

Amendment #1  
 Issued on: September 20, 2013

For Request for Proposals RFP-MQD-2014-005  
 QUEST Integration (QI) Managed Care to Cover Eligible Medicaid and Other Eligible Individuals

#	Question #	RFP Section #	RFP Language	Amendment
1	4	20.100, 19th row of table  RFP Timeline	Row reads:  Request teleconference number for capitation rate orientation on November 12, 2013	Row is amended to read:  Request teleconference number for capitation rate <del>orientation</del> <u>meeting with applicants to discuss final capitation rates on November 12, 2013 December 9, 2013</u>
2	5	20.870, second paragraph  Rules for Withdrawal or Revision of Proposals		Insert the following as the last sentence of the second paragraph of the section:  <u>Applicants may withdraw their bid without incurring penalties as described in Section 100.700.</u>
3	6	30.200, Provider  Definitions/Acronyms	Definition reads:  <b>Provider</b> - An individual, clinic, or institution, including but not limited to allopathic and osteopathic physicians, nurses, referral specialists and hospitals, responsible for the provision of health services under a health plan.	Definition is amended to read:  <b>Provider</b> - An individual, clinic, or institution, including but not limited to allopathic and osteopathic physicians, nurses, referral specialists and hospitals, responsible for the provision of health services under a health plan. <u>Providers are not a subset of subcontractors.</u>

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4	10	30.520, First paragraph, bulleted list  Enrollment Responsibilities	Bullet #4 reads:  <ul style="list-style-type: none"> <li>Enrollment of foster care children shall be as described in Section 30.540.4; and</li> </ul>	Bullet #4 is amended to read with additional bullets added as #6 and #7:  <ul style="list-style-type: none"> <li>Enrollment of foster care children shall be as described in Section 30.540.4; <del>and</del></li> <li>Individuals who have lost eligibility for a period of less than six (6) months; and</li> <li>Exceptions identified in Section 30.560 related to enrollment cap or limit.</li> </ul>
5	16	30.540.3, Fourth sentence of section  Additions to Existing Cases	Sentence reads:  If the new member is 19 years or older, he or she will be enrolled in the same health plan as the primary insurer.	Sentence is amended to read:  If the new member is 19 years or older, he or she will be enrolled in the same health plan as the primary <del>insurer</del> <u>client</u> .
6	28, 29	40.210, Second paragraph  General Provisions	Sentence reads:  The health plan needs to contract with enough providers for their members to have timely access to medically necessary covered services. The health plan is responsible for assuring that members have access to providers listed in Section 40.230.	Sentence is amended to read:  The health plan needs to contract with enough providers for their members to have timely access to medically necessary covered services. The health plan is responsible for assuring that members have access to providers listed in Section <del>40.230</del> 40.220.
7	36	40.230, First paragraph, bulleted list		Insert the following as bullet point #4:  <ul style="list-style-type: none"> <li><u>Behavioral Health (routine visits for adults and children) - Appointments</u></li> </ul>

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		Availability of Providers		<u>within twenty-one (21) days;</u>
8	39	40.270, Second paragraph  Federally Qualified Health Center (FQHCs) and Rural Health Centers (RHCs)	Sentence reads:  If a member is assigned to a FQHC or RHC as their PCP, the health plan shall allow the member to receive covered services at any other FQHC or RHC without prior authorization.	Sentence is deleted and two sentences are added as sentence two and three of the section:  <del>If a member is assigned to a FQHC or RHC as their PCP, the health plan shall allow the member to receive covered services at any other FQHC or RHC without prior authorization.</del>  <u>The health plan shall allow all members to receive covered services that are urgent in nature at any FQHC or RHC without prior authorization. The health plan shall require the FQHC to refer the patient back to and inform the assigned PCP or help the individual select a new PCP.</u>
9	49	40.740.2.a, Fourth paragraph  Standard behavioral health services for Adults and Children	The paragraph reads:  The psychiatric evaluation and treatment of members who have been criminally committed to ambulatory mental health care settings (i.e., those on conditional release to the DOH) shall be the clinical and financial responsibility of the appropriate State agency. The health plan shall remain responsible for providing medical services to these criminally committed members.	The paragraph is amended to read:  The psychiatric evaluation and treatment of members who have been criminally committed to ambulatory mental health care settings (i.e., those <del>on conditional release</del> <u>with legal encumbrances</u> to the DOH) shall be the clinical <del>and financial</del> responsibility of the appropriate State agency. The health plan shall remain responsible for providing medical services to these criminally

