

Technical Proposal Question & Answer

Issued on: September 14, 2011

For Request for Proposals RFP-MQD-2011-003

QUEST Managed Care Plans to Cover Eligible Medicaid and Other Eligible Individuals who are not Aged, Blind, or Disabled

Question #	RFP Section #	RFP Page #	Para #	Question	Answer
1	20.100	16		Will an oral presentation be part of the evaluation/scoring process?	No
2	20.100	16		<p>Capitation Rates Orientation, scheduled for October 17, 2011.</p> <p>Since this is a key part of the proposal process, can the DHS allocate at least 2 hrs, or as much time as reasonably needed, for this meeting to allow enough time for discussions?</p> <p>Can the DHS add additional lines for the conference call? During the orientation meeting, the number of callers exceeded the available conference lines.</p>	<p>Section 20.200 describes that the Capitation Rate Orientation is scheduled for two hours. DHS will extend this orientation as long as the questions being asked are meaningful, have not previously been addressed, and are related to the current procurement.</p> <p>Additional lines will be added to this orientation.</p> <p>See #3 of Amendment #1.</p>
3	20.100	16	2	The timeline table indicates that the capitation rates will be issued on October 7th. Are these rates expected to be released before or after the 2 pm technical proposal deadline?	No specific time is established for issuing the capitation rates.

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4	20.100	16	2	The timeline indicates the start up date is April 1, the historical renewal date is July 1. Is it the State's intention that new contract provisions and rates will be commence on April 1, 2012 and the first "contract period" be for 20 months? Thereafter, will the contract year be January 1st to December 31st? Additionally, how will the increase in the "VDHC" % of the network be measured if the first contract period is longer than 12 months?	The initial contract period is for nine (9) months (April 1, 2012 through December 31, 2012), then the contract year will run from January 1 through December 31. The first VDHC benchmark is applicable to the first nine-month contract period, and the second benchmark is applicable to the subsequent twelve-month contract period.
5	20.100	16	table	Will there be an opportunity to ask clarifying questions in response to the state's answers to the technical proposal questions issued on 9/14?	See #1, #4, and #94 of Amendment #1.
6	20.300	18		Will health plans be able to submit follow-up questions if the DHS' responses on September 14 th require clarification? Or will there be some other opportunity for dialogue/questions?	See question #5.
7	20.700	21 - 22	1	"QUEST Financial Reporting Guide" link incorrectly brings you to the same document as the "QUEST Encounter Data/Financial Summary Reconciliation Form" link. Can the link be updated to go to the appropriate reporting guide?	DHS is in the process of revising the QUEST Financial Reporting Guide. We will post the revised reporting tool when it is completed.

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8	21.200	28	1	Does the Proposer have discretion regarding the naming conventions for the electronic files submitted to DHS or does DHS have specific requirements for this?	There are no naming conventions required for the response to this procurement.
9	30.200	38		There are several sections within the RFP that reference APRNs that include a definition in section 30.200 on page 58, and section 40.250 on page 122. Since DCCA maintains two separate applications and qualifications for APRNs, can these references be reviewed for consistency of wording throughout the RFP?	DHS has made amendments to Sections 30.200 and 40.250 to provide clarity to APRNs utilization in the QUEST program. See #7 and #24 of Amendment #1.
10	30.200	40		“Benefit Year”. Example: The commencement of services begins April 1 st . If the first benefit period under this new procurement April 1, 2012 through December 31 2012, is it accurate to assume that benefits used by an existing member from January 1, 2012 through March 31, 2012 would not be counted under this new procurement?	Yes. Benefits provided under the current QUEST contract will not be counted toward the next contract’s coverage. However, if the benefit period is less than twelve months, DHS may pro-rate the benefits.
11	30.200	42		“Clean Claim”. Please provide an example of a claim that meets the definition of ‘It includes a claim with	The definition of “Clean Claim” provided in Section 30.200 is directly from 42 C.F.R. § 447.45, Timely claims payment.

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				errors originating in a State’s claims system”.	This CFR must be followed even in managed care. This definition describes that if the claims processing system (in this definition, the State system but in managed care would include the health plan’s claims processing system) causes an error, then the claim should be treated as a clean claim.
12	30.200	50		Should this section reflect the updated description for HEDIS as “Healthcare Effectiveness Data and Information Set”?	See #8 of Amendment #1.
13	30.200	64	“Sub-contract” definition	Does the definition of "Subcontract" include provider agreements?	No.
14	30.320	67	1 st paragraph	Should the 1 st sentence on QUEST-Net benefits be removed and replaced with the eligibility requirements since the benefits will be defined in section 40.710?	See #9 of Amendment #1.
15	30.330	67		QUEST-ACE. Should the last part of this sentence read “Uninsured adults ineligible for QUEST with incomes not exceeding 133% of FPL subject to the QUEST-ACE enrollment limit are eligible for QUEST- Adult ACE benefits as described in Section 40.710.1 in QUEST-Adult and	See #10 of Amendment #1.

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				shall be mandatorily enrolled.	
16	30.400	71	1	Sections 60.130, 31.410, and 30.400 seem to conflict with each other. Section 60.130 says the health plan shall be responsible for billing and collecting a members' premium share, but section 31.410 says the MQD administers the billing and collection of the members' share of their monthly premium rate, and section 30.400 says the DHS shall manage the Premium Share Billing System. Which is correct? If the plan will be responsible for billing and collecting member premiums, when will this responsibility begin and when will plans receive more detailed requirements?	See #11 and #21 of Amendment #1. The health plans shall be responsible for billing and collecting members' premium share, if applicable, as described in Section 60.130 upon contract implementation.
17	30.510	72	2	How will the state's actuary capture the expected claims five days prior to enrollment in the rates, since that has not been covered in the program before?	DHS will answer this question as part of the proposed capitation rate questions that will be responded to on the date specified in Section 20.100 of the RFP.
18	30.510	72	2nd bullet	What is considered "appropriate" medical expenses?	Medical expenses that are medically necessary and part of the covered benefit. For example, for an adult twenty-one years or older, the purchase of eyeglasses would not be covered. For a child under the age of twenty-one, the purchase of eyeglasses would be covered.

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19	30.520	74	2	This differs from Section 30.510. Please clarify.	These sections have been reviewed and are not inconsistent.
20	30.520	74	2	Will DHS consider providing health plans with a minimum number of members in year 1 through auto-assignment, so that a statistically valid sample can be taken to meet necessary HEDIS measures and CAHPS scores for the year 2 quality portion of the auto-assignment? If not, will DHS extend the year 1 auto-assignment methodology until plans have reached the necessary minimum enrollment? (Analysis suggests that ~ 12,000 members are required to provide results for statistically sound measures.)	No, auto assignment will be equally distributed as set forth in section 30.520. However, only factors that are applicable to all participating plans will be considered in the auto-assignment methodology.
21	30.520	74	2	Assuming incumbents are awarded contracts, how will a newly entering health plan be evaluated on the quality factors (related to the auto-assign algorithm), considering the limited number of members available to new plans?	If a measure cannot be applied to all participating plans, it will not be considered in the quality factors.
22	30.520	74	2nd para, 2nd bullet	What month will the quality portion of the auto assignment algorithm be updated?	January, beginning 2014. See #2 of Amendment #1.
23	30.520	74	2 nd paragraph	Is any consideration being given to “risk adjusting” quality measures, to not penalize plans that have a population	No. However, the benchmarks and thresholds that are developed for both HEDIS and CAHPS takes into

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				that significantly differs from the population another plan may be serving, particularly higher risk members (including but not limited to characteristics such as: ethnicity/cultural factors, homelessness, primary care provided by a community health center, etc.)?	consideration Medicaid populations overall who are a higher risk than the general population.
24	30.520	74	2 nd paragraph, 2 nd bullet	In terms of scoring proposals and rewarding health plans that offer greater value, we urge you to limit the baseline HEDIS scores as a factor in qualifying a bidder. Would you consider linking the auto-assignment algorithm to those Plans that support supplemental services and offer more shared savings? Their value-added contributions are far more important to us than marginally precise HEDIS comparisons.	No. Since the bids will be essentially fixed, the value comes from the quality of patient-centered health outcomes achieved, thus making them of even greater importance.
25	30.530	75	1 st bullet	We would suggest that the quality portion of the auto-assignment be implemented at the beginning of a calendar year since both benefit period and contract period will be based on a calendar year.	This is a good suggestion. DHS will move the implementation of the quality portion to January 1, 2014. See #2 of Amendment #1.
26	30.530	76		Is the initial open enrollment period 1/1/12 thru 1/30/2012?	DHS has not determined the specific dates of the open enrollment period at this time.
27	30.530	76	1 st paragraph	Will the thirty day period be the first thirty days within the 90 day period? Or	It is any thirty (30) day period within the ninety (90) day period.

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				is it any thirty day span within the 90 day period?	
28	30.530	76	1 st paragraph, 3 rd sentence	<p>Should this sentence read “All new enrollments that occur during this period shall be effective on the Commencement.....”?</p> <p>If not, what is this 3rd sentence referring to? Is it referring to the 30-day period within the 90 days prior to commencement?</p>	<p>No, as the heading of the section refers to initial enrollments.</p> <p>Yes, it is referring to the 30 day initial enrollment period.</p>
29	30.530	76	2 nd paragraph	<p>Is the 2nd paragraph referring to new enrollees entering the QUEST program during this initial enrollment period?</p> <p>If so, can additional language be added to this paragraph to clarify the situation? Example: “In the event an individual who is new to the QUEST program does not select a health plan during this period, the DHS shall assign....”</p>	No, the section refers to “existing QUEST program members.” Newly eligible members will be addressed in the same manner as set forth in the preceding section for Enrollment Responsibilities.
30	30.530	76	3	What provisions are available for new applicants to build membership if members currently enrolled in a QUEST health plan [and that health plan wins a contract] fails to go through initial open enrollment? Will the algorithm described in section 30.520 be adjusted to allow a new applicant to gain	<p>Section 30.530 provides existing members choice of health plan.</p> <p>No, the algorithm will not be adjusted to ensure new health plans have adequate enrollment.</p>

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				adequate enrollment in the shortest period of time [in 6 to 9 months]?	
31	30.540	77		Can additional language be added to this section for clarification? “Throughout the term of the contract, all newborns of medical recipients shall be automatically enrolled into the health plan of the mother by the DHS retroactive to the date of birth upon receipt of a complete 1179 from the health plan per section 50.240. ”	No. The current wording of the paragraph is consistent with DHS’ intention.
32	30.550	77	4	Will individuals who did not select a plan and are enrolled in a health plan that was awarded a contract in the previous and current procurements be eligible for the 30-day grace period?	Yes.
33	30.570	79	1 (table)	Enrollment cap for Oahu is 60% of island enrollment. Will 60% of the Medicaid population on Oahu be allowed to enroll into an MCO program? Please clarify.	Yes. DHS may limit a health plan’s enrollment on Oahu once they have reached 60% of enrollment on the island of Oahu.
34	30.580	82	1 st bullet	Would a change in “Telephone number” impact a member’s status or eligibility?	No. A change in telephone number would not change a member’s status or eligibility if this was the sole change.
35	30.600	82	Bottom bullet	If a transitioning member is enrolled in a QUEST plan that also participates in QExA, will that member be auto-assigned to the QExA plan for continuity	Yes. If a member is in a QUEST health plan that also participates in the QExA program, the member will be auto-assigned to that same health plan when

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				of care purposes?	transitioned to QExA. However, the member will be offered choice of health plan and retain their rights to choice afforded described in the enrollment provision in the QExA contract.
36	30.600	83	4 th bullet	Should this disenrollment reason have the same language as the 2 nd bullet in 30.360?	No.
37	30.600 & 50.530	82 & 261	9 & 1	Please describe the provisions and requirements for a member being waitlisted for a long term care bed at an acute hospital. Please describe how the provision in section 30.600 impacts the hospital reimbursement provisions in section 50.530?	Please reference §40.740.1 h Members Waitlisted for a Long-Term Care Bed or Placement into a Long-Term Care Facility. Health plans may establish a per-diem reimbursement rate for waitlisted patients as opposed to diagnostic-based methodology for acute-care hospital stays.
38	30.710	85	3	This sections states that the health plan is responsible for cornea transplant & bone graft. It's also referenced in Section 40.710.2 (QUEST Keiki Benefit Package). Does this also apply to adults? If so, it should it be included in Section 40.710.1 (QUEST Adult Benefit Package), and/or Section 40.760.1?	Yes. See #28, #30, and #39 of Amendment #1.
39	30.710	87	1st bullet	Please clarify when the QExA date is effective for members determined permanently disabled. This section states that individuals determined permanently disabled are transferred to	See #14 of Amendment #1. DHS has amended Section 30.710 to be consistent with Section 30.900.

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				<p>QExA effective the first day of the second month following the <u>receipt</u> of a completed ADRC packet. Section 30.900 (pg 98, paragraph 2), states that effective date is no later than the first day of the second month following the date the ADRC packet is <u>approved</u> by DHS. In the Balanced Budget Act Provision, does Section 438.56.e of the Federal Register (Timeframe for Disenrollment determinations) apply to ADRC enrollments? If so, should the effective date of enrollment into the QExA plan be the first day of the second month following the date the ADRC packet was <u>submitted</u> (instead of the date the ADRC packet was approved)? The timeframe would be much better if referenced from the date of submission or receipt of the completed ADRC packet as it is now, because it reduces another level of variability that relates to when the packet is reviewed.</p>	<p>In addition, 42 CFR Section 438.56e does not refer to the ADRC process but the disenrollment processes described in Section 30.600 of the RFP.</p>
40	30.710 and 30.900	87; 98 & 99	1 st bullet on pg. 87; 4 th paragraph on page 98 and 2 nd	<p>In relation to ADRC, page 87 states that if determined permanently disabled, the individual is transferred to a QExA plan effective the 1st day of the second month following the receipt of a completed ADRC packet per the</p>	<p>See response to question #39.</p>

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			paragraph on page 99	established ADRC process. However, on page 98, it states that enrollment into the QExA plan is no later than the first day of the following month following the date the ADRC packet is approved by DHS . This same language also appears on page 99 as applied to newborns that are determined to be disabled. Please clarify which statement is accurate.	
41	30.730	88	1st bullet	Health plans do not have a contract or business associates agreements with DHS-contracted agencies. Can we send it to designated staff?	Health plans should refer their members in need of EPSDT dental services to the DHS-contracted agency. This requirement does not ask the health plan to contact the DHS-contracted agency thereby requiring a business associate agreement.
42	30.730	88	2 nd paragraph, 2 nd sentence	Should language mentioning benefit limits be added to clarify that medically necessary dental services are subject to limits within the adult benefit plan?	See #15 of Amendment #1.
43	30.820.1	91	1	How many children were determined newly eligible for the SEBD program in 2010? How many in total are currently enrolled?	The SEBD program within CAMHD is not part of DHS. DHS does not have this information.
44	30.820.1	91	2	This section states that “health plans shall have a process in place to identify and refer to CAMHD, children/youth that are unstable, of moderate-high risk and in need of the SEBD program.”	The health plan makes a referral to the DOH CAMHD and DOH CAMHD performs an assessment to determine eligibility in their program.

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				What assessment tools are plans required to use for this purpose or will the DOH CAMHD perform an assessment to see if a member meets the criteria for such services?	
45	30.820.1 40.751 40.753 40.762 51.220	92 207 216 220 310	2 (6 th bullet) 3 9 1 1	Beyond the assessment tool described in section 40.740.2.C [paragraph 1 4 th bullet], does DHS have criteria for behavioral health and health status assessments as referenced in these RFP sections? If yes, please specify. If no, what are the criteria for the applicant's behavioral health and health status assessment tools?	<u>30.820.1</u> - see response to question #44. <u>40.751</u> - health plans develop their own assessment tools consistent with guidance in this Section and 42CFR438.208(c). <u>40.753</u> - see Appendix I. <u>40.762</u> - this comprehensive examination is performed by a health care provider (e.g., physician, APRN, clinic, etc.). Health plans may require use of the EPSDT screening tool (DHS 8015) found in Appendix I. <u>40.751</u> - health plans develop their own assessment tools consistent with guidance in this Section and 42CFR438.208(c).
46	30.820.2	94	3	If a health plan is able to provide cleft/craniofacial care services, do they still need to use the Kapiolani's service? If it is still required, how is reimbursement for these services determined?	No. If a health plan is able to perform these services without using Kapiolani's cleft and craniofacial clinic, then they are not required to utilize this provider.
47	30.900	98	2	If disenrollment to a QExA takes longer than the first day of the second month following the date of the ADRC packet is approved by DHS, will the enrollment	Yes.

