can e-visit encounters be provided for specialty services for tele-health?	Health plans should limit their use of telehealth to that approved under the State

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			section		Plan for direct expenses; at this time, this is primarily behavioral health. Health plans may fund other telehealth services as an administrative expense. In these instances, health plans shall not submit an encounter. Finally, health plans shall inform DHS of instances where they are using non-covered telehealth for informational purposes only.
94	60.130	414	1	Will a member's eligibility be tied to their timely payment of premium or cost share to the health plan?	DHS currently does not require any premiums. With regards to cost share, a member's eligibility is not tied to their timely payment of cost share to their health plan.
95	60.300	N/A	N/A	Are there any restrictions where provider/facility claims can be processed?	DHS identifies in Section 51.410 that claims processing staff are not required to live in Hawaii. Therefore, provider/facility claims may be processed outside of Hawaii.
96	60.310	419	2	The Medicaid fee schedule is referenced in the RFP (e.g. "The health plan shall reimburse non-contracted FQHCs and RHCs at rates no less than the Medicaid fee schedule if those providers are necessary for network adequacy."). Can an updated fee schedule be posted to the Med-QUEST website?	DHS will update its fee schedule on its Med-QUEST Division (MQD) website by October 15, 2013. The MQD does not have a fee schedule for home and community based service providers, with the exception of 1915c DD/ID waiver providers. HCBS are not otherwise covered in the fee-for-service

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				Can a list of Medicaid fees for LTSS (HCBS) providers be released?	<p>program.</p> <p>Former Nursing Home Without Walls (NHWW) and Residential Alternatives Community Care Program (RACCP) fee schedules from 2008 are available upon request.</p>
97	72.220	462	Item 10	<p>The RFP notes in item 10 that "Failure to use DHS approved materials for marketing during Initial Enrollment or APC" may incur a penalty to the health plan of "Loss of all auto-assignment for contract year for that Initial Enrollment or APC". All other penalties listed in this section are for fixed dollar amounts with this exception. This particular penalty will not be equal for all health plans and will have a different value, depending on the auto-assignment situation for each health plan. Would it not be appropriate to have a fixed dollar penalty for this violation?</p> <p>Is it correct to assume that a health plan that is capped or opted out of auto-assignment would never be subject to this type of penalty?</p> <p>Would there be any type of penalty if this</p>	<p>Failure to use DHS approved marketing materials is within the control of the health plan and completely avoidable.</p> <p>A health plan that is capped or has opted out of Initial Enrollment or APC would not be marketing for either Initial Enrollment or APC.</p> <p>Suspension of new members with the health plan (including default enrollment) is an allowable sanction under 42 CFR 438.702(4). DHS has determined that the sanction of auto-enrollment suspension best addresses the infraction of failure to comply with contractual requirements regarding marketing.</p>

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				type of violation occurred to a capped/opt-out health plan?	
98	72.470	470	1	Do health plans include information on waivers of operational contract requirements in the Technical Proposal, or will there be another format or opportunity to inform DHS?	No. Waiver requests will not be processed during technical proposal submission. Health plans will be offered an opportunity to submit waiver requests after contract award. Please note that “DHS reserves the right to revoke these waivers (waivers of contract requirements) at any time.”
99	80.100	471	1	Is it permissible to use a smaller font size and single spacing for tables within our proposal?	Yes. However, font size shall be no smaller than 8 point font in tables.
100	80.100	471	1	Can screen shots be used as an illustration in the RFP response, and will the State allow a smaller font than the required 11 point font RFP requirement?	Yes. However, font size shall be no smaller than 8 point font in illustrations.
101	80.100	471	1	Can exhibits and attachments include smaller than 11 point font?	Yes. However, font size shall be no smaller than 8 point font in exhibits and attachments.
102	80.100	471	1	Is there a minimum/maximum font size for graphics (e.g. flowcharts, tables, etc.?)	The minimum size for graphics is 8 point font. DHS does not have a maximum size.
103	80.100	471	2	Since maximum page numbers include restating the question, would the State consider allowing 9 or 10 point font for restating some of the lengthier questions?	Yes. Applicants may use single-spaced, 8 point font to restate the questions.
104	80.210	473	J	This paragraph requires the applicant to	See #21 of Amendment #1.

