

Amendment #1
 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

#	RFP Section #	RFP Language	Amendment
1	20.100, Table RFP Timeline		Table is amended by inserting between “Written Responses to Technical Proposal Questions” and “Proposal Due Date” the following 2 items: <u>Submission of Questions on Amendments: September 16, 2011</u> <u>Written Responses to Questions on Amendments: September 23, 2011</u>
2	20.100, Last row of table RFP Timeline	Row reads: Commencement of Quality Portion of Auto-Assignment on July 1, 2013	Row is amended to read: Commencement of Quality Portion of Auto-Assignment on July 1, 2013 <u>January 1, 2014</u>
3	20.200, Second paragraph Orientation	Sentence reads: A second orientation for applicants for the proposed capitation rates will be held on the date identified in Section 20.100 from 9:00 to 11:00 am H.S.T. via meeting in person, via teleconference, or by another method deemed appropriate by DHS.	Sentence is amended to read: A second orientation for applicants for the proposed capitation rates will be held on the date identified in Section 20.100 from 9:00 to 11:00 am H.S.T. via meeting in person, via teleconference, or by another method deemed appropriate by DHS. <u>in room 577A in the Kakuhewea Building, 601 Kamokila Boulevard, Kapolei, Hawaii. In addition, applicants may access the orientation via teleconference. Applicants shall e-mail to QUESTRFP@medicaid.dhs.state.hi.us no later than 2:00 pm H.S.T on October 14, 2011 to</u>

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			<p><u>receive the teleconference number. The e-mail requesting the teleconference information shall identify each of the persons calling into the teleconference to include their name, organization, and position.</u></p>
4	20.300 Submission of Written Questions		<p>Section is amended by inserting at the end, the following paragraph:</p> <p><u>Applicants may submit questions on any previously posted amendments ONLY. These question shall be in writing and submitted via e-mail or on diskette in Word 2010 format or lower, to the following mailing address or e-mail address:</u></p> <p style="text-align: center;"><u>Ms. Dona Jean Watanabe</u> <u>Med-QUEST Division (MQD) - Finance Office</u> <u>1001 Kamokila Boulevard, Suite 317</u> <u>Kapolei, Hawaii 96707-2005</u> <u>Email Address: questrfp@medicaid.dhs.state.hi.us</u></p> <p><u>The applicant shall use the format provided in Appendix M for the submission of questions. Applicants must submit written questions on the amendments by 4:30 p.m. (H.S.T.) on the date identified in Section 20.100. The DHS shall respond to the written questions on the amendments by the date identified in Section 20.100. No verbal responses shall be considered as official. The DHS shall not respond to any questions posed on issues that do not appear in any amendments.</u></p>

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5	20.500, First paragraph Tax Clearance		Amend the paragraph by adding the following as the last sentence of the first paragraph: <u>The applicant shall utilize Hawaii Compliance Express to obtain an IRS tax clearance.</u>
6	30.200, Action Definitions/Acronyms		Amend the definition by adding the following as the third bullet point of the sixth bullet point: <u>If the provider does not choose to join the network or does not meet the qualifications, the member is given a choice of participating providers and is transitioned to a participating provider within 60 days.</u>
7	30.200, Advanced Practice Registered Nurse (APRN) Definitions/Acronyms	Definition reads: Advanced Practice Registered Nurse (APRN)- A registered nurse with advanced education and clinical experience who is qualified within his/her scope of practice under State law to provide a wide range of primary and preventive health care services, prescribe medication, and diagnose and treat common minor illnesses and injuries.	Definition is amended to read: Advanced Practice Registered Nurse <u>with Prescriptive Authority (APRN-Rx)</u>- A registered nurse with advanced education and clinical experience who is qualified within his/her scope of practice under State law to provide a wide range of primary and preventive health care services, prescribe medication, and diagnose and treat common minor illnesses and injuries <u>consistent with §16-89, Subchapter 16, HAR.</u>
8	30.200, Health Plan Employer Data and Information Set (HEDIS)	Title reads: Health Plan Employer Data and Information Set (HEDIS)	Title is amended to read: Health Plan Employer Data and Information Set <u>Healthcare Effectiveness Data and Information Set (HEDIS)</u>