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				date to QExA be retroactive to the first day of the second month following the date of the ADRC packet approval by DHS?	
48	30.900	99	1	How will DHS inform QUEST plans that a newborn's mother is QExA so that the plan knows that DHS Form 1179 is also needed?	The QUEST health plan is not responsible for notifying DHS about newborns to a QExA mother. However, newborns of a QExA mother shall be auto-assigned into a QUEST health plan until choice is made.
49	30.900	99-100	3 rd &1 st	What is the exact timing for the member to be transferred to SHOTT? Will the responsibility for the member take place immediately when the member is determined to be eligible for SHOTT?	The health plan will cease responsibility for the member on the date the member is enrolled into SHOTT by DHS.
50	30.900	100	Last sentence	What is the current cost to DHS per case for disability determinations?	Approximately \$300.
51	30.900	101	1	What is the current denial rate for disability determinations?	Approximately 10%.
52	30.900	101	1	Section 30.900 states the penalty for discordant ADRCs is 20%/year. In Section 51.540.9, the penalty is 10% for discordant ADRCs and no timeframe is specified. Please clarify what the penalty is. The penalty for 20% year discordant ADRCs is better as penalizing discordant ADRCs per quarter would not be a good idea as the numbers of ADRC submissions per quarter can be too small.	The penalty is 10% (see amendment #15). The penalty is assessed annually to address the small number of submissions per quarter. See #20 of Amendment #1.

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53	31.120	102	1	In the event a plan participates in both QUEST and QExA, does the State anticipate there would be two separate EQRO evaluations, or a single combined review?	Areas that can be combined will be consolidated in the EQRO evaluation; however some sections are distinct and will require separate evaluation.
54	31.200	105	1	A sentence in the first paragraph reads: “The health plan shall comply with the requirements of all the policy memorandums during the course of the contract and execute each QUEST memorandum when distributed by MQD during the period of the contract.” Should a policy memorandum as described above result in additional cost or risk to the applicant will the applicant have the right to negotiate the terms of the policy memorandum or terminate its contract? Will all changes to either QUEST policy or the applicant’s contract that could result in additional cost or risk to the applicant be processed as a contract amendment?	QUEST memoranda are often used to describe Department policy that is not incorporated into the contract. The health plan will follow Sections 71.400 and 71.600 with regards to contract modifications.
55	31.200	105	2 nd paragraph of section	All QUEST policy memos issued prior to commencement of services on 4/1/12 are ineffective. Health plans will be informed 30 days prior to service commencement of memos that the DHS specifically determined to remain in effect.	Health plans should utilize the Request for Proposals (RFP-MQD-2011-003) to establish their policies and procedures. Any policy guidance that DHS has issued previously that shall remain in effect will be provided at least thirty days prior to commencement of services to members.

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				Will replacement instructions be provided at that time for the prior memos that will no longer be in effect? (Some of these changes may require workflow or P&P revisions).	
56	31.300	105		Who has the DHS selected to assist the DHS during the readiness review?	This function will be procured. DHS does not have a vendor at this time.
57	31.300	105-106	1	When will the readiness reviews be scheduled and how much prior notice will plans receive before their readiness review?	No timeframe has been established for on-site health plan readiness reviews. Health plans will be given at least thirty (30) days notice prior to any on-site health plan readiness reviews.
58	31.410	108	9	Sections 60.130, 31.410, and section 30.400 seem to conflict with each other. Section 60.130 says the health plan shall be responsible for billing and collecting a member's premium share, but section 31.410 says the MQD administers the billing and collection of the member's share of their monthly premium rate, and section 30.400 says the DHS shall manage the Premium Share Billing System. Which is correct? If the plan will be responsible billing and collecting member premiums, when will this responsibility begin and when will plans receive more detailed requirements?	See response to question #16.

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59	40.210	113	Last sentence	When will DHS provide health plans with the format to report application denials or terminations attributable to providers appearing on any federal or state exclusion list?	After contract award.
60	40.210	114	10	Section 40.210 states "The health plan shall have an established provider network that meets the requirements of this RFP at the time of proposal submission." Does this statement mean that our contracts must contain all requirements of section 40.500 Provider Contracts at the time of proposal submission?	The provider network must be established at the time of proposal submission, but provider contracts may be amended subject to the clause on page 141 to bring existing contracts into compliance with the terms in this RFP prior to readiness review.
61	40.220	115		Will the DHS issue minimum provider-to-member ratios for specialists as there have been in previous RFPs.	No. The requirements in section 40.220 are the minimums, however no specific ratio's for specialist are being required.
62	40.220	116		Can DHS provide the number of SPMI members in QUEST, so the number of required providers per member with SPMI can be determined?	The total numbers have remained consistently stable the past several years. The number newly diagnosed is not tracked. Currently, the QUEST plans have identified approximately 1,950 SMI. Below is an approximate breakout by island. E Hawaii 375 W Hawaii 145 Lanai 1 Kauai 50 Maui 275

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					Molokai 4 Oahu 1,100
63	40.220	116	1 st paragraph, 2 nd sentence	Can you clarify that this sentence means that the provider to member ratio needs to be met on a per island basis?	Yes. On a per island basis.
64	40.220	117	1	Have the geographic areas with a demonstrated shortage of qualified physicians been defined, or will plans be responsible for documenting to the state? If the latter, what will be the standard and process for defining such areas?	DHS is posting a listing of where QUEST members reside based upon zip code to the Request for Proposals (RFP) Documentation on the MQD website at www.med-quest.us . Health plans must document that they have adequate providers for access in all areas that the health plan submits a proposal to serve.
65	40.220	117	Table	Specialized Residential Treatment and Residential Treatment are required providers for the SPMI program but are not listed under Section 40.720.1 as additional benefits available for members with SPMI designation. Was this an oversight?	No. Specialized Residential Treatment facilities provide services that are described in Section 40.740.2.c.v, Therapeutic Living Supports.
66	40.220	119	2 nd paragraph, 1 st bullet	What does this section mean? Is a provider required to submit a waiver to 'close' his/her panel which must be approved by the DHS?	Yes.
67	40.230	119	1 st bullet	Can the first bullet be modified to read "...Immediate care at a hospital emergency department (twenty-four (24) hours a day..."	No. Immediate care may be provided in an urgent care center as well.

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68	40.230	119	4 th bullet	Please clarify “PCP visits (routine visits for adults and children) - Appointments within twenty-one (21);” is this 21 hours, days, weeks?	The number refers to days, i.e. 21 days. See #23 of Amendment #1.
69	40.230	119	4th bullet	Please clarify the acceptable wait time for PCP visits (routine visits for adults and children). Should this be 21 <u>days</u> ?	See question #68.
70	40.230	119	Bullet #4	Statement doesn't seem to be complete ... "PCP visits ... Twenty-one (21); and". Can we get clarification?	See question #68.
71	40.230	119	Bullet 6	“Network providers accept members for treatment unless the provider has requested a waiver from this provision and the health plan has received a waiver from DHS.” Does this requirement apply to PCPs seeking to close their panels to new patients?	Yes.
72	40.250	123	Last paragraph on page 123	The reduction of the PCP to member ratio from 600 to 300 seems to limit access, especially on the neighbor islands. We understand that this limit is applied only in the PCP auto-assignment process and does not apply to members who select their PCP. We want to promote access to timely, quality care. Many times that means auto-assigning a member to a PCP. Part of the value of partnering with health	The purpose of this is to help ensure access to primary care providers by requiring a greater number to be networked. Health plans may submit a waiver to DHS for specific PCPs.

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				plans is to leverage the plan's broader patient base as a potential patient pool for the provider's practice. There are several PCP providers who have an exclusive relationship with one health plan. Are those providers subject to this limitation? Can we obtain a waiver from DHS on behalf of the provider if the provider indicates that they are able to accommodate more than this number of members.	
73	40.250	124	2	Section 40.220 Specific Minimum Requirements (page 118) states arrangements must be made with another provider with admitting privileges on the same island of service. Should this section state the same?	Yes. In Section 40.250, pg. 124, second paragraph, it states: "If a PCP (including specialists acting as PCPs) with an ambulatory practice does not have admission and treatment privileges, the provider shall have a written agreement with at least one other provider with admitting and treatment privileges with an acute care hospital within the health plan's network."
74	40.250	124	2 nd paragraph	Since the use of hospitalists is becoming more prevalent statewide, can the requirement for admission and treatment privileges be relaxed? Many neighbor island PCPs are using hospitalists to care for their patients.	See question #73. If a PCP does not have admission or treatment privileges, the provider shall have an agreement with someone that does have admitting or treatment privileges. This alternate provider may be the hospitalist (or hospital that contracts with hospitalists).

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75	40.250	126	1	This section requires the health plan to notify members within 15 calendar days after a PCP notifies the health plan of termination. If a PCP notifies the health plan significantly in advance of the termination date (e.g. 6 months, 9 months, one year, etc.), can the health plan instead notify the members within 30 days of the PCPs actual date of termination?	Yes.
76	40.270	126	1	If FQHCs do not enter into a contract with the applicant, what criteria will DHS use to assess an applicant's network to determine if the applicant has a "...adequate capacity and an appropriate range of services for vulnerable populations"?	If the applicant has PCP's and the various requirements in section 40.220 in the more geographically difficult to serve areas of the State, in sufficient numbers to serve that area. i.e., if the plan seeks to serve Maui, then it must have sufficient pediatricians (or any other specialties to include but not limited to behavioral health and case management) to serve Hana (or any other geographically remote area).
77	40.270	126	1 st paragraph	The RFP references a function of care coordination to include referral to services such as translation and transportation. The 1115 waiver requires plans to provide FQHC services. There is now an acceptable standard definition for these care enabling services. Why can't the	The RFP specifies services that a health plan must make available to all members. Neither DHS nor the RFP mandates that patients be limited to one provider type to access those services

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				RFP and subsequent contracts define more precisely these FQHC services as a deliverable?	
78	40.280	127	2	How will the member be enrolled in a health plan that has these providers in its network? Does the member contact DHS to request a plan change?	Yes. On the basis that the service is not offered by their current health plan. If the member initially contacts the health plan's customer service department, the health plan should relay that request to DHS via their designated contract liaison.
79	40.500	133	#4	Should the requirements of #52 be combined with #4?	No. There is a difference between the two terms.
80	40.500	133	#5	Can a provider impose a no-show fee to members with a QUEST-ACE and QUEST-Net eligibility category if an acknowledgment of the provider's no-show policy is signed before a no-show fee is assessed?	No. The only time a provider may implement a no-show fee is if the service provided is not a Medicaid-covered service. In addition, the benefit for both QUEST-ACE and QUEST-Net will be the same as the QUEST benefit for adults.
81	40.500	135	#20	"Require the provider to provide medical records or access to medical records to the health plan and the DHS or its designee, within sixty (60) days of a request." Does this provision also apply to appeal requests? If so, can it be revised to allow for a shorter period within which medical records must be provided in cases of an appeal or somehow revised to match the resolution	Health plans may require a shortened timeframe to request information for an appeal.

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				<p>timeline for Member appeals? For example, if the health plan has 30 days to respond to an appeal, the provider has 10 days to provide the records.</p> <p>Allowing providers to submit medical records inhibits the health plan's ability to resolve appeals within the member appeal (30 day) timeframe. "Refusal to provide medical records, access to medical records or inability to produce the medical records to support the claim/encounter shall result in recovery of payment." If the provider does not provide medical records based on the health plan's request, is the member held harmless?</p>	
82	40.500	137	#33	<p>What does this section mean? Is a provider required to submit a waiver to 'close' his/her panel which must be approved by the DHS?</p>	Yes.
83	40.500	140	#50	<p>How would a provider become aware of a patient's prior coverage period so that they could be in compliance with this requirement?</p>	Prior period coverage will be identified on the DHS On-Line system as the enrollment date in the health plan.
84	40.500	140	51	<p>Item 51 indicates a provider contract should require, if applicable, annual cost reports to be submitted to MQD. Which providers are required to submit cost reports to MQD?</p>	Both hospitals and nursing facilities.

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85	40.500	141	#5	How does #5 differ from #4?	A no-show fee is a fee that a provider may impose if a member fails to show up for an appointment. This is different from a provider seeking payment for a covered service for any reason to include but not limited to a provider that is not satisfied with their reimbursement fee and requires members to enhance their reimbursement from the health plan.
86	40.500	142	2 nd paragraph	Would a health plan from the previous QUEST procurement that has been awarded a contract in this procurement be required to submit copies of the signature page of all finalized and executed contracts during the readiness phase?	Yes.
87	40.610	144	3rd bullet	"The member's right to a State administrative hearing, how to obtain a hearing and rules on representation at a hearing." Please define "rules."	Please see HAR §17-1402-11.
88	40.620	145	3	Is member consent required if an appeal is submitted by a provider on the member's behalf?	Yes. Written consent is required as defined in 42 CFR§438.402(b)(1)(ii).
89	40.620	145	3	"The health plan shall have policies and procedures for a provider grievance system that includes provider complaints, provider grievances and provider appeals. Provider complaints, provider grievances and provider	The health plan shall submit to DHS for approval all situations where the accreditation standards are in conflict with DHS standards. In most cases, if the stricter standard is in the benefit of the member, DHS will allow the health plan to

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				appeals shall be resolved within sixty (60) days of the day following the date of submission to the health plan." If accreditation standards are stricter, should the health plan follow DHS or accreditation resolution timeframes for provider complaints, grievances, and appeals?	follow accreditation resolution timeframes.
90	40.620	147	3	"The grievance and appeals process shall provide for the timely and effective resolution of any disputes between the health plan and provider(s)." Define "timely and effective."	See § 40.620, page 145 first paragraph. Timely is 60 days or less. Effective refers to a dispositive resolution either for or against the provider.
91	40.630	153	7 th bullet	Please provide examples of 'adjudication procedures'?	This section should describe how a provider submits and has claims paid.
92	40.640	154	1 st paragraph	Is a separate provider call center required or can a health plan operate a call center that handles both provider and member calls within one call center?	The call center can handle both provider and member calls as long as the health plan is able to report on statistics related to each separately.
93	40.640	154	4 th bullet	Please provide an example of a blocked call.	The caller is unable to connect i.e., busy signal or not accepting a call from 'private number.'
94	40.640	155	2 nd paragraph	Please review the 2 nd sentence in this paragraph. Not clear as to the guidance this sentence is trying to provide to the health plan.	Allows the non-PCP (emergency room MD) to authorize an outpatient follow-up without requiring authorization from the PCP if doing so would cause unnecessary delay to the member for such follow up specialty care.

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95	40.640	155	2 nd paragraph	Please review the 2 nd sentence in this paragraph. Not clear as to the guidance this sentence is trying to provide to the health plan.	See response to question #94.
96	40.650	156	1	Please explain your definition of "real-time". We are assuming that this means the information on the website must match the information in our claims system at the time of inquiry. Please provide your definition.	This 'real-time' tracking system shall allow providers (and members) the ability to determine utilization of their patients (or themselves). Health plans shall establish this tracking system for both inpatient and outpatient usage. Health plans shall include in the tracking both claims data in the health plan's possession as well as prior authorization issued.
97	40.650	156	1	Real time utilization tracking: Please clarify whether DHS expects tracking to occur via claims or authorizations. If claims are used, tracking may be limited due to providers having 365 days to submit. If authorizations are used, the tracker would not be reporting actual utilization to date. Additionally, many plans do not require outpatient providers such as PCPs and Specialists to request authorization for basic services. Guidance from DHS on its expectations and preferred methodology would be appreciated. Also please clarify whether DHS is requiring the same functionality for inpatient days.	See answer to question #96.