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				committed members. <u>In addition, the health plan may be billed for standard behavioral health services provided to these members.</u>
10	55	40.800, First sentence, first paragraph  Self-Direction	Sentence reads:  The health plan shall provide all members assessed to need personal assistance services (as defined in Section 40.730.3.n) and respite services (as defined in Section 40.730.3.q) the opportunity to have choice and control over their providers (referred to as self-direction).	Sentence is amended to read:  The health plan shall provide all members assessed to need personal assistance services (as defined in Section 40.73 <u>4</u> 0.3.n) and respite services (as defined in Section 40.73 <u>4</u> 0.3.q) the opportunity to have choice and control over their providers (referred to as self-direction).
11	69	41.500, Third sentence, first paragraph  Out of State/Off Island Coverage	Sentence reads:  This includes referrals to an out-of-state or off-island specialist or facility, transportation to and from the referral destination for an off-island or out-of-state destination, lodging, and meals for the member and one (1) attendant.	Sentence is amended to read:  This includes referrals to an out-of-state or off-island specialist or facility, transportation to and from the referral destination for an off-island or out-of-state destination, lodging, and meals for the member and one (1) attendant, <u>if applicable.</u>
12	80,81, 83	51.320, First paragraph  Reporting and Investigating Suspected Provider Fraud and Abuse	Paragraph reads:  If the health plan becomes aware of fraud and abuse from any source or identifies any questionable practices, it shall conduct a preliminary investigation. A credible allegation of fraud and/or abuse is defined as an allegation that has indicia of reliability	Paragraph is amended to read:  If the health plan becomes aware of <u>suspected</u> fraud <del>and</del> <u>or</u> abuse from any source or identifies any questionable practices, it shall conduct a preliminary investigation. <u>If the findings of the preliminary investigation determines there is</u>

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			that comes from any source and has been verified. Fraud is not determined by either the MQD or the health plan. Based on all the evidence gathered, the MQD or the health plan only determines that there is the potential that an identified activity could be fraudulent. Health plans are required to report that there is credible allegation of fraud or abuse to the MQD within 30 calendar days of completing a preliminary investigation and making such a determination.	<u>a credible allegation of fraud, the health plan must report to the DHS within 30 days of completing the preliminary investigation.</u> A credible allegation of fraud and/or abuse is defined as an allegation that has indicia of reliability that comes from any source and has been verified. Fraud is not determined by either the <del>MQD DHS</del> or the health plan. Based on all the evidence gathered, the <del>MQD DHS</del> or the health plan only determines that there is the potential that an identified activity could be fraudulent. <del>Health plans are required to report that there is credible allegation of fraud or abuse to the MQD within 30 calendar days of completing a preliminary investigation and making such a determination.</del>
13	86, 87	51.410, Table  General Requirements	Row #23 reads:  Catastrophic Claims Coordinator (includes business continuity planning and recovery coordination)	Row #23 is amended to read:  <del>Catastrophic Claims Coordinator (includes</del> <u>Business continuity planning and recovery coordination</u> <del>or</del>
14	90	51.520.6, Fifth sentence in Section  Provider Suspensions and Termination Report	Sentence reads:  Denied credentialing.	Sentence is amended to read:  <del>Denied credentialing.</del>
15	90	51.520.6		The following is added as the fourth

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		Provider Suspensions and Termination Report		sentence:  <u>The health plan shall submit all denied credentialing for any reason on their quarterly report.</u>
16		51.580.1, Fourth sentence, first paragraph  Accuracy, Completeness, and Timeliness of Encounter Data Submissions	Sentence reads:  The State will provide each plan an Encounter Timeliness and Accuracy Report at least monthly, in addition to the error reports the plan receives from the SFTP server after each encounter submission.	Sentence is amended to read:  <del>The State</del> <u>DHS</u> will provide each <u>health plan</u> an Encounter Timeliness and Accuracy Report <del>at least</del> monthly, in addition to the error reports the <u>health plan</u> receives from the SFTP server after each encounter submission.
17		51.580.1, First bullet, first paragraph  Accuracy, Completeness, and Timeliness of Encounter Data Submissions	Bullet reads:  <ul style="list-style-type: none"> <li>• Accuracy and Completeness – One accuracy rate is the Current Pended Rate, which is calculated based on new system pends for each encounter submission divided by the total encounter lines in that submission. The State also calculates average Current Pended Rates for the past three (3), six (6), and twelve (12) months. Another accuracy rate is the Cumulative Pended Rate, which is calculated based on cumulative pends divided by the sum of the total encounter lines in the past twelve (12) months’ submissions. The</li> </ul>	Bullet is amended to read:  <ul style="list-style-type: none"> <li>• Accuracy and Completeness – <u>DHS will measure accuracy with the following measures:</u> <ul style="list-style-type: none"> <li>○ <del>One accuracy rate is the Current Pended Rate</del> <u>for the latest month and the cumulative average for the past three (3) and six (6) months</u> <del>which that</del> is calculated based on new system pends for each encounter submission divided by the total encounter lines in that submission. <del>The State also calculates average Current Pended Rates for the</del></li> </ul> </li> </ul>