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				certify that he or she is authorized to makes decisions “as to the prices quoted”. Because the rates will not be available before the proposals are submitted, and applicants are not in fact quoting process, we respectfully request that “as to the prices quoted” be replaced with “as to this offer”.	
105	80.220	474	Last	Section 80.220 states: “The information required above shall be supplied for each affiliated company that serves Medicaid members and any subcontractors the applicant intends to use.” Is the intent of this request to include information on affiliates that serve Medicaid members in Hawaii?	No. The intent is that the applicant provides information on any affiliated company of the applicant (i.e., parent company) and its subcontractors.
106	80.230	475	P	This paragraph seems to indicate that a hard copy of the Tax Clearance must be provided, but § 20.600 indicates that Tax Clearance is all done online. If the certificate is not available at the time of submission, an applicant is permitted to instead submit a statement with the proposal indicating that certificates will be submitted in accordance with § 20.600. If at the time of submission the applicant has a current certificate available online, may it also offer a statement regarding availability in lieu of a hard copy?	Applicants may provide a hard copy of their compliance with Hawaii Compliance Express (HCE) to fulfill this requirement.

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107	80.230	476	1	The applicant is required to provide “the most recent completed risk based capital (RBC) amount”. Could you clarify this request? Are you looking for the amount of the applicant’s RBC as of the most recently completed fiscal quarter? Also, this question asks for the RBC amounts for the applicant’s affiliates “where applicable”. Should applicant provide the RBC amounts for each affiliate that is subject to RBC requirements or only for those affiliates that would be providing services under the RFP?	Yes. DHS is interested in the RBC of the most recently completed fiscal quarter. In addition, applicants shall provide RBC amounts for each affiliate that is subject to RBC requirements.
108	80.300	Various	Various	May we provide attachments supporting the technical response beyond those that are specifically requested? For example, may we choose to provide attachments for section 80.310 part A?	Applicants can provide attachments for Section 80.310A, however, the attachments will be included as part of the 15 page maximum.
109	80.310 A	476	Bullet A	The RFP notes that “...and any subcontractors who will be providing direct services and that the applicant intends to use in the QUEST Integration program” We are requesting clarification so that we can properly identify the subcontractors that DHS would like listed. What is the definition of 'direct services'	This question requires that the applicant describe their experience providing services to Medicaid and Medicare populations. Direct services refers to non-clinical services that are directly related to health plan operations. DHS allows the applicant to include experience of an affiliated company, a company with the same parent company as the applicant, and any subcontractor. The applicant can choose which subcontractors best support

Question #	RFP Section #	RFP Page #	Para #	Question	Answer
				<p>as it relates to a subcontractor?</p> <p>Does ‘direct services’ refer to health care related services or to services where the subcontractor interacts with a health plan's members face-to-face?</p> <p>Which of the following would DHS expect a health plan to list under this requirement?</p> <ul style="list-style-type: none"> • PBM, printing and mailing vendor, peer-to-peer review entity, after-hours phone service, credentialing verification organization, nurse advice line, member survey vendor <p>Should the second half of the 3rd sentence be interpreted as two separate requests?</p> <ul style="list-style-type: none"> • 1st to list subcontractors who will be providing ‘direct services’ • 2nd to list any subcontractors that will be used by the health plan <p>Or is it a request to list only subcontractors that a health plan will use to provide ‘direct services’ (a subcontract that did not provide ‘direct services’ would be excluded from the list)?</p>	<p>their experience providing services to Medicaid and Medicare populations.</p>

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110	80.310	476-477	B	This question asks the applicant to provide certain information regarding Medicaid program contracts “past and present”. Is there a “look back period”? Could the applicant limit its response to current Medicaid contracts and those that had been terminated within the last five years? We believe experience older than this would be less useful than more current experience with respect to evaluating an applicant’s experience. Further, the entire response for § 80.310 is limited to 15 pages, so this requirement disadvantages applicants with greater experience because it will limit the space they will have to fully respond to the other elements of § 80.310.	Applicants should provide information on Medicaid contracts from most recent to older. The question limits the applicant to ten (10) contracts. Section B, C, E, F, and G are not included in the maximum page limit.
111	80.310.C	477		For clarification of “financial conflict of interest” in question 80.310 C – Is it appropriate for health plans to solicit and submit letters of recommendation from physicians, employees or leadership of a provider organization (clinic, hospital, etc.), in which one of the organization’s executives is also board member of the health plan? Are all individuals within the clinic/organization considered to have a financial conflict of interest in the health plan or just the board member	Health plans may obtain letters of recommendations from leaders of provider organizations such as clinics and hospitals. However, if one of the leaders of such an organization receives compensation as an employee, board member or officer of the health plan, or the organization that the individual represents or is employed by receives other compensation that is not generally available to other providers, then this would be considered a financial conflict