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98	40.650	156	1 st paragraph	Please provide examples of functionality that would meet this requirement: "...functionality to allow providers to make inquiries and receive responses from the health plan regarding care for the member,"	The examples provided in the RFP are health plan eligibility, electronic prior authorization request and approval, and utilization of limited member benefits.
99	40.650	156	1 st paragraph	Please provide clarification on what is considered "real-time system to track utilization of limited member benefits". Is utilization based on claims data, prior authorization/ referral data or both?	See answer to question #96.
100	40.700	157	4	If a health plan offers additional services, with the cost of the services be considered either "medical expenses" or "administration costs" in the Gain Share Program calculation?	Administration costs.
101	40.710	158		Will the RFP include a list of services and items not covered by the QUEST program (similar to Appendix O in the current contract)?	No.
102	40.710	158		Please provide clarification on how the QUEST Adult and Keiki benefits listed in the bullets on pages 158-160 (Adult) and pages 161-162 (Keiki) should be interpreted by the health plans. Are these the only benefits available within the respective benefit package and if there isn't a specific limit	Adults These are the only benefits available for adults in the QUEST program. If there is no specific benefit limit, then that category of benefit has no quantitative limit. Keiki There could be additional benefits that a health plan may be required to provide

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				indicated within the bullet, then that particular category of benefit has no quantitative limit?	based upon EPSDT requirement identified in Section 40.753.
103	40.710	158		<p>Can the DHS review the listing of benefits that are bulleted within the Adult and Keiki benefit packages to ensure that there is consistency in the naming convention and that the lists are complete?</p> <p>There are benefits listed in the Adult package that are not listed in the Keiki package. (e.g. Diabetic supplies, Interpreter Services/Translation Services, etc)</p> <p>There are benefits listed in the Keiki package that are not listed in the Adult package. (e.g DME, Emergency and Post Stabilization services, Medical services related to dental needs, Other practitioner services, Vision & hearing services, Urgent care services, Sterilizations and hysterectomies, etc)</p>	<p>Diabetic supplies are covered under DME and medical supplies. DME and medical supplies are not a covered benefit under QUEST Adult.</p> <p>The following services are listed under 40.710.1 QUEST:QUEST Adult Benefit Package, bullet point #3 (Twenty (20) outpatient medical or behavioral health visits):</p> <ul style="list-style-type: none"> - Medical services related to dental needs; - Other practitioner services; - Vision & hearing services; - Urgent care services <p>The following services are listed under 40.710.1 QUEST:QUEST Adult Benefit Package, bullet point #2 (Ten (10) inpatient hospital days for medical and surgical care:</p> <ul style="list-style-type: none"> - Post-stabilization - Sterilization and hysterectomies. <p>Emergency services and Emergency Medical Services are the same benefit.</p>

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					<p>Interpreter Services/Translation Services has been removed since this benefit (described in Sections 50.430 and 50.495) are for all served in the QUEST program.</p> <p>See #25 and #26 of Amendment #1.</p>
104	40.710	158		Is there a specific list of excluded services that the DHS will provide that is similar to Appendix O from prior RFPs?	No.
105	40.710	158		Are renal dialysis services a covered benefit with the QUEST – Adult benefit package? Is it a covered benefits in the QUEST-Keiki program? If not a benefit of either/both programs, please explain how and where affected beneficiaries will obtain coverage for these services.	<p>Renal dialysis is a benefit for QUEST-Keiki. See amendment #19, #29, and #31 of Amendment #1.</p> <p>QUEST members that have end stage renal disease should be disenrolled from the QUEST program through the ADRC process described in Section 30.900.</p>
106	40.710.1	158		Are there any other service categories that are excluded from adult benefit coverage limitations similar to cancer treatments (70.754)?	Both pregnancy-related services (Section 40.740.1.n) and behavioral health services (40.740.2.c) do not have limitations as well.
107	40.710.1	158		QUEST, under the Definitions section, states the standard benefits package is for non-pregnant adults. However, in Section 40.710.1, it does not mention the exclusion of pregnant women. It's also misleading because Section 40.740.1 includes Pregnancy Related services (n). Please clarify the language to make it	<p>The QUEST Adult benefit package is for pregnant women. Pregnant women receive unlimited pregnancy-related services as described in Section 40.740.1.n.</p> <p>See #36 of Amendment #1.</p>

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				clear that the QUEST Adult benefit package is for non-pregnant adults.	
108	40.710.1	158	Entire section 40.710.1	Does the adult benefit package include off-island and/or out-of state-services? If yes, which services?	Yes. If the service is medically necessary, a covered benefit, and is not available to the member on island or in the State.
109	40.710.1	158	Entire section 40.710.1	If the adult benefit package includes out-of-state services, what should a health plan do if out-of-state providers refuse to accept the member because of the limited inpatient hospital days or outpatient visits, especially if the health plan does not plan to exceed the benefit limits established by DHS?	It is incumbent on the health plan to meet the member's medical needs. If this is not possible in network, the health plan will need to make accommodations to find those services out of network, or arrange for them to be available. Perhaps the plan will need to explore other providers.
110	40.710.1	158	Entire section 40.710.1	Are DME and supplies excluded from the adult benefit?	Yes. Except for diabetes supplies as described in Section 40.710.1.
111	40.710.1	158-160	Q-Adult benefit listing	The benefit listing is somewhat vague. Is it possible to list the benefits in a manner similar to the QUEST-Keiki benefit list on page 161?	Both sections 40.710.1 and 40.710.2 provide lists. Section 40.710.1 provides more detail than 40.710.2. DHS has modified the list to make easier to understand. See #25 of Amendment #1.
112	40.710.1	158-161		What is the QUEST Adult coverage for: - Implants - External prosthetic devices/aids (such as braces) - Orthotics - Blood on an outpatient basis	QUEST Adult does NOT provide coverage for: - Implants - External prosthetic devices/aids (such as braces) - Orthotics

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				<ul style="list-style-type: none"> - Blood in an inpatient setting and ASC - Inpatient acute rehab 	<p>Inpatient acute rehabilitation is included as a benefit for QUEST Adult (see #25 in Amendment #1).</p> <p>Transfusion of blood should NOT be denied in an outpatient, inpatient, or ASC setting.</p>
113	40.710.1	159		Are physician visits performed during an inpatient stay subject to any benefit limitations?	Medically necessary inpatient physician visits provided during a covered inpatient day are not limited.
114	40.710.1	159		A QUEST-Adult member exhausts all 10 benefit days and remains hospitalized. As of the 11 th day, the health plan is no longer liable for the facility payment. Would the same be true for professional services (e.g., MD inpatient visits) provided as of the 11 th day	Yes.
115	40.710.1	159		Are there other State resources available to cover maternity care if an adult member's inpatient and outpatient medical visits benefits are exhausted prior to or during the maternity episode?	<p>Pregnancy-related services are not limited. Pregnant women shall receive any medical service necessary for the health of the woman and her fetus during her pregnancy and up to sixty days post partum.</p> <p>See #36 of Amendment #1.</p>
116	40.710.1	159	1 & 2	Is parity for behavioral health services in addition to the adult limited inpatient hospital days and outpatient health visits? If not, will there be an opportunity for a 2:1 exchange as	Yes. There is an opportunity for an exchange of outpatient visits for behavioral health visits as described in Section 40.720.1.f, but no an exchange for inpatient days.

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				currently practiced? This option is referenced in 40.720.1 Additional Behavioral Health Services for Adults but does not appear in the 40.710.1 QUEST: QUEST Adult Benefit Package.	
117	40.710.1	159	2 nd bullet	Should the 3 rd sentence, beginning with “Family planning services including...”, be moved to a separate bullet since these are drugs and family planning devices and should not be counted towards the 20 visit limit? If this section is not moved, can language be added to sentence for clarification?	Family planning services are counted towards the twenty (20) outpatient visits as described in Section 40.710.1, bullet point #3. See #33 of Amendment #1.
118	40.710.1	159	2 nd bullet	Can “physician services” be modified to include “physician services including surgical procedures performed during one of the three outpatient hospital or ambulatory surgical center procedures”?	Physician services utilized during the three outpatient hospital or ambulatory surgical center procedures should NOT be counted towards the twenty (20) outpatient visits.
119	40.710.1	159	2 nd bullet	Please clarify the difference between the “home health” item in the 2 nd sentence of the 2 nd bullet and the 5 th bullet on page 159 entitled “Home Health Services”.	See #25 of Amendment #1. Home health is an outpatient visit and should be counted toward the twenty (20) outpatient visit limit.
120	40.710.1	159	2 nd bullet	PT, OT, ST services are included in 2 sections within the covered benefit section. Home Health 40.710.1 (e) and Rehabilitation Services 40.710.1 (r). For	Yes. See #34 and #35 of Amendment #1.

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				clarification purposes, should these services be removed from the Home Health services section?	
121	40.710.1	159	2 nd bullet	Please confirm that the services that are identified as “home health” in this bullet are subject to the 20 visit limit and these services are defined in section 70.740.1 e.	See #25 of Amendment #1. Yes. Home health visits are subject to the twenty (20) outpatient visits.
122	40.710.1	159	2 nd bullet	Are vision appliances covered? How often are new lenses allowed?	No. Neither vision appliances (i.e., glasses or contact lenses) or hearing aids covered in the QUEST Adult program.
123	40.710.1	159	3 rd bullet	Are there any benefit limits for diagnostic tests?	Diagnostic tests shall be in conjunction with covered outpatient visits. Limits are consistent with the outpatient benefit limit.
124	40.710.1	159	3 rd bullet	Diagnostic tests include 'therapeutic services' that are covered with outpatient visits. What constitutes therapeutic services?	See section 40.740.1.q.
125	40.710.1	159	4 th bullet	For clarification purposes, can the description be modified to read “Three (3) outpatient hospital services or ambulatory surgical center procedures...”?	See #25 of Amendment #1.
126	40.710.1	159	4 th bullet	Are the partial hospitalization, intensive outpatient hospital or specialized residential services (section 40.720.1) included in the “Three (3) outpatient hospital...” benefit limits?	No.

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127	40.710.1	159	6 th bullet	Please add any applicable long-term care and hospice service limits to this bullet	See #25 of Amendment #1.
128	40.710.1	159	All	If a member enters the program during the benefit year, are his/her benefit limits pro-rated for the year?	No.
129	40.710.1 and 40.710.1 (y)	159 and 192-193	2 nd bullet	For the QUEST Adult benefit package, please clarify if vision and hearing services include vision aids (glasses, etc.) and hearing aids if medically necessary. Are the guidelines listed in 40.710.1(y) applicable to both the QUEST-Adult and QUEST-Keiki plans. Of note is that benefit limitations for vision services is listed only for the QUEST-Keiki program.	See question #122.
130	40.710.1	160		It was mentioned at the RFP Orientation that members requiring dialysis treatment will be enrolled in a QExA plan. Will all patients receiving any form of dialysis be switched to QExA? If not, for those who aren't enrolled in a QExA plan, will their dialysis treatment be counted towards the 20 outpatient medical visit limit?	Renal dialysis could be covered if part of a covered inpatient day or as an outpatient hospital procedure. However, health plans should submit ADRC paperwork when the member has end stage renal disease prior to needing chronic dialysis. See #19 of Amendment #1. .
131	40.710.1	160	1	Are outreach services referenced in this section related to physical outreach or does this also include telephonic or mail	See #27 of Amendment #1.

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				outreach efforts?	
132	40.710.1	160	1 st paragraph, 3 rd sentence (after bullets)	QUEST-Adult does not include outreach services. Could you please provide a definition for the term 'outreach' and specific examples of outreach services? Does this mean that for the QUEST-Adult population, the health plan would only be responsible for outreach services to members with special health care needs? A QUEST-Adult member may be identified with a disease management condition but determined to require only minimal follow-up services that may be classified as outreach. Are any outreach services to QUEST-Adult covered under the MQD admin load paid to health plans?	See #27 of Amendment #1.
133	40.710.1	160	2	Are telephonic case management services for members with BH needs not characterized as having a special health care need (SHCN) no longer covered by QUEST?	DHS was not aware that telephonic case management services for BH clients not having a SHCN was ever a specific covered benefit in QUEST, but the health plan could provide as an administrative expense.
134	40.710.1	160	2 nd paragraph, 3 rd sentence	Can the DHS provide a cross walk of all relevant Hawaii Administrative Rules that are a source document for the QUEST Adult and Keiki benefit packages?	The HAR is in process of being aligned to the changes to the State Plan and the benefit package in this RFP. The revised HAR will function as the source document and be publicly available.
135	40.710.1	160	5 th bullet	If an adult member has exhausted his/her	No.

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				20 outpatient visits, would a non-emergent transportation service be a covered benefit for the trip to the 21 st outpatient visit that is not covered?	
136	40.710.1	160	8th	Are pregnancy-related services excluded from benefit limitations? If so, can language be added to clarify coverage?	Yes. Section 40.740.1.n describes coverage for pregnancy-related services.
137	40.710.2	161		Will 19 and 20 yr old members who are eligible under the Basic Health Hawaii program receive the Keiki or Adult benefit?	Any eligible 19 or 20 year old will receive the QUEST Keiki benefit.
138	40.710.2	161		A child undergoes the CAMHD evaluation process and is determined SEBD during a mental health residential stay. From the SEBD determination date, who is responsible for payment of the residential stay – the health plan or CAMHD?	The health plan shall continue to be responsible for payment for the residential stay until the treatment plan is developed. CAMHD is responsible from the date that they develop a treatment plan for the member. The treatment plan does not necessarily correlate with the SEBD date.
139	40.710.2	162	Item t.	Sterilizations are listed in the Keiki package. Is this an error?	No. This is a State Plan service that must be available for all members, with appropriate consent, consistent with Federal requirements.
140	40.720	162	1	Are members who are not categorized as SPMI eligible to participate in IOP, PHP, and PSR services if they do not meet the diagnostic criteria but might benefit from treatment as determined by their BH provider or health plan?	Section 40.740.2.c describes that the health plan's medical director is able to determine that additional behavioral health services are medically necessary for the member's health and safety on a case-by-case basis for provisional eligibility. Thereby, if the health plan's medical

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					director determines that benefits such as IOP, PHP, or PSR are beneficial, then the health plan's member may receive these services.
141	40.720	163-164	Both pages	Methadone treatment is a covered benefit per 40.720. If a member is receiving methadone treatment, they often will need daily medication appointments. Will these visits count toward the maximum number of outpatient visits?	The receipt of methadone treatment does not count towards the outpatient visit limit. See #25 and #42 of Amendment #1.
142	40.720.1	163	1	How many adults are newly diagnosed as having SPMI each year and how many with this diagnosis are currently enrolled in QUEST?	See question #62.
143	40.720.1	163	1 st paragraph	Are there any limits on psychosocial rehabilitation? Are there any limits on therapeutic living supports?	No. However, both of these services must be medically necessary for provision of services.
144	40.720.1	163	a., b., c., d.	Is there a limit to the number of services for a. intensive care coordination/case management, b. partial hospitalization or intensive outpatient services, c. psychosocial rehabilitation, and d. therapeutic living supports?	No.
145	40.720.1	163	d.	Please provide further clarification and guidance on what therapeutic living supports pertain to.	Therapeutic services include individual, family and group therapy and aftercare. Family/collateral therapeutic support and

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					education. PSR where it prevents institutionalization. Therapeutic living supports are provided by specialized residential treatment providers.
146	40.720.1	163	Item e and f	Additional services are provided for members who are determined to meet SPMI criteria. If the member utilizes all SPMI benefits related to inpatient and outpatient benefits but require more, they may utilize benefits from the base plan. To ensure benefits are available for medical services, please clarify if is the DHS' intent for the health plan to obtain consent or approval from the members in order to utilize services from the base benefit.	DHS does not make this requirement, but the health plan may implement these types of policies and procedures if they wish.
147	40.720.1 a	163		Are ICC/CM services subject to any benefit limits?	No.
148	40.720.1 e	163		Are there other State resources available to cover the cost of an inpatient stay for a SPMI member who exhausts the 20 inpatient day benefit?	No.
149	40.720.1 f	163		Should the last sentence in this bullet read "If all six (6) behavioral health outpatient visits are used, the member may use available outpatient medical or behavioral health visits from the base	No. Even though the visits may be pulled from the bank of (20) outpatient <u>medical or behavioral health visits</u> , we are addressing the maximum number of outpatient behavioral health visits.

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				benefit package (thereby giving the member a minimum of six (6) and a maximum of twenty-six (26) medical or behavioral health outpatient visits).”	
150	40.740.o	165	2	RFP refers to “other medically necessary durable medical equipment covered by the Hawaii Medicaid Program”. Can the DHS expand on this or provide a list of Hawaii Medicaid DME supplies? For example, are Poise Pads or detachable shower heads covered items?	DHS requires that a health plan determines if an item is medically necessary. The DME items identified in this section are related to QUEST Keiki and are covered under EPSDT. DHS does not have an all inclusive list of Hawaii Medicaid DME supplies for EPSDT.
151	40.740.1 (b)	165		Please clarify if DME and medical supplies are covered under the QUEST Adult benefit plan. It was not listed as a benefit on pages 158-160.	DME and medical supplies are not covered under QUEST Adult. However, diabetes supplies are a covered benefit.
152	40.740.1(f)	174	3 rd sentence	Are there any hospice benefit limits for children?	No.
153	40.740.1	174	1 st paragraph, last sentence	Sixty days of hospice services may be provided to adult members while awaiting transition into QExA. Please clarify the QUEST health plan’s responsibility if the transfer into a QExA plan for a member in hospice care takes longer than 60 days. Will the MQD retro-enroll the member into the QExA plan as of the 61 st day of hospice care?	The QUEST health plan is responsible for identifying that someone should be transitioned to QExA and submitting a complete ADRC packet to MQD as described in Section 30.900. If the QUEST health plan meets their contractual obligation as described in Section 30.900, then the MQD is able to assure that the transition to QExA occurs within sixty (60) days. If the QUEST health plan does NOT submit a complete ADRC packet in a timely manner, then the MQD will not

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					retro-enroll the member into the QExA health plan on the sixty-first (61) day of hospice care.
154	40.740.1	174	g.	For adults, does a physician visit in the hospital count toward outpatient visits or is it included in available inpatient days?	It is included in covered inpatient days.
155	40.740.1	178	1	Who is responsible for the member on the 61st day of the wait-list care if the member was not enrolled in a QExA health plan?	See answer to question #153. The process is the same for hospice and long-term care.
156	40.740.1.1	180	1 st paragraph 2 nd sentence	To clarify, please add language to include ‘ambulatory surgery center’ and ‘outpatient facility’ to the list of locations.	The sentence reads “including, but not limited to...” DHS understands that physicians practice in multiple locations and is not attempting to capture every location possible, just provide some examples.
157	40.740.1. o	183		Are Rx's for home infusion drugs covered? Is that omission intentional?	Home infusion medications would be covered.
158	40.740.1. o	184	Last paragraph	Does the DHS have any plans to carve-out prescription drug coverage during the initial contract term? What circumstances would compel the DHS to consider this benefit carve-out?	Current statute does not allow prescription drug coverage to be carved out. A change in statute would so compel.
159	40.740.1	184	3	“The health plan shall cover treatment of non-pulmonary and latent tuberculosis that is not covered by DOH.” What is covered by DOH?	The Department of Health (DOH) covers treatment of active tuberculosis in an outpatient setting.
160	40.740.1	186	2	Do the smoking counseling services	Yes. Please refer to Section 40.710.1,

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				count toward the outpatient visit limit?	bullet point #3. See #26 of Amendment #1.
161	40.740.1.s	186	2	Is telephonic smoking cessation counseling with the member allowable? The RFP only references in-person sessions.	No. CMS did not approve federal match for telephonic smoking cessation counseling. The State Plan identifies that services will be delivered in an outpatient hospital/clinics or physician/ providers offices.
162	40.740.1	187-188	item t.	Our current provider handbook lists situations when informed consent cannot be given and when the Form 1146 is not required. Will these still apply?	Yes.
163	40.740.1	188	Bullet 2	Is form 1145 required for emergency hysterectomies?	No.
164	40.740.1	188	Bullet 3	Is this a new form for Patient's Acknowledgement of Prior Receipt of Hysterectomy Information? Bullet #1 says Hysterectomy Acknowledge Form (DHS 1145). Also, why does it say DHS Form 1146, as that is the sterilization form?	Neither the DHS 1145 and 1146 are new forms. Both forms need to be completed by the member and their provider in non-emergency situations.
165	40.740.1.v	190	3	Are outpatient BH office visits and treatment programs eligible to receive transportation services for members without access to these services? Are transportation services limited to only medical Medicaid appointments?	Transportation is allowed only to Medicaid-covered services.