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	Definitions/Acronyms		
9	30.320, First paragraph QUEST-Net	Paragraph reads: QUEST-Net provides coverage for medical, dental, behavioral health and prescription drug services. (Benefit package shall be QUEST-Adult in Section 40.710.1.)	Paragraph is amended to read: QUEST-Net provides coverage for: <ul style="list-style-type: none"> • <u>Uninsured adults with incomes not exceeding 133% of the FPL who were previously enrolled in QUEST or QExA but who become ineligible because their income or assets exceed QUEST or QExA program's limits; and</u> • <u>QUEST or QExA recipients who voluntarily enroll in QUEST-Net.</u> medical, dental, behavioral health and prescription drug services. (Benefit package shall be QUEST-Adult in Section 40.710.1.)
10	30.330 QUEST-ACE	Section reads: Uninsured adults ineligible for QUEST with incomes not exceeding 133% of FPL subject to the QUEST-ACE enrollment limit are eligible for QUEST-ACE benefits as described in Section 40.710.1 in QUEST- Adult and shall be mandatorily enrolled.	Section is amended to read: Uninsured adults ineligible for QUEST with incomes not exceeding 133% of FPL subject to the QUEST-ACE enrollment limit <u>and shall be mandatorily enrolled.</u> are eligible for <u>Benefit package shall be QUEST-Adult</u> QUEST-ACE benefits as described in Section 40.710.1. in QUEST-Adult and shall be mandatorily enrolled.
11	30.400, Bullet point #14, first paragraph Overview of the	Bullet reads: <ul style="list-style-type: none"> • Manage the Hawaii Prepaid Medicaid Management Information System (HPMMIS) 	Bullet is amended to read: <ul style="list-style-type: none"> • Manage the Hawaii Prepaid Medicaid Management Information System (HPMMIS)

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	Department of Human Services (DHS) Responsibilities	and the Premium Share Billing System;	and the Premium Share Billing System;
12	30.600, Second sentence, first paragraph Disenrollment Responsibilities	Sentence reads: The DHS shall process all disenrollment requests submitted in writing by the member or his or her authorized representative.	Sentence is amended to read: The DHS shall process all disenrollment requests submitted <u>orally or</u> in writing by the member or his or her authorized representative.
13	30.600, Bulleted list, third paragraph, Disenrollment Responsibilities		Paragraph is amended by adding the following as the second bullet point: <ul style="list-style-type: none"> • <u>The member missed Annual Plan Change due to temporary loss of Medicaid eligibility and was reenrolled in their former health plan as described in Section 30.570.</u>
14	30.710, Second bullet, fifth paragraph State of Hawaii Organ and Transplant (SHOTT) Program	Bullet reads: <ul style="list-style-type: none"> • If the individual is determined permanently disabled, he/she is transferred to one of the QExA health plans, effective the 1st day of the second month following the receipt of a completed ADRC packet per the established ADRC process. 	Bullet is amended to read: <ul style="list-style-type: none"> • If the individual is determined permanently disabled, he/she is transferred to one of the QExA health plans, effective <u>no later than</u> the 1st day of the second month following the receipt <u>approval</u> of a completed ADRC packet per the established ADRC process.
15	30.730, First sentence, fourth paragraph Dental Services	Sentence reads: The health plan shall provide any dental or medical services resulting from a dental condition that are provided in a medical facility (e.g., inpatient hospital and ambulatory surgical center).	Sentence is amended to read: The health plan shall provide any dental or medical services resulting from a dental condition that are provided in a medical facility <u>subject to the benefit limits described in Section 40.710.1</u>

#	RFP Section #	RFP Language	Amendment
			(e.g., inpatient hospital and ambulatory surgical center).
16	30.810, First sentence of the paragraph: School Based Services	Sentence reads: The DOE shall provide all school health services.	Sentence is amended to read: The DOE shall provide all school health services <u>including transportation.</u>
17	30.820.1, First sentence of the first paragraph Behavioral Health Services for Children/Support for Emotional and Behavioral Development (SEBD) Program	Sentence reads: The DOH, through its Child and Adolescent Mental Health Division (CAMHD), shall provide behavioral health services to children and adolescents age three (3) through age twenty (20) determined to be eligible for the SEBD program through CAMHD and in need of intensive mental health services.	Sentence is amended to read: The DOH, through its Child and Adolescent Mental Health Division (CAMHD), shall provide behavioral health services, <u>including transportation,</u> to children and adolescents age three (3) through age twenty (20) determined to be eligible for the SEBD program through CAMHD and in need of intensive mental health services.
18	30.820.4, First sentence of the second paragraph Zero-To-Three (Early Intervention) Program	Sentence reads: The Zero-to-Three program provides services for the developmentally delayed and biologically at risk children aged zero (0) to three (3) years old.	Sentence is amended to read: The Zero-to-Three program provides services, <u>including transportation,</u> for the developmentally delayed and biologically at risk children aged zero (0) to three (3) years old.
19	30.900 Aid to Disability Review Committee (ADRC)		Amend to include as the fifth paragraph of the section: <u>The health plan shall identify members who are disabled according to Disability Evaluation Under Social Security (Blue Book) due to any advanced</u>