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				themselves?	of interest.
112	80.315.1.G3	480	G.3	Please provide clarification of what is required for 80.315.1.G.3: "The LTSS providers' abilities to adapt under new ACA regulations."	The ACA identifies several new regulations for LTSS providers. Some of these regulations include but are not limited to Section 2301 and 6201.
113	80.315.1.G.3	480	7	Which of the new ACA regulations must be included in the provider network analysis in the technical proposal? Are you referring to ACA population changes, or some other aspect of ACA?	See answer to question #112.
114	80.315.2	481	1	The RFP notes, "DHS will request from the applicant a sampling of provider contract signature pages for contract verification". Since the sampling of signature pages will take place after November 1st, can a phrase be added at the end of the last sentence to clarify when the signature pages are due? (' will be requested after the proposal due date.')	The request will be after the proposal due date. A due date will be provided when the request for signature pages is provided to the applicant.
115	80.315.2	484	2	Should the electronic file of the provider listing be on a separate CD from the entire technical proposal CD (referenced in section 21.200 on page 27, paragraph 5)?	This is not necessary. If the proposal and the provider listing can fit on the same CD, then that is preferable.
116	80.315.3	484	4	The RFP notes, "The applicant shall use the format for the LOI provided in Appendix T. No substitutions will be	Applicants must use the LOI issued with the RFP.

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				<p>accepted.”</p> <p>We have been using an LOI with HCBS providers that is similar to Appendix T.</p> <p>We have submitted a copy of our LOI with 2 areas that are slightly different than Appendix T. Does the attached LOI meet the format for the Appendix T?</p> <p>LOI differences:</p> <p>1) Appendix T states “for provisions of HCBS Services” vs. ours says “for provision of services”</p> <p>2) Additional paragraph in our LOI: “This Provider is eligible to participate in state and federally funded programs and will notify XXX in the event that they or any individual covered under this provider (or Group) becomes debarred, suspended, or otherwise excluded from participating in state and federally funded programs.”</p>	
117	80.315.4	486	3 (chart)	The chart in section 80.315.4 refers to "Acute Care Hospitals" and the chart in section 40.240 refers to "Hospitals". Are these the same thing, or is there a difference between the two?	See answer to question #37.

Question #	RFP Section #	RFP Page #	Para #	Question	Answer
118	80.315.4	487	5	The paragraph indicates that a provider may only be included once on the map, even if the provider has multiple locations. This may not provide an accurate picture of access. Is there another way applicant could include a provider's other locations in its response?	See #23 of Amendment #1.
119	80.335.3	498	Third paragraph "C."	Does "Heath Home" mean the definition covered under Section 2703 of the Affordable Care Act?	See #24 of Amendment #1. No. Health plans can develop their own medical home model.
120	80.345.1	500	C	Please clarify that the prohibition on reimbursing terminated providers does not include reimbursement for emergency services.	QI health plans may not reimburse any provider who is terminated from either the Medicare or Medicaid program including emergency services.
121	80.345.3 and 100.570	501 and 521	1 and paragraph 3, item 2	On page 501, the RFP notes that "Adequacy of proposed staff shall be judged based on an enrollment of approximately 20,000 members." This is in conflict with page 521 which notes "Staffing structure that demonstrates an effective operation to meet the requirements of the contract and to properly administer a program with a minimum of 25,000 members. Which membership level should be used in a bidder's response?	See #28 of Amendment #1.
122	100.400	508	4 (chart)	Are the section numbers on the Technical	See #25, #26, and #27 of Amendment #1.

Question #	RFP Section #	RFP Page #	Para #	Question	Answer
				<p>Proposal Evaluation charge correct? For example, 80.315.6 is missing; 8.315.3 is called "Required LTSS Providers" in the RFP, but labeled as "Attachment: Maps of Providers" in the chart, 80.315.4 is called "Maps of Providers" in the RFP, but labeled as "Availability of Providers Narrative" in the chart; and 80.315.5 is called "Availability of Providers Narrative", but labeled as "Provider Services Narrative" in the chart. Are these differences between the RFP and the Technical Proposal Evaluation chart intentional?</p>	
123	100.510	512	Last bullet	<p>Per the RFP, the HEDIS validation report is the document that should be attached for 80.310 G.</p> <p>Is '80.310 G' the correct reference for the item that is being evaluated?</p>	See #22 of Amendment #1.
124	100.520	513	Paragraph 2, Item 5	<p>This section has the following evaluation criteria entitled "Applicants with signed contracts for LTSS instead of LOIs".</p> <p>Was the intent of the 100.520 criteria to determine if the bidder had submitted contracts for nursing facilities only as indicated on page 116, Section 40.210 or was this meant for the evaluator to check</p>	Though DHS is allowing submission of a LOIs for HCBS providers, the existence of a signed contract will be scored higher than a LOI. The rationale is that a signed contract commits the provider to participate in the QUEST Integration program; a LOI does not have the same commitment.