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166	40.740.1. v	190	4	The last sentence of this section states the health plan is responsible for the arrangement and payment of the travel costs for the member and the attendant as well as the lodging and meals associated with off-island or out-of-state travel due to medical necessity. This could be interpreted as lodging and meals are only covered for the attendant. For clarification/interpretation purposes could the sentence be changed to: The health plan is responsible for the arrangement and payment of travel costs (airfare, ground transportation, lodging and meals) for the member and the attendant associated with off-island or out-of-state travel due to medical necessity.	See #37 of Amendment #1.
167	40.740.1	192	1	Is routine vision (exams/eyeglasses) an adult benefit? This paragraph mentions only members under age 21. But subsequent paragraphs (page 193) mention glasses for adults. Is the benefit no longer limited to 24 months?	See #38-#40 of Amendment #1. Vision services are provided as an option for outpatient visits, although eyeglasses and contact lenses are not covered. See response to question #122.
168	40.740.1	193	1	Are adult glasses not limited to 24 months? Please define what is meant by "significant change in Rx"?	See response to question #122 and #167. An ophthalmologist or optometrist would need to determine that the change in prescription is significant as part of the vision exam. The health plan shall not

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					deny the service unless their licensed clinical staff that has appropriate clinical expertise in treating the member's condition has reviewed the determination in accordance with Section 50.900.
169	40.740.2. a	195	1	Are adult members criminally committed to outpatient BH treatment (those on conditional release to the DOH) eligible to receive any BH services from the health plan and, if so, which services are they eligible to receive and under what parameters?	The health plan is responsible for providing any medical services (i.e., all services other than behavioral health). These services include but are not limited to inpatient and outpatient services. The health plans are responsible for outpatient BH services that are civilly committed.
170	40.740.2. a	195	4	Are crisis residential services and residential services the same? Are residential services a benefit in the QUEST program?	Crisis residential services are a benefit in the QUEST program. DHS is unsure where the benefit 'residential services' that is described in the question is described.
171	40.740.2. a	195	First paragraph on page	How will members who are on conditional release to the Dept of Health be designated to the health plan to ensure coverage of medical services only and will the health plan be responsible for coordinating medical and behavioral services even though the behavioral health services are covered by the state?	QUEST members on conditional release receive their additional intensive interventions of behavioral health services from the Adult Mental Health Division (AMHD) as described in Section 40.740.2.c. Health plans are required to provide standard behavioral health services for these members as described in Section 40.740.2.a. Coordination of standard behavioral health services continues to be a responsibility of the health plan.

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172	40.740.2. a.v	196	4	Medically necessary alcohol and chemical dependency services – “substance abuse services can only have limits or prior authorization requirements that are co-extensive with physical treatments.” How does this affect the benefit limit of 26 outpatient visits outlined later in the RFP?	Substance abuse services must be consistent with mental health parity. Substance abuse services are included as behavioral health and are part of the twenty-six outpatient visits allowable. They shall be provided no less than the amount provided through physical health limits. See #41 of Amendment #1.
173	40.740.2. c	197- 198	1	This section states that “health plans shall have a process in place to identify adults with SPMI who are in need of additional behavioral health services based on the criteria listed below.” What assessment tools are plans required to use for this purpose? Does a provider (psychiatrist) need to perform the assessment or can a care manager?	The health plan shall define their process for determining who meets the criteria established by DHS.
174	40.740.2. a	199	2	Members who do not meet the requirements listed above, but are assessed by the health plan's medical director that additional services are medically necessary for the member's health and safety, shall be evaluated on a case-by-case basis for provision eligibility. Is there a timeframe for the case-by-case evaluation?	The health plan should assure that the timeframe meets the health and safety needs of their member.

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175	40.740.2.c	199	1	Is it correct to make the interpretation that after a maximum of 6 months of extensive outreach and engagement efforts that members who remain unengaged are ineligible to receive additional behavioral health services?	Yes. But if they meet the criteria at a later date, the health plan shall offer these services again.
176	40.740.2.c	200-201		Page 200 indicates that one reason for discharge from the program is stability for at least 3 months with a GAF >50. Page 201 identifies one of the ICM criteria for Level I (Routine) is GAF at or near baseline for greater than 6 months and the condition is stable for more than 6 months. It seems that the discharge and service descriptions are contradictory. Please provide further guidance.	The ICM criteria on pg. 201 does not define the GAF level, only that it is at or near baseline for greater than six months. If the GAF is greater than 50 and has been stable for at least three (3) months with no anticipated change and the member is able to remain stable without additional intensive services, then the member should be discharged from receiving these additional services. This is a different criteria than described in the ICM requirements.
177	40.740.2.c	201	2	If member is new to additional SPMI services or to health plan, how is baseline determined; and what is the expected initial intensity at which member is expected to be served?	The health plan shall assess client and make a medically necessary determination of case management frequency. The health plan should then follow the member in accordance with that frequency and make a determination as to if the initial GAF is baseline or if through provision of services, the member's GAF improves. Over time, the health plan should be able to determine the baseline GAF for their member.

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178	40.740.2. c	202	3	Partial hospitalization and intensive outpatient programs are also combined together in this section. Is DHS making a distinction between the two services or are the terms being used interchangeably?	The terms are being used interchangeably.
179	40.740.2. c	202	4	Partial Hosp and Intensive Outpatient Hosp: do these services apply to inpatient/outpatient benefit limits? If so, how would DHS like the plans to calculate this?	No. These services do not apply to either inpatient or outpatient benefit limits.
180	40.740.2. c	203	2	Psychosocial rehabilitation and clubhouse are described in a single section and the terms appear to be interchangeable, although the services are somewhat different. Is DHS using both terms interchangeably, or is there a distinction that is made between the two services?	DHS is aware that psychosocial rehabilitation (PSR) is part of the Clubhouse program and the two are correlated. DHS is interested in the health plans providing both PSR and Clubhouse services for their members understanding that PSR is provided in a Clubhouse setting.
181	40.740.2. c	203	2	Regarding PSR/Clubhouse. Are these services now considered the same? If it is expected that health plans make clubhouse services available to members, are the existing clubhouses now open to non-AMHD served members? Do the existing Clubhouse have capacity for new members? Does AMHD have the capacity to contract with the health plans to provide	No. See question #180. Health plans should make Clubhouse open to their members. DHS understands that DOH is interested in contracting with QUEST health plans to provide Clubhouse services.

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				Clubhouse services?	
182	40.740.2.c	204	3 rd paragraph	Currently, are there any plans for the DHS to carve-out behavioral health services during the initial contract term? What circumstances would compel the DHS to consider this benefit carve-out?	There are no current plans for DHS to carve-out behavioral health services though DHS is maintaining this as an option in the future.
183	40.740.2.c	204	3	Does the statement "the DHS may carve out BH services at a future date" include all BH services or only those for the SMI and SEBD populations? How would this look?	Only additional behavioral health services for their SMI population (additional SEBD behavioral health services are already carved out). This would look similar to the DHS' Community Care Services (CCS) program.
184	40.751	205	1	"The health plan shall use the State-defined criteria below to identify members with SHCNs as quickly as possible." Does the State have information on the number of children and adults in QUEST that are currently identified as SHCN, by qualification category (e.g., high ER utilizers) and overall?	No.
185	40.751	206	1st bullet	Can the health plan set parameters to define "chronic" & "polypharmacy"?	Yes.
186	40.751	206	4th bullet	Does this mean SHCN criteria is met when: - the member has used half the allowable visits only in the <u>first</u> 6 months of the benefit period (vs during any continuous 6 months of the benefit	SHCN criteria is when the member has used half of the allowable visits in the first six (6) months of the benefit period (both inpatient or outpatient) or the member has used twelve (12) of the allowable outpatient visits at anytime during the

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				<p>period), and/or</p> <ul style="list-style-type: none"> - the member has used 12 of the allowable visits during anytime during the benefit period? <p>Also, should the word "outpatient" be added to the beginning of the sentence: "Adults who have utilized either half of their allowable <u>outpatient</u> medical or behavioral health visits...."?</p>	<p>benefit period.</p> <p>The word outpatient should not be added to the beginning of the sentence.</p>
187	40.751	208	1 st paragraph	<p>“All assessments shall be performed by appropriately trained and credentialed health care professionals.”</p> <p>Please clarify the specific credentials required for health plan staff to perform assessments on members with SHCNs?</p>	<p>The medical professional making the determination that the member is SHCN shall have appropriate certification for that discipline subject to Medicaid licensure requirements.</p>
188	40.752	212	1	<p>In identifying and developing case coordination and case management services for top 1% utilizers, what does top utilizer mean, and is it utilizers of outpatient services, inpatient services, behavioral health services, pharmacy services, etc?</p>	<p>On a cost basis, the most expensive 1% of the health plan’s members.</p>
189	40.753	214	1st bullet	<p>Is the health plan able to determine the method (e.g. letter, posters in OB clinics, telephone calls, etc.) for notifying pregnant women?</p>	<p>The health plan may choose the method, but it should be verifiable that the notification occurred. A poster would therefore be insufficient.</p>
190	40.753	216	1	<p>“Screening for developmental delays, autism, and behavioral health conditions,</p>	<p>DHS has processes and tools for EPSDT visits that are found in Appendix I of this</p>

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				shall be done using standardized, validated screening tools as recommended by current national guidelines and the State’s EPSDT program.” Does the State have instruments and criteria in use today that will be mandated for use by the plans? If so, can it provide them?	RFP.
191	40.754	219	1	Will the benefit limits for adult members diagnosed with cancer be lifted completely, or will only those benefits related to the member’s cancer diagnosis be unlimited?	Only those benefits related to the member’s cancer diagnosis.
192	40.763	222	2 nd bullet	The section reads, “Covering all medical costs for the member while the member is in an ADAD slot;” Does this mean that the member is not subject to the benefit limits while in an ADAD slot?	The member is still subject to medical program benefit limits while in an ADAD slot.
193	40.900	226	Last sentence	Please provide clarification for handling a visit for a second opinion for an Adult after all outpatient visits have been exhausted.	Second opinions are only allowed if the original diagnosis or visit is a covered visit. The second opinion is required even after all outpatient visits have been exhausted.
194	41.100	226	3	Does the adult benefit package include off-island and/or out-of state-services? If yes, which services?	Yes. If the service is medically necessary, a covered benefit, and is not available to the member on island or in state.
195	41.100	226	3	If the adult benefit package includes out-of-state services, what should a health plan do if out-of-state providers refuse to	It is incumbent on the health plan to meet the member’s medical needs. If this is not possible in network, the health plan will

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				accept the member because of the limited inpatient hospital days or outpatient visits, especially if the health plan does not plan to exceed the benefit limits established by DHS?	need to make accommodations to find those services out of network, or arrange for them to be available. Perhaps the plan will need to explore other providers.
196	41.310	229 - 230		Will the DHS facilitate a transfer of medical information such as a pregnancy state or authorizations to a receiving health plan to ensure appropriate continuation of services during transition of care? If yes, when will the DHS work with health plans to determine scope of information and file layouts?	Yes. The DHS will work with the health plans that have been awarded contracts to determine scope of information and file layout after Contract Effective Date.
197	41.320	230	3	If a QUEST adult changes plans during a patient confinement and has exhausted the inpatient benefit, is the new health plan responsible on date of enrollment? Does the new plan use the accumulated benefits from the former health plan or does the member benefit accumulator re-set to zero even though it is not a new benefit year?	No. See Appendix J for description of responsibility during an inpatient hospital stay. The member's usage transfers with them to the new health plan. The member does NOT re-set their benefit eligibility.
198	50.100	233	1 st paragraph	Can the DHS provide examples of what is expected of the health plans when performing annual 'outreach' to their members to help them maintain Medical Assistance eligibility”?	This is for the health plan to determine. The approach taken should be reasonable to achieve the goal of reminding members or their annual eligibility review. Examples include telephone calls to members or working with providers to remind members during appointments.

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199	50.100	233	2 nd sentence	<p>Please clarify if the member's eligibility review date changes or if it remains constant. If the date changes, what circumstances would change the member's eligibility review date.</p> <p>How would the health plan be notified of a change in the member's eligibility review date?</p>	A member's eligibility review date may change based upon eligibility criteria such as additions to the case (i.e., birth of a child) or change in address (i.e., moving from one island to another island). The change in eligibility review date will be provided in the health plan's 834 file.
200	50.200	233	1	<p>On average, how many children and adults are newly enrolled in QUEST each month and what is the auto assignment rate? On average, how many children and adults lose eligibility each month?</p>	On average, monthly QUEST has approximately 3,900 additional members with a loss of approximately 1,200 members (both adults and children).
201	50.200	234	3 (bullets)	<p>The member enrollment packet shall include: "A health plan membership card that includes the member number, which does not have to be the same as the Medicaid ID number which has been assigned by the DHS, and an expiration date which is the member's eligibility review date in the next calendar year". Is it DHS' intent that plans send out the member ID card ahead of the member selecting a PCP and then send another ID card once the member has made a selection? (refer to 50.470 first paragraph)</p>	Yes.

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202	50.200	234	Last sub bullet	Suggest adding language so bullet reads "...PCP within ten (10) calendar days from the date identified on the enrollment packet.	The ten days for the member to choose a PCP should include mail time as described in Section 50.220. DHS will not make the requested change since it does not conform with our intent.
203	50.200	234-235	Last solid bullet on page 234 and first bullet on page 235	Please clarify if your intent is for the health plan to develop 2 different flyers or handouts – one for PCP-related information and another separate one for member-related information. Or can the health plan develop one flyer/ handout that consolidates both sets of information?	The health plan may include both on the same flyer as long as the information to the member is clear. Please note that the flyer must be reviewed and approved by DHS in accordance with Section 50.430 of the RFP.
204	50.210	235		Can language be added to clarify that health plan responsibility is subject to applicable benefit limitations?	See #45 of Amendment #1.
205	50.210	236	1	Transition of Care: If the limits exhaust during the Transition of Care period, is the health plan that the member was enrolled in on admission still responsible through change in level of care or discharge, whichever comes first?	Yes.
206	50.210	236	1	Transition of Care: If the member is cancelled at the end of the month but is still in the hospital, does the health plan continue to cover the member past the 10 day limit?	No.
207	50.210	236	1 st paragraph	Please clarify that the health plan is responsible to cover facility services	See Appendix J.

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				<p>until discharge or change in level of care (whichever comes first) for a member who loses QUEST eligibility altogether and is terminated from the health plan (does not get enrolled into another plan) during an inpatient stay.</p> <p>Please also clarify who is responsible for facility services when a QUEST Adult member exhausts all inpatient benefits during a non-cancer related inpatient stay.</p>	No health plan is responsible for inpatient hospital stays once a member has exhausted their non-cancer related inpatient benefits unless a new benefit period starts.
208	50.220	237	1	Does the 10 days to assign a PCP begin from the date the member enrollment packet was mailed to the member?	Yes, not including the time calculated to mail the enrollment packet to the member as described in Section 50.220.
209	50.220	237	Whole section	<p>Is this example accurate for determining date member should be auto assigned to a PCP?</p> <p>Enrollment date January 1st, date on enrollment packet letter January 3rd, packet mailing date January 4th, estimated receipt date of packet is January 9th (5 days from mailing date), PCP auto assigned on January 14th (January 3rd + 10 calendar days +1).</p>	No. The packet mail date is the 4 th , 5 days for mail estimates delivery on the 9 th , and 10 days from the estimated delivery date is the 19 th . Auto assignment would occur on the 20 th .
210	50.230	237		What is the expected turnaround of an 834 transaction from the DHS after the health plan has submitted the monthly address change file?	The day after the change of address is entered into the HAWI eligibility system.