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			<u>chronic renal disease that has lasted or can be expected to last for a continuous period of at least 12 months prior to requiring dialysis. DHS shall expedite ADRC packets for members with advanced chronic renal disease. DHS shall enroll these members into QExA as soon as ADRC packets are approved.</u>
20	30.900, Last paragraph of the section, second sentence Aid to Disabled Review Committee (ADRC)	Sentence reads: If ADRC referrals from the QUEST health plan are determined to be not disabled for more than 20% of health plan’s annual referrals, the health plan shall be required to reimburse DHS for the cost of disability determinations over the allowable threshold.	Sentence is amended to read: If ADRC referrals from the QUEST health plan are determined to be not disabled for more than 20% <u>10%</u> of health plan’s annual referrals, the health plan shall be required to reimburse DHS for the cost of disability determinations over the allowable threshold.
21	31.410, Third paragraph Hawaii Prepaid Medical Management Information Systems (HPMMIS)	Paragraph reads: The MQD also operates the Premium Share Billing system that administers the billing and collection of the members’ share of their monthly premium rate when applicable.	Paragraph is deleted: The MQD also operates the Premium Share Billing system that administers the billing and collection of the members’ share of their monthly premium rate when applicable.
22	40.210, First sentence, seventh paragraph General Provisions, Provider Network	Sentence reads: The health plan shall not include in its network any providers or providers whose owners or managing employees have been excluded from participation by the U. S. Department of Health and Human Services, Office of Inspector General (OIG), or have been excluded by the DHS from	Sentence is amended to read: The health plan shall not include in its network any providers or providers whose owners or managing employees have been excluded from participation by the U. S. Department of Health and Human Services, Office of Inspector General (OIG), <u>Section 1128 or Section 1128A of the</u>

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		participating in the Hawaii Medicaid program and all other state Medicaid programs.	<u>Social Security Act</u> or have been excluded by the DHS from participating in the Hawaii Medicaid program and all other state Medicaid programs.
23	40.230, Fourth bullet, first paragraph Availability of Providers	Bullet reads: <ul style="list-style-type: none"> • PCP visits (routine visits for adults and children) - Appointments within twenty-one (21); and 	Bullet is amended to read: <ul style="list-style-type: none"> • PCP visits (routine visits for adults and children) - Appointments within twenty-one (21) <u>days</u>; and
24	40.250, Second bullet, second paragraph Primary Care Providers (PCPs)	Bullet reads: 1. An advanced practice registered nurse with prescriptive authority (APRN-Rx) who: <ol style="list-style-type: none"> a. Is a registered professional nurse authorized by the State to practice as a nurse practitioner in accordance with State law; b. Is certified as a nurse practitioner by a recognized national certifying body that has established standards for a nurse practitioner; and c. Possesses a master’s degree in nursing; or 	Bullet reads: 1. An advanced practice registered nurse with prescriptive authority (APRN-Rx) who: <ol style="list-style-type: none"> a. Is a registered professional nurse authorized by the State to practice as a nurse practitioner in accordance with State law <u>and §16-89, Subchapter 16, HAR;</u> b. Is certified as a nurse practitioner by a recognized national certifying body that has established standards for a nurse practitioner; and e. Possesses a master’s degree in nursing; or
25	40.710.1, Bullet points two through seven QUEST: QUEST Adult Benefit Package	Bullets read: <ul style="list-style-type: none"> • Ten (10) inpatient hospital days for medical and surgical care to include post-stabilization services, sterilization and hysterectomies or inpatient hospital psychiatric care; • Twenty (20) outpatient medical or behavioral health visits. These visits include family 	Bullets are amended or reformatted to read: <ul style="list-style-type: none"> • Ten (10) inpatient hospital days for medical and surgical care to include: <ul style="list-style-type: none"> ○ post-stabilization services, ○ sterilization and hysterectomies, ○ <u>acute rehabilitation hospitals, or</u> ○ inpatient hospital psychiatric care;