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			<p>following accuracy targets apply:</p> <ul style="list-style-type: none"> <li>○ Current Pended Rate of five percent (5%); and</li> <li>○ Cumulative Pended Rate of twenty-five percent (25%).</li> </ul>	<p><del>past three (3), six (6), and twelve (12) months.</del></p> <ul style="list-style-type: none"> <li>○ <u>Twelve (12) months new pends that is calculated based upon the last twelve month pended errors divided by total encounter lines (including resubmitted adjusted, void and denied encounters).</u></li> <li>○ <del>Another accuracy rate is the Cumulative Total Pended Rate, which that</del> <u>is calculated based on cumulative pends total pended errors divided by the sum of the total encounter lines in the past twelve (12) months' submissions.</u></li> </ul> <p>The following accuracy targets apply:</p> <ul style="list-style-type: none"> <li>○ Current Pended Rate of <u>less than five percent (5%); and</u></li> <li>○ <u>Current pended rate of less than five percent (5%) for cumulative averages for the past three (3) and six (6) months; and</u></li> <li>○ <u>Cumulative twelve month pended rate less than ten percent (10%); and</u></li> <li>○ Cumulative <u>Total Pended Rate</u> of twenty-five percent (25%).</li> </ul>
18		51.580.1, First bullet, second paragraph	Bullet reads:	Bullet is amended to read:

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		Accuracy, Completeness, and Timeliness of Encounter Data Submissions	<ul style="list-style-type: none"> <li>The most recent month on the latest Encounter Timeliness and Accuracy Report either the Current Pended Rate is still greater than five percent (5%) OR the Cumulative Pended Rate is still greater than twenty-five percent (25%), a penalty amounting up to five percent (5%) of the monthly (initial month's submission) capitation payment may be assessed against the health plan for failing to submit accurate encounter data.</li> </ul>	<ul style="list-style-type: none"> <li><u>In <del>T</del>the most recent month on the latest Encounter Timeliness and Accuracy Report a penalty amounting up to five percent (5%) of the monthly (initial month's submission) capitation payment may be assessed against the health plan for failing to submit accurate encounter data if:</u> <ul style="list-style-type: none"> <li>o Current Pended Rate is still greater than five percent (5%);</li> <li>o <u>Cumulative averages for the past three (3) and six (6) months are still greater than five percent (5%);</u></li> <li>o <u>The average of the cumulative latest twelve months is greater than ten percent (10%); <del>or</del> and</u></li> <li>o <del>The Cumulative Total Pended Rate is still greater than twenty-five percent (25%). a penalty amounting up to five percent (5%) of the monthly (initial month's submission) capitation payment may be assessed against the health plan for failing to submit accurate encounter data.</del></li> </ul> </li> </ul>
19	17	51.800, Table  Timeframes during RFP Implementation	Row #14 reads:  Enrollment limit for auto-assignment in Section 30.560 at 90-days prior to APC by DHS	Row #14 is amended to read:  Enrollment limit for auto-assignment in Section 30.560 at 90-days prior to APC by <u>DHS-Health Plan</u>

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20	17	51.800, Table  Timeframes during RFP Implementation		Row #15 is added:  <u>Enrollment cap for auto-assignment in Section 30.560 at 90-days prior to APC by DHS</u>
21	104	80.210, Bullet point J Attachment: Transmittal letter	Bullet reads:  J. A statement that the person signing this proposal certifies that he/she is the person in the applicant's organization responsible for, or authorized to make, decisions as to the prices quoted, that the offer is firm and binding, and that he/she has not participated and shall not participate in any action contrary to the above conditions; and	Bullet is amended to read:  J. A statement that the person signing this proposal certifies that he/she is the person in the applicant's organization responsible for, or authorized to make, decisions as to <del>the prices quoted</del> <u>this offer</u> , that the offer is firm and binding, and that he/she has not participated and shall not participate in any action contrary to the above conditions; and
22	123	80.310, First sentence, bullet point G  Experience and References (15 pages maximum not including attachments B, C, E, F, and G below)	Sentence reads:  The health plan's most recent HEDIS validation evaluation issued July 2013 from the State of Hawaii.	The sentence is amended to read:  The health plan's most recent <del>HEDIS validation evaluation</del> <u>HEDIS® 2013 Compliance Audit™ (hereby called HEDIS validation evaluation)</u> issued <u>from the State of Hawaii with July or August 2013 on the front cover</u> <del>from the State of Hawaii.</del>
23	118	80.315.4, Sixth paragraph	Paragraph reads:  Finally, when a provider has multiple	Paragraph is amended to read:  Finally, when a provider has multiple