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211	50.420	242-243	2 nd paragraph; last paragraph of page 242	<p>Health plans are required to educate its members and may utilize classes, individual or group sessions, etc.</p> <p>Also, the health plan must submit its member education materials and training plan, etc., to DHS for review. Since there is no time frame provided in this section other than for the readiness review, do we submit an annual member education topic list/plan to the DHS which would include member magazine articles, educational mailers and campaigns?</p>	Health plans selected from this RFP will have to submit these materials as part of readiness review. Thereafter, any changes to the materials will need to be approved by MQD. It is up to the plan to determine a timetable to adjust or refresh these materials.
212	50.430 51.710	244 365	2	Will DHS consider extending the timeframe for translation certification as historically, it has taken longer than 30 days for the vendor to provide.	The health plan may request a waiver if they are unable to have their written materials translated within thirty (30) days.
213	50.440	245	1 st paragraph	For clarification, can the 2 nd sentence be written as “ Annually , the health plan shall mail to all enrolled members a Member Handbook, one per household. ”	See #48 of Amendment #1.
214	50.460	252	1 st paragraph	Can a health plan have separate provider directories for each island?	No. There is no requirement for the health plan to mail a new directory if the member changes geographic area, thereby the member may need provider information on more than one island.
215	50.460	252	2 nd paragraph,	Can the 2 nd sentence be modified to read “This web-site directory shall be	No. Since the provider directory is mailed out to new members monthly, the hard

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			2 nd sentence	updated....”	copy provider directory should remain updated.
216	50.470	253	1	Can plans request waivers from the ID card requirement if all required information is accessible 24/7 by calling a toll-free number?	No.
217	50.470	253	3 rd bullet	Does the effective date on the ID card need to be updated due to a member’s rate code change? What is the definition of “effective date”?	The effective date does not need to be updated with a change in rate code. The effective date is the date on the 834 file that the member became eligible with Medicaid or entered your health plan, whatever is later.
218	50.480	254	3	Please define "monitor remotely", as in "...health plan call center shall have the capacity for DHS to monitor remotely...." Does this mean DHS will monitor "live" calls or phone metrics?	DHS should be able to monitor “live calls.”
219	50.480	254	3 rd paragraph	Please provide clarification on the “capacity for DHS to monitor remotely” requirement. What does the health plan need to provide to the DHS?	An access number or something to this effect for DHS to be able to listen remotely to calls being answered in the health plan’s call center.
220	50.480	254	4	How does the state plan to remotely monitor the health plan's toll-free call center?	DHS plans to monitor health plan’s call centers on a regular basis to assure that Medicaid clients’ needs are being addressed.
221	50.490	256	1	Please explain your definition of "real-time". We are assuming that this means the information on the website must	See response to question #96.

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				match the information in our claims system at the time of inquiry.	
222	50.490	256	1 st paragraph	The DHS is requiring the health plan to have a secure web portal for a member to access their claim and prior authorization information. Is utilization based on claims data, prior authorization/referral data or both?	See response to question #96.
223	50.490	256	3	Will access of real-time utilization be an acceptable alternative (especially for health plans that have access to real-time encounters)?	Health plans with access to real-time utilization should make this information available to their members' via the web.
224	50.500	257		How does this apply to CHCs that already get PPS that should include coordination of services?	CHCs should have the same opportunity as non-CHCs.
225	50.500	257		We agree that care coordination and care management are key to managing complex patients and reducing hospital readmissions and other cost drivers. We have found that complex patients present with multiple co-morbidities that could benefit from care coordination. Why does the RFP emphasize care coordination/care management that is single disease specific and why does it focus on patients that have maximized hospital services? Can	Section 50.500 describes the patient-centered, accessible, comprehensive, coordinated, and evidence-based care that is being incentivized, which would include identification and care coordination of high risk individuals.

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				we be assured that care coordination can be supported at health care homes that have identified an alternative population of patients with potential to be high utilizers?	
226	50.500	257		The Health Care Home model, with two levels of compliance, is a good start. Community health center consumers, however, have defined a second set of standards for health care homes that they feel directly relate to quality and performance outcomes. What if health plans agree, as some have, to support services such as traditional healing or workforce/job referral? Should this not be recognized as value added services? It is these advanced health care home activities that mean a lot in high poverty communities and the health care home model should be emphasizing community engagement.	The medical home criteria in the RFP are based on and in alignment with the criteria proposed by the Centers for Medicare & Medicaid Services, Agency for Healthcare Research and Quality, National Committee for Quality Assurance, American Academy of Family Physicians, American Academy of Pediatrics, and American College of Physicians. These criteria are such that all primary care providers have the potential to participate and benefit. Additionally, these are minimum criteria, and providers and health plans can discuss other criteria. However, health plans cannot reimburse for non-Medicaid covered services, although management/incentive payments can be broadly used once received by providers.
227	50.500	257	1	How will Value-driven Health Care concepts, like capitation, performance incentives, and gain sharing, be incorporated in the capitation rates?	The intent is shift to a health rather than disease oriented paradigm in which more is paid for upstream high quality care (such as prevention and disease

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					<p>management) that pays for itself by decreasing downstream expenditures (such as emergency room visits and hospitalization). Other places that have implemented these new processes have not increased capitation payments to implement value-driven health care. Using patient-oriented outcome measures such as decreased hospitalization, decreased readmission, and decreased ER use should result in decreased expenditures. The incentive amounts should be structured to be cost-beneficial.</p>
228	50.510	257		<p>We are very supportive of value-driven services and the need to recognize and promote those accordingly through alternative reimbursement mechanisms. Several payment models/approaches were described in the RFP. Please clarify that this section does not limit the flexibility of a health plan and provider to embark in alternative reimbursement arrangements/options for value-driven services.</p>	<p>The section states the principles of value-driven health care that are required. Within these principles is flexibility to operationalize.</p>
229	50.520	258		<p>The limit on outpatient visits for adults seems to be a barrier to supporting the value driven health care initiative. What are the DHS expectations in this regard related to administering the adult</p>	<p>The outpatient visit limit creates an even greater value and importance of incentivizing proactive and population-based care that can occur outside of the examination room.</p>

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				benefit?	
230	50.520	260	2	Will the health plans receive a higher level of reimbursement to assist with the required increase of payments needed to be made to certified Medical Homes?	See response to question #227.
231	50.520	260	9	In lieu of the Platinum and Gold standards for a medical home will an applicant be allowed to use their own specifications or requirements?	Principles have been detailed, and DHS prefers a consistent approach that benefits the provider participating in multiple health plans. Health plans that are awarded contracts will be required to submit a value-driven health care plan for approval.
232	50.520	261	1	NCQA recognition is not required, but, if the PCP has this recognition, they would be considered gold level, correct?	Yes.
233	50.530	261	1	Please explain the applicability of the requirement that "health plans shall not reimburse hospitals on a per diem basis." Does this requirement apply to all hospital contracts or just provider contracts that contain value-driven health care concepts? We are assuming that we are still allowed to reimburse other hospitals without value-driven contracts on a per-diem basis. Please explain if this is correct.	DHS would like to see health plans reimburse hospitals on a (APR/APS) DRG basis; however, the limited covered inpatient days is inconsistent with this approach, should an individual's use exceed the limit. DHS does not require use of DRGs at this time, but is expected to require DRG-based reimbursement should it lift the limit on covered inpatient days.
234	50.530	261	1	Is this section requiring health plans to contract with hospitals at DRG reimbursement to achieve Value-Driven	No. See response to question #233. While DHS encourages use of (APR/APS) DRG-based reimbursement, it does not require it

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				Health Care Schedule at Section 50.550?	at this time. The value driven health care requirement for hospitals has flexibility so long as some payment is tied to performance and/or involves risk-sharing and/or gain-sharing.
235	50.530	261	1 st paragraph	<p>There seems to be conflicting direction in this 1st paragraph with the “shall not” and the “However”. Can the sentence be re-written to allow health plans to adopt new payment methodologies where deemed appropriate?</p> <p>Can additional language be added to clarify that reimbursement methodologies may be impacted by new adult benefit limitations? For example, moving away from per diems for hospitals, when adults have a limited number of days that are covered, may not be feasible.</p>	See response to question #233 and #234.
236	50.530	261	1 st paragraph	Please provide some examples of situations in which per diem pricing would be allowed/acceptable, in addition to the wait-listed scenario.	The CMS-DRGs are less well developed for neonatal and pediatric cases, but APR/APS-DRGs may address much of this. Some have also raised concerns about APR/APS-DRGs for mental health admissions. However, DHS is not requiring use of DRGs at this time. When required, DHS would like to allow per diem reimbursement for cases in which the

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					DRG has a high variance.
237	50.540	261		A reference is made to Plans contracting with networks that can vertically integrate services. We believe you are considering future "accountable care organizations." Would this allow networks organized by health care homes to receive such contracts? Can these networks encompass logical community service areas that share common values rather than island-wide networks?	At this time, in this procurement, DHS is not allowing networks organized by health care homes to receive contracts with DHS. But, DHS is open to looking at such models in the future as long as these networks assume responsibility for and are able to provide all required covered services to individuals receiving care in the network. DHS does not prohibit such entities from having provider contracts with health plans.
238	50.540 51.410	261 318	1 All	If an applicant will implement a "provider led organization" is it acceptable for the applicant to subcontract with an administrator for certain operational functions and some of the key personnel described in section 51.410 to be employees of the subcontractor? Will "provider led organizations" as described in section 50.540 be given preference during evaluation and contract award? Would the requirement that the prime applicant have responsibility for not less than 40% of the work (referenced in Section 10.400 of the RFP), apply to oversight	The contracting between selected health plans and providers to meet the value driven health care section requirements in no manner alters or obviates any other requirement in the RFP. The prime applicant is expected to perform not less than 40% of the work directly (rather than through subcontractors).

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				responsibility generally, or would the prime contractor be expected to perform 40% of the work directly (rather than through subcontracts)?	
239	50.550	262	1	How will the 10% requirement be calculated?	Based upon the corresponding denominator of reported in-network primary care providers and hospitals
240	50.550	262	2	Is the percentage of primary care providers and hospitals a combined 10% for year 1 or 10% of PCPs and 10% of hospitals?	10% of PCPs and 10% of hospitals.
241	50.550	262	3	What information is required for review by DHS for the value-driven health care plan? Since the plan is required at least 90 days before implementation, does this mean that by 12/31/2011, 10% of provider contracts must incorporate value-driven concepts by 4/1/2012 per the Value-driven Health Care Schedule?	The health plan should include a description of how they intend to implement the requirements of this section. This includes, but is not limited to, general approach, ascertainment of provider eligibility, measures selected, and percentage/amount of reimbursement available as incentive. For the first year, 10% of primary care provider and of hospital contracts should include value driven health care principles by 4/1/2012.
242	50.550	262	3	Please provide detailed and comprehensive specifications for the “value-driven health care plan” described in this section.	Health plans that are awarded contracts will be responsible for describing their plan for implementation value-driven health care consistent with the requirements outlined in Section 50.500. Additional guidance is provided in #241.

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243	50.550	262	All	Please provide clarification related to the percentages of PCPs and Hospitals in the table on page 262. Do these percentages indicate the PCPs and Hospitals that must accept “value driven” contracts?	These percentages reflect the minimum proportion of in- network providers that must have such contracting with the health plan.
244	50.550	262	Value-Driven Health Care Schedule	Since multiple PCPs can be included within one contract (clinic, group practice, etc.), can the percentages be based on number of individual providers covered under a value-driven contract?	Yes.
245	50.710	266		Since other types of accreditation are allowed under state law (example: URAC), can the list of acceptable accreditations be expanded beyond NCQA? If not, please provide rationale.	No. DHS has a more rigorous requirement that not only better benefits our clients but also more closely aligns with the contractual requirements.
246	50.710	266	1	Will a proposal from a new applicant, with a valid license as required by this RFP, who agrees to actively pursue NCQA certification should they be awarded a contract, be acceptable?	Yes. Per the terms of §50.710, the health plan must obtain the accreditation. Failure to do so may result in breach of contract.
247	50.710	266	1	According to Section 50.710 of RFP-MQD-2011-003: Accreditation, the health plans bidding on this RFP must be accredited by the National Committee for Quality Assurance (NCQA) for its QUEST program. Pursuant to the facts provided above regarding Hawaii state law, CMS and URAC Accreditation, will the Department of Human Services	HRS 432 applies to commercial insurance. In its contracting, the State can add specific requirements of its contractors. The accreditation requirements in this RFP are permitted. DHS chooses to require a more rigorous requirement not only for the benefit of our clients but also because it is consistent with our use of quality measures and with the requirements of the Balanced

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				accept URAC Health Plan Accreditation to demonstrate compliance with the requirements of RFP-MQD-2011-003?	Budget Act.
248	50.720	268	Paragraph 3, 4 th bullet	Please provide specific requirements for the “closure/resolution letter” as referenced in this bullet?	This reference is related to any quality of care issues to include abuse. The health plan is responsible for investigating these issues and sending a letter describing the health plan’s actions. This section reiterates the member’s rights that are required in 42 CFR Part 438, Subpart F and §51.100 of this RFP.
249	50.730	269	2	“The health plan shall submit its QAPI Program documentation for review to DHS with its RFP proposal.” Please clarify the exact documentation being requested. There are no attachments noted in the technical proposal section 80.330.1-QAPI Program for this purpose.	The health plans should submit its own operating documents that fulfill the requirements and obligations of this section. This may include a narrative as well as policies and procures, or other documentation that would normally be submitted as part of the accreditation process. How the health plan responds is matter of consideration in determining responsiveness to this RFP, and therefore the MQD does not seek to be overly prescriptive in determining how the health plan responds or how it fulfills this requirement.
250	50.730	271	6 th and 1 st bullet	Please provide specific requirements for the “written delegation agreement” as referenced in this section.	Please see 42 CFR 438.230 for the specific requirements for written delegation agreements identified in this section.
251	50.760	281	3	If the applicant has an NCQA certified	Yes.

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				disease management program will the applicant be allowed to integrate “depression” practice guidelines in other medically related practice guidelines rather than having a stand alone depression program?	
252	50.770	282		Which populations are subject to HEDIS reporting (particularly, are limited benefit adults included, if health plans are may not capturing all services due to exceeding of benefit limits)?	For the HEDIS score calculations, include all of your members served under this contract.
253	50.770 & 51.570.9	283 & 356	3 & 1	It would be helpful if DHS could provide a description of each data element to be included in the “Dashboard”. This will help applicants determine the system specifications, level of effort, and cost associated with this requirement.	The items on this Dashboard are very basic health plan reporting items such as membership, summary of in-network providers, call center statistics (both member and providers), claims processing stats (both paper and electronic), information on member and provider grievance and appeals, and some basic utilization data such as hospitalizations and readmissions.
254	51.125	295	2	"The health plan shall have in place written policies and procedures for processing grievances in a timely manner to include if a grievance is filed by a provider on behalf of the member or member’s authorized representative and there is no documentation of a written form of authorization, such as an AOR	This information is found in Section 51.700. It is sixty (60) days after contract award.