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		<p>planning, home health, medical services related to dental needs, other practitioner services, physician services, podiatry, preventative services, rehabilitation services, smoking cessation, urgent care, vision, and hearing services. Family planning services including family planning drugs, supplies and devices to include but not limited to generic birth control pills, medroxyprogesterone acetate (Depo-Provera), intrauterine device (IUD), and diaphragms. Behavioral health visits include alcohol and substance abuse treatment medication management, psychiatric or psychological evaluation and treatment, and methadone management.</p> <ul style="list-style-type: none"> • Diagnostic tests (laboratory tests, radiology services, diagnostic and therapeutic services) associated with the covered outpatient medical visits; • Three (3) outpatient hospital or ambulatory surgical center procedures (including sleep laboratory services and surgeries performed in a free-standing ambulatory surgery center (ASC) and hospital ASC); • Home Health Services; • Long-term care and hospice services; 	<ul style="list-style-type: none"> • Twenty (20) outpatient medical or behavioral health visits. These visits include: <ul style="list-style-type: none"> ○ family planning ○ home health, ○ medical services related to dental needs, ○ other practitioner services, ○ physician services, ○ podiatry, ○ preventative services, ○ rehabilitation services, ○ smoking cessation, ○ urgent care, ○ vision, and hearing services, and ○ Family planning services including family planning drugs, supplies and devices to include but not limited to generic birth control pills, medroxyprogesterone acetate (Depo-Provera), intrauterine device (IUD), and diaphragms. ⊖ behavioral health visits include: <ul style="list-style-type: none"> ▪ alcohol and substance abuse treatment, ▪ medication management, <u>or</u> ▪ psychiatric or psychological evaluation and treatment; and ▪ methadone management. • Diagnostic tests (laboratory tests, radiology services, diagnostic and therapeutic services) associated with the covered outpatient medical visits to include but not limited to: <ul style="list-style-type: none"> ○ <u>laboratory tests,</u> ○ <u>radiology services, or</u> ⊖ <u>diagnostic; <u>and</u></u>

#	RFP Section #	RFP Language	Amendment
			<ul style="list-style-type: none"> ○ therapeutic services; ● Three (3) outpatient hospital <u>procedures</u> or ambulatory surgical center procedures (including sleep laboratory services and surgeries performed in a free-standing ambulatory surgery center (ASC) and hospital ASC) <u>to include but not limited to:</u> <ul style="list-style-type: none"> ○ <u>sleep laboratory services, and</u> ○ <u>surgeries performed in a free-standing ambulatory surgery center (ASC) and hospital ASC);</u> ● Home Health Services; ● Long-term care and hospice services <u>for sixty (60) days or less;</u>
26	40.710.1, Bullet points eleven and thirteen QUEST: QUEST Adult Benefit Package	Bullet points read: <ul style="list-style-type: none"> ● Smoking Cessation; ● Interpreter Services/Translation Services; 	Bullet points are deleted: <ul style="list-style-type: none"> ● Smoking Cessation; ● Interpreter Services/Translation Services;
27	40.710.1, Second sentence, second paragraph	Sentence reads: These services do not include outreach services.	Sentence is deleted: These services do not include outreach services.
28	40.710.2, First bullet point, #a QUEST: QUEST Keiki Benefit Package	Bullet reads: a. Cornea transplants and bone graft services;	Bullet is deleted: a. Cornea transplants and bone graft services;