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		Attachment: Maps of providers (not include in page maximum)	locations, the applicant will assure that they are only listed once on the map. For example, if a provider practices on Oahu and Maui, then the provider may be listed on the Oahu map or the Maui map, but not both maps. In addition, if the provider practices in several locations on Oahu, they may only be listed in one location on Oahu.	locations, the applicant <del>will assure that they are only listed once on the map</del> <u>may include them on all islands that they practice, but only once per island</u> . For example, if a provider practices on Oahu and Maui, then the provider may be listed on <u>both</u> the Oahu map <del>or and</del> the Maui map, <del>but not both maps</del> . In addition, if the provider practices in several locations on Oahu, they may only be listed in one location on Oahu.
24	119	80.335.3, Bullet point C  QAPI Narrative-Value-Based Purchasing (VBP)	Bullet reads:  C. The applicant shall describe its health home model.	Bullet is amended to read:  C. The applicant shall describe its <del>health</del> <u>medical</u> home model.
25	122	100.400, Second paragraph, Provider Network and Services portion of Table  Technical Proposal Evaluation	Provider Network and Services portion of Table reads:  See end of these amendments	Provider Network and Services portion of Table is amended to read:  See end of these amendments
26	122	100.520, First sentence, second paragraph  Provider Network and Services (150 points possible)	Sentence reads:  80.315.1 to 80.315.3	Sentence is amended to read:  80.315.1 to 80.315. <del>3</del> <u>4</u>

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27	122	100.520, First sentence, third paragraph  Provider Network and Services (150 points possible)	Sentence reads:  80.315.4 to 80.315.5	Sentence is amended to read:  80.315.4 <del>5</del> to 80.315.5 <del>6</del>
28	121	100.570, Third paragraph, bullet point #2  Health Plan Administrative Requirements (150 points possible)	Bullet reads:  <ul style="list-style-type: none"> <li>Staffing structure that demonstrates an effective operation to meet the requirements of the contract and to properly administer a program with a minimum of 25,000 members.</li> </ul>	Bullet is amended to read:  <ul style="list-style-type: none"> <li>Staffing structure that demonstrates an effective operation to meet the requirements of the contract and to properly administer a program with a minimum of <del>25,000</del> <u>20,000</u> members.</li> </ul>
29		100.700, Second sentence, second paragraph  Contract Award	Sentence reads:  If an awarded applicant requests to withdraw its bid without incurring penalties, it must be requested in writing to the MQD before the close of business (4:30 p.m. H.S.T.) on the Contract Award date identified in Section 20.100.	Sentence reads:  If an awarded applicant requests to withdraw its <del>bid proposal without incurring penalties</del> , it must be requested in writing to the MQD before the close of business (4:30 p.m. H.S.T.) on the Contract Award date identified in Section 20.100.
30	127	Appendix D, Proposal Letter		Replace Appendix D, Proposal Letter with the letter at the end of this document.

100.400 Technical Proposal Evaluation  
 Table in second paragraph of the section

<u>Evaluation Categories</u>	<u>Available Points</u>	<u>Points Needed to Pass</u>
Section/Title		
80.315 Provider Network and Services	<b>150</b>	<b>112.5</b>
80.315.1 Provider Network Narrative	100*	
80.315.2 Attachment: <del>Required Providers</del> Required acute, primary care, and behavioral health Providers		
80.315.3 Attachment: Required LTSS Providers		
80.315.34 Attachment: Maps of Providers		
80.315.45 Availability of Providers Narrative	50*	
80.315.56 Provider Services Narrative		
*The subsections of these sections are combined together and only receive a single rating score.		

**STATE OF HAWAII**

**Department of Human Services**

**PROPOSAL LETTER**

We propose to furnish and deliver any and all of the deliverables and services named in the attached Request for Proposals for ~~behavioral health~~ medical services. The administrative rates offered herein shall apply for the period of time stated in said RFP.

It is understood that this proposal constitutes an offer and when signed by the authorized State of Hawaii official will, with the RFP and any amendments thereto, constitute a valid and legal contract between the undersigned applicant and the State of Hawaii.

It is understood and agreed that we have read the State's specifications described in the RFP and that this proposal is made in accordance with the provisions of such specifications. By signing this proposal, we guarantee and certify that all items included in this proposal meet or exceed any and all such State specifications. ~~We also affirm, by signing this proposal, that we have reviewed the reference materials in the State's documentation library and that we have used this documentation as a basis for submitting our firm fixed price cost proposal.~~

~~It also understood that failure to enter into the contract upon award shall result in forfeiture of the surety bond.~~ We agree, if awarded the contract, to deliver goods or services which meet or exceed the specifications unless proposal is withdrawn in accordance with Section 100.700.

\_\_\_\_\_  
Authorized  
Date

\_\_\_\_\_  
Applicant's Signature/Corporate Seal

\_\_\_\_\_