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				form." Please define "timely" if other than 30 days.	
255	51.125, 51.135	295, 298	page 295: 3rd paragraph, page 298: 2nd bullet	"As part of the grievance system policies and procedures, the health plan shall have in effect mechanisms to (1) ensure reasonable attempts were made to obtain a written form of authorization." Please define "reasonable."	The health plan can determine their own verbal and/or written timeframes for members to submit requested documents, which must be received within thirty (30) calendar days of the initial grievance request.
256	51.125	296	1st bullet	"Send a written acknowledgement of the grievance within five (5) business days of the member's expression of dissatisfaction." Please identify who the acknowledgement letters must be sent to in addition to the member or party filing the grievance, if any.	The member or the party filing the grievance with consent from the member.
257	51.125	296	2nd bullet	"Convey a disposition, in writing, of the grievance resolution within thirty (30) days of the initial expression of dissatisfaction." Please identify who the written disposition letter must be sent to in addition to the member or party filing the grievance, if any.	The member or the party filing the grievance with consent from the member.
258	51.135	297	Last para	Can a provider submit an appeal on the member's behalf without oral or written authorization from the member?	No. In order for a provider to file an appeal for a member, they must have obtained authorization from the member pursuant to 42 CFR 438.402(b)(ii).
259	51.135	297	Last para	"An oral appeal may be submitted in order to establish the appeal submission date; however, this must be followed by	A written verification must be provided within 30 days of initial request. If written verification is not provided within 30 days,

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				a written request." What is the timeframe in which a written request must be received? What if a written request is not submitted? May the health plan send the requesting party a form appeal request document for their completion?	the health plan should dismiss the case and send a letter indicating so and the reason to the member. Yes. The health plan may develop a request document subject to approval by MQD.
260	51.135	298	3rd bullet	"Send an acknowledgement of the receipt of the appeal within five (5) business days from the date of the receipt of the written or oral appeal." Please indicate who the acknowledgement letter must be sent to in addition to the member or appealing party, if any.	The member or the appealing party if consent is obtained.
261	51.135, 51.140	298, 302	Page 298: 4th bullet, page 302: 1st paragraph	"Provide the member or his or her representative a reasonable opportunity to present evidence, and evidence of allegations of fact or law, in person as well as in writing." Please define "reasonable."	Please see 42 CFR 438.406 for Federal Grievance System requirements.
262	51.135, 51.140	299, 301	Page 299: 2nd paragraph, page 301: 4th paragraph	"For any extension not requested by a member, the health plan shall give the member written notice of the reason for the delay." Please confirm. Acknowledgement letter (sent to member) will indicate appeal resolution due date (30 days). If extension is requested by the member, are we	The extension does not require a new letter. No

Question #	RFP Section #	RFP Page #	Para #	Question	Answer
				required to send the member a letter confirming the extension and the new due date? Is written notice required to the provider?	
263	51.135	299	2	"The health plan may extend the resolution time frame by up to fourteen (14) additional days if the member requests the extension, or the health plan shows (to the satisfaction of MQD, upon its request for review) that there is need for additional information and how the delay shall not adversely affect the member." If accreditation standards are stricter, should the health plan follow DHS or accreditation resolution timeframes?	The health plan may impose a stricter timeframe upon itself if doing so is to the benefit of the member.
264	51.135	299	3rd bullet	"The right to request a State administrative hearing, and clear instructions about how to access this process." Please define "clear instructions."	Please conform to the requirements in HAR §17-1703-4.
265	51.135	299, 300	Page 200: 1st paragraph, page 300: 1st paragraph	Page 299 indicates, "For standard resolution of an appeal, the health plan shall resolve the appeal and provide a written notice of disposition to the parties as expeditiously as the member's health condition requires, but no more than thirty (30) days from the day the health plan receives the appeal." First	If the member (or their authorized representative) files an appeal, then the health plan shall send a resolution notice within thirty (30) days of the date the appeal is filed. The provider may or may not be party to the appeal. If the provider is one of the parties of the

Question #	RFP Section #	RFP Page #	Para #	Question	Answer
				paragraph on page 300 indicates, "The health plan shall notify the provider in writing within thirty (30) days of the resolution." Please verify if written notice of disposition is sent to all parties (page 299) or only the provider (page 300).	appeal, then their notice shall be sent within thirty (30) days of the date the appeal is filed. If the provider is not party to the appeal, then the health plan shall notify the provider within thirty (30) days of the resolution.
266	51.135	300	1st bullet	"The right to request to receive benefits while the hearing is pending, and how to make the request." Please define "how to make the request."	See HAR §17-1703-10 for the requirements.
267	51.135	300	Last sentence in 51.135	Should the reference be to "member," not "provider"?	No. See answer to question #263.
268	51.140	300	1	"The health plan shall establish and maintain an expedited review process for appeals. The member, his or her representative or provider may file an expedited appeal either orally or in writing. No additional follow-up shall be required." Please clarify "no additional follow-up shall be required." Does this mean that expedited appeal requests are not required to be received (by the health plan) in writing?	Yes.
269	51.140	300	1st para	Can a provider submit an expedited appeal on the member's behalf without oral or written authorization from the member?	No. See 42 CFR 438.402.

Question #	RFP Section #	RFP Page #	Para #	Question	Answer
270	51.140	300 - 301	Page 300: 4th paragraph, page 301 1st paragraph	Page 300: "For expedited resolution of an appeal, the health plan shall resolve the appeal and provide written notice to the affected parties as expeditiously as the member's health condition requires, but no more than three (3) business days from the time the health plan received the appeal." Please indicate if the date of receipt counts as the first business day, or if the next business day is considered the first business day. (See footnote on page 292.)	It is the day after receipt, see footnote on page 292.
271	51.140	300, 301	Page 300: 2nd paragraph, page 301: 4th paragraph	"An expedited appeal is only appropriate when the health plan determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function" Page 301: "If the health plan denies a request for expedited resolution of an appeal, it shall." Please confirm that the member cannot deem an appeal as expedited, only the health plan or the treating provider. Also, please verify if "provider" should be interpreted as a "physician" and not a facility or ancillary provider. Additionally, can the health plan deny a provider's request for an	<ol style="list-style-type: none"> 1) The member may request an expedited appeal, but the health plan makes the determination if the appeal should be expedited (e.g., jeopardy to member's life, etc.). 2) The provider is not only physician. See the definition of provider on page 59. 3) The health plan may deny the provider's request for an expedited appeal.

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				expedited appeal?	
272	51.140	301	1	"The health plan shall make reasonable efforts to also provide oral notice to the member with the appeal determination." Is this required of the health plan? Define "reasonable" and "timeline."	Reasonable is a measure of industry standard in Hawaii, and should take into consideration the facts of the particular case.
273	51.140	301	2	"The health plan may extend the expedited appeal resolution time frame by up to fourteen additional (14) days if the member requests the extension or the health plan needs additional information and demonstrates to the MQD how the delay shall not adversely affect the member." If accreditation standards are stricter, should the health plan follow DHS or accreditation timeframes?	The health plan may impose a stricter timeframe upon itself if doing so is to the benefit of the member.
274	51.140	301	3	"The health plan shall notify the MQD within twenty-four (24) hours (or sooner if possible) from the time the expedited appeal is lost." Define "lost."	The denial is upheld by the health plan.
275	51.140	302	1st bullet	"Transfer the appeal to the time frame for standard resolution." Would the standard appeal receipt date be the same date that the original request was received for the expedited appeal?	Yes.
276	51.140	302	2nd bullet	"Make reasonable efforts to give the member prompt oral notice of the denial." Define "reasonable."	Reasonable is a measure of industry standard in Hawaii, and should take into consideration the facts of the particular case.

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277	51.150	304	2	"In the event of an expedited State administrative hearing the health plan shall submit information that was used to make the determination, (e.g. medical records, written documents to and from the member, provider notes, etc.). The health plan shall submit this information to the MQD within twenty-four (24) hours of the decision denying the expedited appeal." What address should the health plan use to submit information and by what method (mail, courier or electronic)? Is this required for all expedited appeals that have an adverse decision?	As described in Section 51.140, pg. 301, paragraph two: The DHS shall provide information on the method of notification to the MQD within sixty (60) days of contract award.
278	51.150	304	2	"The health plan shall submit this information to the MQD within twenty-four (24) hours of the decision denying the expedited appeal." Is it correct that health plans must submit the information used to make the determination in all denial cases, even if the member has not filed a request for an expedited State administrative hearing?	It appears the question confuses expedited appeals in §51.140 with Expedited State Administrative Hearings in §51.150. The requirement to provide the information used to make the determination only applies in the case of an Expedited State Administrative Hearing (as opposed to the expedited hearing with the health plan).
279	51.155	304 - 305	1	"The health plan shall continue the member's benefits if: • The member requests an extension of benefits; The appeal or request for State administrative hearing is filed in a timely manner,	The health plan should be aware of any reduction of services that would trigger a notice of action. The health plan will deal directly with the member for any appeal to the health plan. For a State administrative

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				<p>meaning on or before the later of the following: Within ten (10) days of the health plan mailing the notice of adverse action; or The intended effective date of the health plan's proposed adverse action. • The appeal or request for State administrative hearing involves the termination, suspension, or reduction of a previously authorized course of treatment; • The services were ordered by an authorized provider; and • The original authorization period has not expired." How will the health plan know if the above requirements were met?</p>	<p>appeal, the health plan will receive formal notice of the hearing from DHS.</p>
280	51.155	305	1	<p>"If the health plan continues or reinstates the member's benefits while the appeal or State administrative hearing is pending, the health plan shall continue all benefits until one of following occurs: • The member withdraws the appeal; • The member does not request a State administrative hearing within ten (10) days from when the health plan mails a notice of adverse action; • A State administrative hearing decision adverse to the member is made; or • The authorization expires or authorized service limits are met." How will the health plan be notified?</p>	<p>If appealed to the health plan, communication would occur directly between the health plan and the member. If a case goes to administrative hearing, an MQD staff member is assigned to the case. As the health plan will have to coordinate the hearing with the MQD staff assigned, they should be in regular communication and any disposition prior to a hearing decision will be communicated to the health plan staff assigned to the case. In the event of a ruling from an Administrative Hearing, the health plan would receive formal notice.</p>

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281	51.155	306	1	"If the final resolution of the State administrative hearing is adverse to the member, that is, upholds the health plan's adverse action, then the health plan may recover the cost of the services furnished to the member while the appeal was pending, to the extent that they were furnished solely because of the requirements of this section." How will the health plan be notified? Within what timeframe?	Formal notice will be issued by the officer appointed to adjudicate the hearing within 90 days. Either MQD or the DHS Administrative Appeals Office (AAO) will furnish the decision to the health plan thereafter.
282	51.155	306	2	"If the health plan or the State reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the health plan shall authorize or provide these disputed services promptly, and as expeditiously as the member's health condition requires." How will the health plan be notified if the state reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending?	The health plan will be aware of the disposition of any appeal directly to the health plan. If the disposition is from a State Administrative Hearing, a decision will be issued by the Hearing Officer and provided to the health plan from MQD or AAO.
283	51.155	306	3	"If the health plan or the State reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the health plan shall pay for those services." How will the health	See responses to questions #281 and #282.

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				plan be notified if the state reverses a decision to deny authorization of services?	
284	51.230	310	1	If during the process of reviewing HPMMIS Health Plan Manual available on the Med-QUEST web site the applicant has questions, can these questions be submitted to DHS for review? The review of a MMIS Manual takes longer than the time frame allowed for questions related to the RFP.	DHS will answer questions regarding HPMMIS Health Plan manual posed by health plans that have been awarded a contract for this procurement after contract award.
285	51.270	312	1	Please provide specific guidance to the requirements related to "...disaster planning and recovery operations appropriate for the health plan industry, and comply with all applicable federal and state laws relating to security and recovery of confidential information and electronic data". To avoid misunderstandings please provide specific references to "all applicable federal and state laws relating to security and recovery of confidential information and electronic data".	The primary Federal law that this is referring to is the Security and Privacy requirements defined in 45 CFR 160, 162, and 164. However, other Federal and State laws may support the necessity for assuring security and confidentiality of electronic data.
286	51.320	314	2	How can a health plan complete its fraud and abuse investigation if the health plan is unable to contact the provider about matters related to the investigation after submitting a discovery of suspected	DHS expects that the health plan has conducted a preliminary investigation prior to reporting to DHS. The health plan should gather all of the information needed from the provider during the preliminary

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				fraud and abuse?	investigation. When the health plan sends the preliminary investigation to MQD and MFCU, MFCU determines that there is fraud, they proceed to criminal charges. If MFCU determines there is no fraud, they will return the case as "no fraud" and the health plan can then involve the provider for recovery and education.
287	51.320	314	2	How should a health plan recover costs for fraudulent services?	Recovery may be facilitated by DHS, MFCU, or another State or Federal agency if the act is determined fraudulent by that agency. With regards to MFCU, if the case is determined to be fraud, the health plan can ask MFCU for approval for the health plan to proceed with recovery.
288	51.330	317	1 st and 4 th sub-bullet	Can you provide examples of the distinction between the two bullet points? <ul style="list-style-type: none"> Monitoring the billings of its providers to ensure members receive services for which the health plan billed Verifying with members the delivery of services as claimed 	The first bullet pertains to the billing of providers (i.e., the front end of the claim, duplicate billing, or other provider related error). The second bullet is verification of services by the member (e.g., verification that service was provided, etc.).
289	51.410	318		Is the intent of setting a minimum FTE requirement for some positions to ensure that required duties are carried out rather than how much time is spent? If so, will	Health plans should have adequate human resources to meet the needs of Medicaid clients served by this contract. DHS has outlined our expectations surrounding

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				health plans have flexibility to show that this intent is met without specifically meeting the minimum FTE requirements? The amount of time spent by each employee of the organization may be quite variable depending on the person and the volume of members in the health plan.	timeframe to manage Medicaid clients in this contract. Health plans are able to submit waiver of requirements if the health plan believes that their population does not require the minimum FTE requirements.
290	51.410	318	All	Given the provisions of section 30.530 - specifically that if a member enrolled in an existing health plan [who retains a contract] does not select a new health plan that member will remain with the existing contract – what provisions will DHS allow for a new applicant to “staff up” as enrollment increases? Specifically, will new applicants be allowed flexibility in meeting full personnel requirements and to have .5 FTE for positions that require a full FTE (e.g., Pharmacy Coordinator)?	Health plans are able to request a waiver from DHS of specific requirements. DHS will base their approval of the waiver on specific health plan situations.
291	51.410	318	Table	For key Executives, can the FTE (1) be constructed from say 0.5 FTE CEO and 0.5 FTE COO = 1.0 FTE?	DHS requires that health plans commit one person full-time to administer the QUEST program. This person does not need to be a CEO or a COO. The health plan needs to decide how they want to staff this position to provide commitment from one position.

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292	51.410	320	2	<p>Can DHS verify that the personnel identified in this section may work on multiple lines of business? For instance, the section indicates that we must have a full FTE Administrator/CEO/COO/Executive Director in HI dedicated to this contract. As a QExA contractor, it would be our intent to have a single FTE Administrator for both programs, and not add another Administrator for the QUEST bid. If there are positions for which this is not acceptable, please identify them.</p>	<p>Any position that requires a FT position for the QUEST program is a position that we require 100% dedicated to the QUEST program and not another line of business.</p> <p>See answers to questions #289-291.</p>
293	51.410	321 vs. 325	4 th line item on table	<p>Please clarify whether the ‘Catastrophic Claims Coordinator’ includes business continuity planning and recovery coordination (seems more relevant to disaster recovery situations).</p> <p>The narrative regarding the catastrophic claims coordinator on page 325 does not include responsibilities for business continuity and disaster recovery.</p>	<p>It is not a requirement that this be the same person, only that the health plan is required to have personnel to address catastrophic claims, business continuity and recovery coordination. Also, that DHS receives the resume(s) and is notified of changes of the person(s) fulfilling these responsibilities.</p>
294	51.420	323	1 st paragraph	<p>Please provide the rationale for the requirement that the quality management coordinator or director be a Hawaii-licensed physician or RN. Could this position be a non-clinician with vast QI</p>	<p>The health plan may request a waiver of the physician or registered nurse requirement for this position. In the waiver request, the health plan would be required to demonstrate the qualifications</p>

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				and operational experience who is supported by licensed clinicians (including medical directors) who are direct reports?	of the person that they are presenting for this position.
295	51.420	323	2 nd paragraph	Please provide the rationale for the requirement that the behavioral health coordinator be a licensed clinician as listed in this section. Could this position be a licensed clinician (that is not among the listed specialties) but has vast BH and operational experience and is clearly supported by licensed clinicians (within the listed specialties) who are direct reports as well as by a Hawaii-licensed BH medical director?	The health plan may request a waiver of the clinicians listed for this position. In the waiver request, the health plan would be required to demonstrate the qualifications of the person that they are presenting for this position.
296	51.500	325		When will report specifications be issued? Will the state provide at least 4 months lead time for health plans to make necessary system & process changes?	DHS will provide at least three (3) months lead time. This is the standard that DHS has utilized with its current health plans performing in the QUEST and QExA programs.
297	51.510	326		Due dates for quarterly reports are April, July, Oct & January. Please confirm that the first due date for reports due in the new contract will be July?	Assuming an April 1 start date, the first report quarter will be April through June, due on July 31, 2012. The time allowed to file the report varies, but most quarterly reports (see table in §51.510).
298	51.510	326		PCP Assignment Report. Is this a report that would cover the prior month?	Yes.
299	51.510	327		The annual FQHC report. This is a calendar year report and a January 31 st	See #63 of Amendment #1.

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				due date will not allow for a complete run out of claims.	The revised date is May 31 st .
300	51.520.1 – 51.570.3	331 – 352	Various	When will the applicant be provided the specific data elements and report formats for the sections that reference: “This report shall be provided in the format to be prescribed by the DHS.”	After the contract effective date.
301	51.520.2	333		Will driving distance be an acceptable alternative to reporting drive time?	No. For example, the drive distance from Hana to Wailuku is very different from the drive time.
302	51.520.3	334		Should title be “PCP Assignment Report” so that it matches report name in the table shown on page 326?	See #66 of Amendment #1.
303	51.520.7	338	3 rd open bullet of 2 nd solid bullet	This RFP requirement calls for the percentage of claims processed to be calculated from date of service. Does it make better sense to calculate this based on the date the claim is “received” by the health plan since health plans cannot control the timeliness of providers’ claims submissions?	Yes.
304	51.520.7	338	3 rd sub-bullet	The intervals (14, 30, 60 and 90 days) for percentage of claims processed is not new in this the RFP however, the current MQD report form requires data for claims processed at 30 and 90 days. What intervals for claims processing are health plans required to report and will the report form be changed to reflect the	See #67 of Amendment #1.