Question #	RFP Section #	RFP Page #	Para #	Question	Answer
				<p>if contracts were present for both nursing facilities <u>and</u> HCBS providers?</p> <p>Would this item be scored differently in a proposal that had HCBS contracts instead of LOIs?</p> <p>It seems that existing QExA plans would be favored in the scoring for this item. Is this the intent of the criteria?</p>	<p>The community had expressed a desire to require an intact provider network at the time of proposal submission, which was a requirement under the most recent QUEST procurement. Instead of requiring health plans have a complete provider network at the time of submitting a proposal in response to this RFP, DHS allows the option of LOIs for HCBS providers only.</p> <p>All applicants can choose to utilize a signed contract or a LOI for HCBS providers. Please note that this is one of nine potential criteria considered upon evaluation of Section 80.315.1 to 80.315.3.</p>
125	20.600, 70.300, 80.230.R	21, 432, 476	2, 2, 2	DCCA only issues Certificates of Good Standing to stock insurance companies. Would a certificate of compliance issued by DCCA suffice for this requirement?	The Insurance Division will issue a Certificate of Good Standing for health plans. This Certificate of Good Standing will only be issued if a health plan meets the solvency standards identified in Chapters 431, 432, or 432D of the Hawaii Revised Statutes (HRS).
126	Contract Form			Will DHS consider adding a binding arbitration clause (as to disputes between the health plan and a QUEST member, including professional liability claims) in the form of the contract?	No.

Question #	RFP Section #	RFP Page #	Para #	Question	Answer
127	Attachment D, Proposal Letter	D-1	3	By signing the proposal letter the applicant is affirming that it has reviewed all documentation and has used it to submit the enclosed firm fixed price cost proposal. However, rates will not be available at the time the proposal is submitted. We respectfully request that the last sentence of the third paragraph be revised to omit the words “firm fixed price cost”.	See #30 of Amendment #1.
128	Attachment D, Annual Disclosure of Ownership	D-13	13	Please clarify that the definition of the term “Subcontractor” does not include parties falling within the definition of “Provider” on page 63 of the RFP.	See answer to question #6.
129	Attachment D, Annual Disclosure of Ownership	D-16	Question 13	This question asks for a list of Hawaii Medicaid providers with which the applicant has had aggregate business transactions of \$25,000 or more during any fiscal year. The applicant is also required to provide listings of providers in response to § 80.315. Is it necessary to specify those providers with which the applicant has had \$25,000 in transactions or could the applicant incorporate its § 80.315 provider listings by reference without filtering by amount?	Applicants should provide their list of providers that they have an aggregate business transaction of \$25,000 or more.

Question #	RFP Section #	RFP Page #	Para #	Question	Answer
130	Attachment D, Background Check Information Form	D-28	1	Could you please provide further clarification regarding who should be considered key personnel? The examples of Chief Executive Officer, Medical Director and Financial Officer are clear, but the examples of consultants, accountants, attorneys, etc. are harder to quantify. Could you provide additional clarity regarding the specific people that should be listed on this form?	Health plans should include their CEO, Medical Director, and Financial Officer of their health plan and any affiliates (or parent companies).
131	Appendix D, Certificate of Liability Insurance (COLI)	D-32	Footnote (1)	In the footnote it states that “the contractor should use the ACORD form currently in use at the time of submission with the contract.” The version included in the RFP is “ACORD 25 (2009/09)”; however “ACORD 25 (2010/05)” is available. Should health plans utilize the current version ACORD 25 (2010/05) in their submission, or is there another version?	Applicants may use either ACORD 25 (2009/09) or ACORD 25 (2010/05).
132	Definitions	62	N/A	The term “Presumptive Eligibility” is defined, however, not used in the RFP. Please clarify how DHS intends to implement “presumptive eligibility” processes as defined in the Affordable Care Act.	DHS is in the process of making these determinations. This should not affect submission of applicant proposals.
133	-	-	-	Can the DHS provide bidders with a Word version of the RFP so bidders may make their own updates?	No. DHS cannot release the Word version of the RFP at this time. Anything released to a potential applicant needs to

Question #	RFP Section #	RFP Page #	Para #	Question	Answer
					<p>be shared with all interested parties. Thereby, DHS would need to post any Word version of the RFP on the State Procurement Office (SPO) website. Any Word document may be altered. DHS would not be able to maintain its accuracy.</p>