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29	<p>40.710.2, Add a new bullet point a, first paragraph</p> <p>QUEST: QUEST Keiki Benefit Package</p>		<p>Amend to add the following bullet point to the bulleted list in the first paragraph:</p> <p><u>a. Dialysis</u></p>
30	<p>40.740.1.a</p> <p>Cornea transplants and Bone Graft Services</p>	<p>Section reads:</p> <p><i>a. Cornea Transplants and Bone Graft Services</i></p> <p>Cornea (Keratoplasty) transplants shall be provided in accordance with the Hawaii Administrative Rules. Bone graft is an orthopedic procedure and not part of the transplant program.</p>	<p>Section is deleted:</p> <p><i>a. Cornea Transplants and Bone Graft Services</i></p> <p>Cornea (Keratoplasty) transplants shall be provided in accordance with the Hawaii Administrative Rules. Bone graft is an orthopedic procedure and not part of the transplant program.</p>
31	<p>40.740.1.a</p> <p>Coverage provisions for Primary and Acute Care Services</p>		<p>Amend section by adding the following as a new bullet point a:</p> <p><u><i>a. Dialysis</i></u></p> <p><u>The health plan shall provide dialysis services when provided by participating Medicare certified hospitals and Medicare certified End Stage Renal Disease (ESRD) providers. The health plan shall assure that only services, equipment, supplies, diagnostic testing (including medically necessary laboratory tests) and drugs medically necessary for the dialysis treatment that are approved by Medicare are provided. The health plan shall allow for dialysis treatments in various settings: hospital inpatient, hospital outpatient, non-hospital renal</u></p>

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			<p><u>dialysis facility or members' home. The health plan shall structure provision of home dialysis to include those items in Medicare's global reimbursement for home dialysis. All facilities providing maintenance renal dialysis treatments to members must be certified as meeting the conditions for compliance with Medicare health, safety and other Medicare requirements.</u></p> <p><u>The health plan shall include the following as part of dialysis services:</u></p> <ul style="list-style-type: none"> • <u>Laboratory Tests including Hepatitis B surface antigen (HBsAg) and Anti-HB testing for patients on Hemodialysis, Intermittent Peritoneal Dialysis (IPD), and Continuous Cycling Peritoneal Dialysis (CCPD);</u> • <u>Hepatitis B vaccines;</u> • <u>Alfa Epoetin (EPO) when provided during dialysis;</u> • <u>Other drugs related to ESRD;</u> • <u>Home dialysis equipment prescribed by a physician;</u> • <u>Continuous ambulatory peritoneal dialysis (CAPD), a variation of peritoneal dialysis, that as an alternative mode for dialysis for home dialysis patients;</u> • <u>Physician's Services; and</u> • <u>Inpatient hospitalization when the hospitalization is for an acute medical condition requiring dialysis treatments; a patient receiving chronic outpatient dialysis is hospitalized for an unrelated medical</u>

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			<u>condition, or for placement, replacement or repair of the chronic dialysis route.</u>
32	40.740.1.c, Ninth paragraph Emergency and Post Stabilization Services, Coverage provisions for Primary and Acute Care Services	Paragraph reads: The emergency room physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the health plan, which shall be responsible for coverage and payment. The health plan is responsible for coverage and payment of medically necessary emergency services. However, the health plan may deny reimbursement for any services provided on an emergent basis to an individual after the provider could reasonably determine that the individual did not have an actual emergency medical condition.	Amend the paragraph by adding the following sentence to read: The emergency room physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the health plan, which shall be responsible for coverage and payment. The health plan is responsible for coverage and payment of medically necessary emergency services. <u>The health plan shall not refuse to cover emergency services based on the emergency room provider failing to notify the member’s PCP or the health plan within ten (10) days of presentation for emergency services.</u> However, the health plan may deny reimbursement for any services provided on an emergent basis to an individual after the provider could reasonably determine that the individual did not have an actual emergency medical condition.
33	40.740.1.d, First paragraph Family Planning Services		Amend paragraph to include as second sentence: <u>Family planning services including family planning drugs, supplies and devices to include but not limited to generic birth control pills, medroxyprogesterone acetate (Depo-Provera), intrauterine device (IUD), and diaphragms.</u>

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34	40.740.1.e, Second paragraph Home Health Services	Sentence reads: The following is a list, but not an inclusive list, of the services that are included in home health services:	Sentence is amended to read: The following is a list, but not an inclusive list, of the services that are included in home health services <u>for QUEST Keiki</u> :
35	40.740.1.e Home Health Services		Amend section to add the following as a third paragraph: <u>Home health services for QUEST Adult shall include skilled nursing and home health aides as part of the outpatient medical visits as described in Section 40.710.1.</u>
36	40.740.1.n Pregnancy-related Services- Services for Pregnant Women and Expectant Parents		Amend the section by adding the following as the first sentence of the first paragraph: <u>The health plan shall provide pregnant women any medically necessary pregnancy-related services for the health of the woman and her fetus without limitation during the woman's pregnancy and up to sixty (60) days post-partum.</u>
37	40.740.1.v, Third paragraph, fourth sentence Transportation Services	Sentence reads: 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.	Sentence is amended to read: The health plan is responsible for the arrangement and payment of the travel costs (<u>airfare, ground transportation, lodging, and meals</u>) 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.