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				RFP?	
305	51.540.2	341	2	The current RFP states that "If approved by the DHS, the health plan may submit call center utilization using alternative methods". Will DHS allow plans to submit call center utilization using alternative formats?	Yes, subject to approval.
306	51.540.5	342	Last para	"The health plan shall submit Member Grievance and Appeals Reports...." Are reports specific to QUEST membership or does it include all of HMSA's membership?	Specific to the population contracted under this procurement or the QUEST population.
307	51.540.9	345	1	This section states that health plans must maintain a standard of 10% or less as deemed disabled and DHS may impose sanctions if the health plan exceeds the 10% standard. Section 30.900 (page 100, last sentence) states that if more than 20% of the referrals are deemed not disabled, DHS will require the plan to reimburse DHS for the cost of the disability determinations. Please clarify the standard and sanctions.	See #20 of Amendment #1. The percentage should be 10%
308	51.550.1	345	1	If a health plan is currently NCQA accredited, will this report be waived?	Yes.
309	51.560.3	350	4th bullet	Please confirm that the intent of this measure is to identify members who utilized greater than 12 outpatient visits (and not the full benefit of 20)?	The intent is to identify members who have utilized greater than twelve (12) outpatient visits. The intention is to start members on care coordination/case

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					management prior to reaching their full benefit of 20.
310	51.560.3	350	5th bullet	The over and under utilization report specifies that the 1% of adult members is based on <u>expenditures</u> . Is the 1% of children also based on expenditures?	Yes.
311	51.560.3	350	5th bullet	Measure requires top 1% by expenditures of adults, but doesn't specifically indicate "expenditures" for children. Please clarify if the intent for "expenditures" or accumulation of services or some other utilization for children.	Yes.
312	51.570.3	352	4	For health plans that are part of an integrated system (consisting of the Health Plan, Medical Group, Hospital), who is "employee" referring to?	Those staff whose employment duties encompass activities or services provided under this RFP.
313	51.570.9	356	1	For the QUEST Dashboard, what specific information will be required on member demographics, provider demographics, call center, claims processing, and member and provider complaints?	See response to question #253.
314	51.570.9	356	1	QUEST Dashboard will involve more time/resources from the health plans and MQD to generate reports on a monthly basis that summarizes information already provided quarterly. Will DHS consider changing the frequency of the	No.

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				report to no more than quarterly and/or can MQD obtain the information from reports already provided by the health plan?	
315	51.580.1	357	Last bullet on page	The RFP requires 60% of encounter data shall be received by the DHS no more than 180 days from date of service. Additionally, the RFP has extended provider claims submission to at least one year. Will the DHS allow health plans some leeway to the 60% encounter requirement given that providers are allowed a longer claim submission timeframe?	The DHS has decreased the percentage of encounter data from 80% in 180 days in its current QUEST contract to 60% in this procurement to allow for the one-year filing deadline of provider claims. Therefore, DHS has already incorporated leeway into this requirement.
316	60.110	368	1	Please provide additional information on the applicant's liabilities and responsibilities for "prior period coverage". How will the applicant be notified about a member with prior period coverage? Will criteria for medical necessity apply to a member's claims during the prior period? Are there specific limitations to a member's benefits during the prior coverage period?	<ol style="list-style-type: none"> 1) Enrollment will be transmitted daily via the 834 file that updates membership and eligibility. 2) The health plan will be liable for services provided to the member if that member has eligibility during the time in question as long as the services provided are medically necessary and covered. 3) The QUEST Adult benefit limitations will apply during the prior period coverage timeframe.
317	60.110	369	4	Please describe the requirements and the applicant's liabilities and responsibilities for retroactive enrollments and	Health plans are responsible for paying for claims during retroactive enrollments. During retroactive disenrollments, a health

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				retroactive disenrollments. Please describe the differences between “retroactive enrollment” and “prior period coverage”.	plan would be responsible for recouping any claims paid during this period. Prior period coverage is the time from up to five days prior to application until the day that the eligibility worker makes an eligibility determination (see Section 30.510). A retroactive enrollment is when the member is retroactively enrolled in the health plan. This may not be associated with their date of eligibility.
318	60.130	370		Collection of premium shares for members is listed as a DHS responsibility under section 31.410. However, this paragraph begins with “The health plan shall be responsible for billing and collecting a members’ premium share...” Is this an accurate statement? Are there any members currently under the QUEST program with a required premium share?	There are no members that are currently in QUEST that have a premium share. However, this may change in the future (see Section 30.350 for reference).
319	60.130	370	1	Sections 60.130, 31.410, and 30.400 seem to conflict with each other. Section 60.130 says the health plan shall be responsible for billing and collecting a members' premium share, but section 31.410 says the MQD administers the billing and collection of the members' share of their monthly premium rate, and section 30.400 says the DHS shall	See response to question #16.

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				manage the Premium Share Billing System. Which is correct? If the plan will be responsible for billing and collecting member premiums, when will this responsibility begin and when will plans receive more detailed requirements?	
320	60.200	370		Will DHS consider adding performance incentives for health plans that achieve rates of improvement over the prior year to acknowledge health plans that show improvement but have not yet achieved the percentiles listed in this section?	No. The incentives are based on achieving explicit thresholds regarding national comparison. This absolute achievement is a patient oriented approach, compared to a health plan oriented approach in which a health plan's performance is measured relative to its own baseline.
321	60.200	370		Will DHS consider setting a separate pool of funds that is fully distributed among the health plans that meet the P4P threshold (rather than a with-hold from capitation)?	No. Whether it is a withhold of higher rates or a separate pool with lower rates, the sum is unchanged. The amount available should be relative to membership size because the membership size represents the impact of the achievement.
322	60.200	370		The Pay-for- Performance incentives, utilizing HEDIS and CAHPS, should be aligned throughout the system. As presented, health plans that have a proportionately higher number of community health center patients will be unfairly affected. Health Centers have higher numbers of homeless patients; COFA patients; and complex	DHS has incorporated P4P in its current QUEST contracts in an incremental fashion with lower thresholds and payment for relative improvement. This RFP furthers the program evolution to set higher standards and goals for the benefit of patients. Medicaid uses the same adjustment methodology as is used for Medicare.

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				<p>patients that with poor compliance that other practices often refuse to see. Furthermore the targets you have set are too far above the baseline to fairly incentivize and motivate. Can you set your targets to create incremental change towards a long range goal? Can you adjust your scoring for adverse selection?</p>	
323	60.200	370	4	<p>To be clear, the applicant’s P4P is all or nothing? Meaning if the applicant misses (even by a small margin) one of more of the criteria as listed in section 60.210 through 60.250 then the \$2.00 PMPM will not be returned to the applicant?</p>	<p>A threshold is specified for each measure. Each measure is independent of the others. The relative weighting for each measure is the percentage of the total available incentive amount that is earned by successfully meeting that measure.</p>
324	60.200	371	2 nd paragraph	<p>Why has the DHS removed the “Meets or exceeds the rate that is an improvement...” criteria from the quality initiatives, as in the current contract to account for plans that are caring for a more difficult population?</p> <p>Meaningful movement towards a goal is an important support from DHS to the health plan. Also, the members of some health plans are tangibly different from others making some populations much more difficult to achieve success with.</p>	<p>See responses to question #320 and #322.</p>

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325	60.220	373	Entire section	We are unclear about how health plans can report the “Plan All Cause Readmissions” measure to earn this incentive. According to NCQA’s 2012 HEDIS Technical Specifications, this measure is reportable only for Medicare and Commercial Plans. Reporting the measure requires downloading a table of weights from NCQA, and there is no table for Medicaid. NCQA-certified HEDIS software cannot produce this measure, and it cannot be audited by the EQRO. Please clarify how Med-QUEST expects plans to report this measure.	DHS will change this measure to “Chlamydia screening” based upon the inability for health plans to download the required table from NCQA for “Plan All Cause Readmissions.” However, when NCQA does develop the tools to have this be a reportable measure for Medicaid, DHS will replace the “Chlamydia screening” with “Plan All Cause Readmissions.” See #70-74 of Amendment #1.
326	60.250	374		Is the getting needed care measure for adults or children?	The Getting Needed Care measure will be alternated annually between adults and children.
327	60.310	374	1	The last sentence states that "health plans shall have an incentive to promote electronic claims submission." Is there a specific target expected for electronic claims submission, for example, 90% of claims submitted?	No.
328	60.310	374	1st paragraph vs 9th paragraph	Please clarify claim filing deadline, is it ‘at least one year’ or is it ‘at least 180 days’? <ul style="list-style-type: none"> Section 60.310 page 374, 1st paragraph indicates ‘Health plans shall allow no less than a one- 	The filing deadline is one year. See #75 and #76 of Amendment #1.

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				<p>year filing deadline for providers to submit claims.'</p> <ul style="list-style-type: none"> Section 60.310 page 376 indicates 'The health plans shall allow providers at least one-hundred and eighty (180) days to submit claims for reimbursement.' 	
329	60.310	374	2	<p>This section states plans shall allow no less than a one-year filing deadline for providers to submit claims. One page 376 (4th para), it states plans shall allow providers at least 180 days to submit claims for reimbursement. Is the timely filing deadline one year or 180 days? Please clarify.</p>	See response to question #328.
330	60.310	374, 376	2 5	<p>Should the 180 days in the last sentence of the 5th paragraph be 365 days given the one-year filing in the 1st paragraph of this section on page 374?</p>	See response to question #328.
331	60.310	375	2 nd paragraph	<p>The RFP includes provisions that allow health centers to be paid on alternative models to PPS. We have been developing a system that would allow a form of PPS to work on conjunction with a Pay for Performance and shared savings model. It aligns incentives, adjusts for population factors and</p>	<p>This alternative option could be used in accordance with the provision in the RFP.</p>

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				promotes integration of care at the community level. It systematically builds HIT and care management capacity at health care homes. To what extent can this “alternative option” vehicle be used to address the issues we have raised in this letter?	
332	60.340	380	1	Will DHS give the applicant at least 90 days notice prior to implementing this requirement?	Yes.
333	60.340	380	4	Is the nonpayment of HAC to hospital or physicians or both?	Ultimately both, but the anticipated initial implementation will apply minimally to hospitals for hospital-acquired conditions.
334	60.520	384	2	Will the catastrophic claims manager policy and procedure manual be available for review prior to the due date of proposals and before DHS announces capitation rates?	The catastrophic claims manager P&P is public information. Health plans may request this information from DHS.
335	60.530	385		Please reconcile the difference between the value driven guidance (50.530) to use new hospital reimbursement methodologies for claim payment and the note indicating that eligible costs will be based on the Medicaid fee schedule. We believe that the health plan’s actual costs based on payment guidelines will be greater and quite different than the hospital reimbursements under the Medicaid fee schedule. Additionally,	The health plans may develop any payment methodology that they choose. DHS applauds that initiative. However, the threshold for implementation of catastrophic care is based on our fees that we pay to hospitals and physicians during hospital stays. This methodology assures consistency between health plans.

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				there are other types of services that health plans may use payment methodologies that also differ from FFS – how would this be reconciled?	
336	60.530	385	2	This paragraph states that the catastrophic thresholds "are based upon the Medicaid FFS schedule, not the health plan's reimbursement structure." Does this statement require the health plan to determine catastrophic case amounts based on the Medicaid FFS schedule?	No. DHS' catastrophic care manager will determine if the catastrophic case meets the threshold or not.
337	60.530	385	2	Is the \$300,000 pro rated during the short benefit years covered under this contract?	Yes.
338	60.530	385	3	Will DHS provide the Medicaid fee schedules for Hawaii hospitals? What do health plans pay mainland hospitals?	The DHS fee schedule for hospitals is public information. Health plans may request this information from DHS. DHS is not aware of what health plans pay Mainland hospitals; DHS does not have access to this information. However, many Mainland hospitals have fee schedules established with DHS.
339	60.530	385	Note below table	Why are 'eligible costs' based on the Hawaii Medicaid fee schedule instead of the Health Plan's actual costs? The Note below the eligible cost table indicates that "Amounts listed above are	Use of the Medicaid fee schedule assures consistency between health plans as well as predictability for DHS. DHS' Medicaid fee schedules are public information to include the fee schedule for

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				<p>based upon the Medicaid FFS schedule, not the health plan's reimbursement structure."</p> <p>If this is an accurate statement, how will DHS release and maintain all applicable Hawaii Medicaid reimbursement schedules for the proper calculation of eligible costs for both medical (including behavioral health) and pharmacy services?</p>	hospitals. Health plans may request this information from DHS.
340	70.720	397	1	Please verify the State wants only current/active litigation (pending). Also, please indicate whether a minimum dollar threshold should be applied.	Yes. Only pending litigation as stated in Section 70.720.
341	70.720	397	2	The litigation section requires a disclosure of pending litigation to which a health plan is a party, including the disclosure of any outstanding judgment. Large organizations likely have ongoing lawsuits to which it is named as a party but that arguably do not affect the health plan's ability to perform under the RFP. Can health plans disclose to DHS only those lawsuits and pending judgments that will affect the health plan's ability to fulfill its obligations under the RFP?	No. All pending litigation as stated in Section 70.720.
342	71.120	398	1	Will current QUEST health plans be permitted to use their current	Current QUEST health plans will be permitted to use their current performance

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				performance bond to meet the performance bond required prior to or at the time of the execution of the contract? Or will a separate performance bond be required?	bond as long as it meets the requirements of Section 71.120.
343	71.200	400	3	The RFP states that the contract price for the extended period (can be four additional 12-month periods) shall remain the same or lower than the initial bid price or adjusted in accordance with the contract adjustment provision therein. Where is the adjustment provision in the form of the contract attached as Appendix K?	See RFP section 71.400, Modification of Contract. See #81 of Amendment #1.
344	71.200	400	All	Section 71.200 provides that "the health plan agrees to enter into a supplemental agreement upon request by the State", even if the supplemental agreement includes a change in the scope of work, term and/or compensation. In the event the health plan and the State cannot agree on the terms of a supplemental agreement, will the existing terms of the agreement continue to apply? Or does the contract modification set forth in Section 71.400 then apply, such that the Plan must proceed according to the contract price and other modifications determined by the State?	Section 71.400 of the RFP applies.

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345	71.310 and Section 1.4 of Appendix K (Page K-7)	402	4	This section sets forth the health plan's insurance requirements. Under this section, the Health Plan must obtain the required coverage from insurance companies licensed to do business in the State of Hawaii. If a Health Plan obtains some or all of the required insurance coverages through programs of self insurance, the requirement of obtaining insurance coverage through companies licensed to do business in the State of Hawaii may be inapplicable to the Health Plan. Can a Health Plan provide all or some insurance coverage through alternative risk management programs, including self-insurance or a combination of self-insurance and insurance, provided that such alternative risk management programs provide protection equivalent to that specified in the RFP?	Yes. However, the health plan must submit acceptable documentation describing the health plan's self-insurance program.
346	71.700	415	4	This section requires the health plan to notify QUEST within two (2) business of the discovery of a breach of confidentiality and provide to QUEST a written report of investigation and resulting mitigation of the breach within thirty (30) business days of the discovery of the breach. This notification	Because of reporting deadlines specified in the HIPAA regulations, the time frame for reporting breaches must necessarily be defined. Clarifying amendments have been made to section 71.700 that confirm that notification shall be within two business days of actual knowledge of a breach.

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				requirement of two business days and thirty days to mitigate seem impractical given (i) the complexities of investigating a potential breach, and (ii) length of time needed to mitigate certain breaches, especially if the breaches are the result of system or IT issues. Can QUEST allow health plans more time to notify of a potential breach and to mitigate the same?	See #83 in Amendment #1.
347	72.100	418	2	Kaiser typically includes binding arbitration in its service agreements. Can Kaiser include a binding arbitration clause, applicable to member claims and disputes only, as part of Kaiser's contract with DHS?	No. DHS is required to include provisions from 42 CFR 438 as well as DHS HAR. Both of these regulations require access to state fair hearing process, therefore the health plan cannot restrict access to hearing by requiring use of binding arbitration.
348	72.210	419	All	This section refers to liquidated damages, assessed "in an amount equal to the costs of obtaining alternative medical benefits for its members." How will such costs be determined, and will the health plan have an opportunity to review, comment on or appeal that determination?	The DHS will determine at that time what measures are required to mitigate the breach. This could vary depending, for instance, on which health plans are available to provide replacement services, and the degree to which the terminated health plan complies with section 71.640 of the RFP.
349	80.100	430	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. Screen shots may be used for illustration, but the font size may not be smaller than 10.

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350	80.100	430	1	Can exhibits and attachments include smaller than 11 point font?	Yes. However, the font size for exhibits and attachments may be no smaller than 10.
351	80.100	430	1	Does the State prefer that proposal numbering start over by section or be continuous throughout the proposal?	DHS prefers to have the proposal numbering start over by section.
352	80.100	430	1	Is there a minimum/maximum font size for graphics (e.g., flowcharts, tables, etc.)?	There is no maximum font size. Minimum font size is 10 for flowcharts, tables, diagrams, and other graphics.
353	80.100	430	2	Is restating the question subject to the same spacing and font size noted above? If not, what spacing and font size is acceptable?	Applicants may restate the question in font size 10, single spacing. In addition, the space that is taken from the restatement of the question on the page will not be counted against the allotted page numbers for the section.
354	80.210	431	1	Please verify whether the transmittal letter must be notarized and, if so, whether it is acceptable to use a non-Hawaii notary.	It is acceptable to use a non-Hawaii notary, but the notary specifications must match the requirements for the State of Hawaii.
355	80.220	433	All	This section requires information for "each affiliated company that serves Medicaid members." Does this include affiliates that will not be performing services under this RFP, and that serve Medicaid members in other States?	No. This requirement is for affiliated companies that serve Medicaid members in Hawaii.
356	80.310	436-437	1	Please clarify whether items B (contract listing), C (letters of recommendation), and/or F (EPSDT measures) can be	See #90 of Amendment #1.

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				considered attachments, and exempt from the page limit for this section.	
357	80.310	437	5 (E)	Will the state accept EQRO evaluation(s) of its subcontractor?	Yes.
358	80.310	438	1	If an offeror only has QExA EPSDT measures, should these be reported, or should the offeror report measures for the non-disabled population in two other states?	The applicant should report on their Hawaii or QExA information.
359	80.315.2	440		DHS has provided that the network scoring shall be worth a maximum of 200 points. Can DHS please provide the maximum amount of points the network provider listing is worth?	The maximum points for provider network will be 150 points. See #92 in Amendment #1.
360	80.315.2	440-445	Entire section	Please clarify if you would like us to submit just one consolidated provider listing spreadsheet or a separate spreadsheet listing for each island/provider type (items A through O) combination, or something in between? So, for each island do you need us to submit separate provider spreadsheet listings for each provider type (PCP, CNM/Ped NP/Fam NP, Specialist, Hospital, Urgent Care Providers, etc.) or can we consolidate some of these provider types together into one spreadsheet?	Please submit one spreadsheet with all of the information included (i.e., island of service).

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361	80.315.2	442	1	How should providers with multiple offices be listed? Should they be shown once, or separately for each office?	Only one provider per island, even if the provider has multiple locations. The provider may be listed more than once if the provider offers services on more than one island (i.e., once per island that the provider serves members).
362	80.315.2	443	Last paragraph	Should the health plans list behavioral providers under the clinic name if the provider is affiliated with a clinic?	Yes.
363	80.315.3	444	1	Please confirm which provider types should appear on the map of specialist providers. For example, should Radiologists be included in the specialist provider map?	All specialists should be included on the map to include radiologists.
364	80.315.3	444	1	When creating a map of specialist, is this one map per island containing all specialists? Should the specialist types be distinguished differently on the map? Please provide more clarification.	For each island, list all providers contracted on that island. The health plan may indicate specialist type if they choose.
365	80.315.3	444	2	Will the state please clarify whether it would like a GeoAccess provider map for the entire state or by island?	By island.
366	80.315.5	445	1	The RFP requires each applicant to restate and answer the question exactly as it appears in the RFP. However, in Section 80.315.5, Provider Services narrative, it asks that you provide a comprehensive explanation of how you intend to meet Provider Service	The question is worded to describe the information that DHS is interested in having the applicant communicate in their response. DHS will not change the wording to the question.

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				requirements described below to include. Instead of using the words “described below to include”, should the sentence read “described in the contract requirements to include items A through D”.	
367	80.315.5	445	1st paragraph #C	Should this requirement use the word ‘submitted’ instead of ‘processed’? “A description of how it will process claims in a timely manner, as described in Section 60.310, as well as work with providers to assure that claims are processed submitted timely;”	DHS will not change the wording to the question. DHS is asking health plans to describe how they work with providers to assure that claims that providers submit may be processed timely (i.e., clean claims, correct forms, correct codes).
368	80.330.4	456	1	If an offeror only has QExA HEDIS measures, should these be reported, or should the offeror report measures for the non-disabled population in two other states?	The applicant should report on their Hawaii or QExA information.
369	80.330.4	456	A	Is the expectation that health plans have formal written policies and procedures relating to meeting HEDIS performance measures requirements, or will a narrative suffice?	A narrative will suffice.
370	80.330.4	456	A	In lieu of formal written policies and procedures, is a narrative description explaining how plans meet HEDIS performance measures requirements acceptable?	Yes.

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371	80.340.6	462	#4	The State has recognized that in certain responses a diagram provides a more comprehensive overview of process flow. Most diagrams do not meet the 11 font requirement. Will the State allow the diagrams and tables used throughout the technical narrative response to use a smaller font than the required 11 point font RFP requirement?	If a diagram describes the process better, then a diagram may be used. The font in the diagram should be no smaller than 10 font.
372	80.340.6	462	1 st bullet at top of page	There is limited guidance in the RFP regarding “contract type”. Can the DHS provide additional background on what type of 834 information would be provided to the health plans for the development of a response to meet the requirement shown below? “Its ability to receive different rate codes and contract types”	For the "Contract Type" and "Rate Code" data elements on the 834 enrollment transaction, the health plan will be sent more than one code value.
373	80.340.6	462	Item #2	Please clarify what the health plan is expected to submit for this narrative.	The health plan is expected to describe the organization's systems infrastructure, especially as it relates to the flow of data through the organization.
374	80.340.6 - A.4	462	A.4	Does the following statement refer to FTP of data/file/reports or does DHS expect other interface(s) between systems? "An explanation of how it will ensure that its systems can interface with the DHS systems and how it will	This primarily relates to the preparation and submission of encounter data as well as being able to receive and process an 834 enrollment transaction.

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				institute processes to insure the validity and completeness of the data submitted to the DHS."	
375	80.340.6.A.3	462	1	Please explain your definition of "real-time." We are assuming that this means the information on the website must match the information in our claims system at the time of inquiry.	See response to question #95.
376	80.340.6.A.3	462	1	Does "health plan user" refer to health plan employees (i.e. users of the health plan's systems)?	Yes. This refers to the health plan employees, subcontractors (i.e., case managers), and providers.
377	90	464		Can the State provide a detailed Actuarial Rate Setting Methodology memo that details the RFP contract period rate setting and assumptions (including historical and prospective utilization and unit cost trends, data used, completion, managed care savings, other adjustments, etc.)? Can the State provide the reimbursement basis upon which the State's actuaries base the capitation rate, e.g. will the capitation rates assume 97% of Medicaid FFS rate(s)?	DHS will answer this question as part of the proposed capitation rate questions that will be responded to on the date specified in Section 20.100 of the RFP.
378	90.200	464	3	Will premium taxes be added as a gross up to the proposed capitation rates for for-profit health plans, as happens in other states? Many states use the premium tax as an opportunity to draw	DHS intends to continue its inclusion of applicable taxes in its payment to for-profit health plans, nursing facilities, and physicians in order to help maximize the receipt of federal funding in Hawaii.

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				down additional federal matching funds, therefore the premium tax revenue is neutralized for the state and for the health plan.	
379	90.200	464	1	What are the rate cells in the program? For example: TANF 0-3 months, TANF 4-11 months, etc. Are there any kick payments for maternity or NICU?	<p>Rates vary by island and aid category (page 464 of RFP) as well as age and gender. Rates vary by the following age/gender bands:</p> <p>Female Ages < 1 Female Ages 1-5 Female Ages 6-11 Female Ages 12-18 Female Ages 19-20 Female Ages 21-39 Female Ages 40-64</p> <p>Male Ages < 1 Male Ages 1-5 Male Ages 6-11 Male Ages 12-18 Male Ages 19-20 Male Ages 21-39 Male Ages 40-64</p> <p>The current rate structure does not include either maternity or NICU kick payments.</p>
380	90.200	464	2	What types of care management expenses are expected to be included as	All care management expenses are included as administrative expenses.

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				administrative expenses?	
381	90.200	464	2 nd paragraph	<p>Please provide additional clarification on how ‘premium tax’ will be accounted for in the development of capitation rates and dealt with in the rates that will be paid. In the last bid there was a “pre-tax rate with the implication that there would be a “post tax rate”, will such a differential exist in this mechanism of reimbursement?</p> <p>Also, would premium tax have any impact in the gain share program?</p>	<p>There will be one “rate” for each health plan.</p> <p>As the premium tax is budget neutral to plans that are subject, there is no impact that differs from plans not subject to it regarding effect on gain share program.</p>
382	90.300	465		Are there any limits on the number of Health Plans per island?	No
383	90.300	465	3	What will be the allowed administrative expenditures percentage for those that serve only Oahu and one other island?	In addition, there will be up to a 1% differential for administration for those plans that serve all islands versus plans that only serve Oahu and one other island. Final rates have not been determined at this time.
384	90.300	465	3	What will the allowed administrative expenditure be for health plans that only service Oahu and one other island?	See #383.
385	90.300	465	All	What will the administration load be for the statewide bid versus the non-statewide bid? Is it 1% higher than the non-statewide bid? If so, does that mean the maximum administrative expense for	Plans are not asked to bid a rate as part of their response to this proposal. The maximum administrative rate in the gain sharing agreement is 10% even though the administrative load used in the rate

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				a non-statewide bid is 9% instead of 10%?	development may be less.
386	90.300	466	2	When will the enhancement payment to the health plans for FQHC & RHC utilization become effective? Will an estimated impact of this enhancement be communicated when the capitation rates are issued?	The payment will be effective at the start of the program, April 2012. The state will provide the underlying methodology to be applied to enrolled membership. The state will provide the aggregate impact of the additional payments to fund the projected difference between average non-FQHC payments and FQHC PPS payments for each encounter.
387	90.300	466	2nd paragraph	Is it the intent of the DHS to hold health plans financially harmless in the implementation of the PPS rates to the CHCs? Are health plans acting as a pass through?	Health plans are expected to manage care and seek to improve quality and efficiency; they are not expected to act as a pass through.
388	90.300	466	3	When will the enhancement payment to the health plans for SMI enrolled members become effective? Will an estimated impact of this enhancement be communicated when the capitation rates are issued?	The payment will be effective at the start of the program, April 2012. The state will provide the underlying methodology to be applied to enrolled membership. The state will provide the aggregate impact of including these additional behavioral health services for SMI clients.
389	90.300	467	1	What information and methodology will be used to account for risk selection between the health plans and to shift revenue between health plans? Will an estimated impact of this budget neutral adjustment be communicated when the	We intend to use both diagnosis and pharmacy data to adjust for risk selection between plans. There is no impact of this adjustment at the time initial rates are released. Once members have selected plans we will provide the estimated impact

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				capitation rates are issued?	to each plan.
390	90.300	467	1	What risk adjustment model will be used to risk adjust rates?	We anticipate we will use the most recent version of the CDPS model that incorporates diagnosis coding, pharmacy claims as well as age and gender to develop prospective risk scores. If modifications of this model are required, those modifications will be communicated to plans.
391	90.300	467	1	Please clarify and explain in greater detail the State's intended actions regarding this statement: "Each year, the risk adjustment process shall be refreshed with the target implementation for the next calendar year."	It is our intent to reset risk scores based on the base year data provided for rate setting each rating period. To the extent that there are changes in the risk mix due to member migration or changes in health status these will be reflected in the most recent enrollment and claims data. Generally there is approximately a six to nine month lag from the end of the base year data and the beginning of the contract period. We intend to use prospective risk scores rather than concurrent risk scores.
392	90.300	467	1 st paragraph	Please provide additional information on the concept of budget neutral rate adjustments that could be performed by the DHS as stated in this paragraph. How can the health plans be prepared so that the DHS can perform a timely risk adjustment and implement during the initial month of enrollment?	Risk scores will be calculated for each individual based on diagnosis coding and pharmacy claims. For each rate cell (island and aid category) these risk scores will be normalized such that they composite to 1.00. To the extent that a plan has a higher or lower risk score rate will be adjusted up or down accordingly. Some modifications

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					may be required due to lack of credibility in some rate cells. We will not need additional data from plans.
393	Appdx C	C-1		With the lengthening of the claims submission time frame, does the “six months following the end of the calendar year...” language need to be adjusted?	This should not be an issue as completion factors should account for lag in completed claims.
394	Appendix C	C-1	1	The description of the gain sharing program says that financial reports will be used to calculate the simple profit and loss statement. How will prior period adjustments to medical expenses and revenue be accounted for in the calculations?	At the time of the development of financials completion factors will be applied to account for unpaid claims incurred during the period. These factors will be calculated by the plans. Plans will provide details such that the state can review for reasonableness. Prior period adjustment expenses in excess of those assumed in the developed completion factors will be counted in the payment period financials.
395	Appendix C	C-1	5	This appendix defines "Total Revenue" as the sum of all capitation payment made to each health plan "during the fiscal year". Should this say instead "for the fiscal year" as this would match costs to revenue? "During the fiscal year" implies that if the state paid for a month in the fiscal year either before or after the fiscal year started, that the revenue would not be included in the calculation. This would mismatch the revenue to the	See #93 of Amendment #1.

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				claims the revenue was expected to cover.	
396	Appendix C	C-1	5	This appendix defines "Total Revenue" as the sum of all capitation payment "made to" each health plan during the fiscal year. Should this say "expected to be made to"? "Made to" implies that there is a strict cutoff of revenue that the health plan receives between the start date and end date of the fiscal year, but what if the state over pays or under pays during a fiscal year period due to an issue with the membership file and the health plan is accruing a potential payable or receivable related to the revenue for that fiscal year? Would the state not want that included in the calculation to match revenue to claims?	See #93 of Amendment #1. To the extent that there is over or under payment due to a membership file issue and plans have accrued a potential payable or receivable related to this issue, this should be included in the calculation. If this is a significant issue efforts should be made to validate that plans and the state have the same expectations.
397	Appendix C	C-1	N/A	What are the definitions of medical expenses and administrative expenses for the calculations? Will they match the definitions used by the state consulting actuary to develop the premium capitation rates. That is, if "care management costs" are built into the premium capitation rates as part of the administrative expense load, will they also be included in the administrative expenses, not the medical expenses, in	Medical expenses and administrative expenses will be calculated consistent with the rate development methodology. Allocation of services as medical or administration will be clear in defined in rate documentation

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				the Medical Loss Ratio calculation and Profit calculation? If not, there is a mismatch of the way the plan is administered.	
398	Appendix C	C-1	N/A	Is the \$2pmpm withhold revenue excluded from the Gain Share calculation?	Yes.
399	Appendix C	C-1	N/A	How will the Gain Share Program change for statewide bidders given that they will receive a higher percentage administrative expense in their rates?	The program is based on a maximum administration percentage of 10%. This is based on amounts spent by health plans, not the amount built into the rates. The formula is not changing for differences in assumed administration rates in the rate development.
400	Section 8.2 of Appendix K	K-15		Subparagraph 8.2.4 of this Section 8.2 requires the provider (health plan) to report to the State in a "prompt and complete manner" any security breaches involving personal information. This reporting requirement (prompt and complete) appears to be inconsistent with the reporting requirement contained in Section 71.700, Page 415 of the RFP, as noted above. The prompt and complete manner standard is in alignment with the standards in the HITECH Act and clarification is required to make the standard in the RFP consistent with the language in	Section 8.2 of Appendix K, General Conditions, relates to "personal information" as defined in section 8.1.1. Section 71.700 of the RFP is broader, and covers information that is confidential under Medicaid, HIPAA and other statutes, including state law protecting social security numbers and personal information. Section 71.700 does not conflict with Appendix K, but may be more stringent. Health plans will always be required to comply with the most stringent confidentiality requirements that apply in a particular situation.

Question #	RFP Section #	RFP Page #	Para #	Question	Answer
				Appendix K.	
401	Appendix L, Question 7	L-19		The question asks what types of liability insurance does the applicant have? Can health plans provide the required coverages through its self insurance program?	Yes. However, the health plan must submit acceptable documentation describing the health plan's self-insurance program.
402	Appendix L, Question 9	L-20		The question asks if there are any "judgments, tax deficiencies, or claims pending against the applicant"? This question, as drafted, is broadly written. Can health plans provide only such claim and judgment information if they affect our ability to perform under the RFP?	No. All pending judgments, tax deficiencies and claims against the applicant.
403	Appendix L	L-27		This sheet requests information about the health plan's insurance coverages and the names of the insurance company. Can health plans provide the required coverages through its self insurance program?	Yes. However, the health plan must submit acceptable documentation describing the health plan's self-insurance program.
404	General Question			Would the state provide the actuarial rate setting letters from the last two years for the QUEST program?	The actuarial rate setting letters are public information. Health plans may request this information from DHS.
405	General Question			Can DHS provide a breakdown, by zip code, of the QUEST membership to allow the applicant to run potential network adequacy?	Yes. This information is posted as an attachment to the Q&A.

Question #	RFP Section #	RFP Page #	Para #	Question	Answer
406	General Question			Has the DHS provided Milliman with a list of all the additional administrative requirements (nurse line, quarterly paper provider directories, secure member web portals, NCQA accreditation, etc) that will impact a Health Plans costs? If so, can the DHS release the list to the Health Plans?	DHS has provided Milliman with the QUEST RFP that includes all of the administrative requirements.
407	General Question			Will the actuary be releasing a data book? If so, when will it be released?	The data book will be released with the rates and rate development documentation.
408	General Question			QUEST is a billion dollar program. Why is there not more emphasis on the projected diffusion of QUEST dollars and the impact on the State economy? While the QUEST program caps administrative costs, and an actuary will surely ratchet down plan risk pool margins, an effective network will continue to produce margins. Should we not consider how the margins are used? Should we not consider plans that hire locally? Should we not promote plans that have creative systems of shared savings?	DHS has included gainsharing and limitations such that the State shares in any profit to help sustain the program. This is in response to previous experience in which the greatest outflow from the State's economy was funds placed in a health plan's reserve. The RFP specifies the substantial local presence requirements.