#	RFP Section #	RFP Language	Amendment
38	40.740.1.y, First sentence, second paragraph Vision and Hearing Services	Sentence reads: Vision examinations, prescription lenses, cataract removal, and prosthetic eyes are covered for all members.	Sentence is amended to read: Vision examinations, prescription lenses, cataract removal, and prosthetic eyes are covered for all <u>QUEST Keiki</u> members.
39	40.740.1.y, Second paragraph Vision and Hearing Services		Paragraph is amended to include the following as the second and third sentence: <u>Vision services for QUEST Adult (excluding visual appliances to include but not limited to prescription lenses, contact lenses or prosthetic eyes) shall be included as part of the outpatient medical visits as described in Section 40.710.1. Cornea (Keratoplasty) transplants shall be provided in accordance with the Hawaii Administrative Rules.</u>
40	40.740.1.y, Third sentence, third paragraph Vision and Hearing Services	Sentence reads: Replacement glasses and/or new glasses with significant changes in prescription are covered within the benefit periods for both adults and children.	Sentence is amended to read: Replacement glasses and/or new glasses with significant changes in prescription are covered within the benefit periods for both adults and children.
41	40.740.2.a.v, First sentence Medically necessary alcohol and chemical dependency services, Standard Behavioral	Sentence reads: Substance abuse services can only have limits or prior authorization requirements that are co-extensive with physical treatments.	Sentence is amended to read: <u>A member's access to Ssubstance abuse services can only have limits or prior authorization requirements that are co-extensive with physical treatments shall be no more restrictive than for accessing medical services.</u>

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	Health Services		
42	40.740.2.a.vi, Section Methadone management services	Section reads: <i>vi. Methadone management services</i> Methadone/LAAM services for <i>adult</i> members are covered for acute opiate detoxification as well as maintenance. The health plan may develop its own payment methodologies for Methadone/LAAM services.	Section is amended to move from 40.740.2.a.vi to 40.740.2.c.vi: <i>vi. Methadone management services</i> Methadone/LAAM services for <i>adult</i> members are covered for acute opiate detoxification as well as maintenance. The health plan may develop its own payment methodologies for Methadone/LAAM services.
43	41.200, First sentence in the first paragraph Advanced Directives	Sentence reads: The health plan shall maintain written policies and procedures for advance directives in compliance with 42 CFR Section 438.6(i)(1)-(2) and 42 CFR Section 422.128.	Sentence is amended to read: The health plan shall maintain written policies and procedures for advance directives <u>as defined in Section 30.200</u> in compliance with 42 CFR Section 438.6(i)(1)-(2) and 42 CFR Section 422.128 <u>in Subpart I of Part 489.</u>
44	41.200, Bulleted list in the first paragraph Advanced Directives	Bulleted list reads: <ul style="list-style-type: none"> • Their rights under the law of the State of Hawaii, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives; and • The health plan’s written policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience. See 42 CFR Section 422.128(b)(1)(ii). 	Bulleted list is amended to read: <ul style="list-style-type: none"> • Their rights under the law of the State of Hawaii, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives; and • The health plan’s written policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience. See 42 CFR Section 422.128(b)(1)(ii); <u>and</u>

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			<ul style="list-style-type: none"> • <u>The health plan shall inform individuals that complaints concerning noncompliance with the advance directive requirements may be filed with the State survey and certification agency.</u>
45	50.210, First sentence, first paragraph Health Plan Responsibilities Related to Enrollment Changes Occurring When a Member is Hospitalized	Sentence reads: The health plan shall be responsible for all inpatient services, as well as any transportation, meals and lodging for one (1) attendant, if applicable, for all members who are enrolled in its health plan on the date of admission to an acute care hospital.	Sentence is amended to read: The health plan shall be responsible for all inpatient services, as well as any transportation, meals and lodging for one (1) attendant, if applicable, for all members who are enrolled in its health plan on the date of admission to an acute care hospital <u>subject to applicable benefit limits.</u>
46	50.240, Third paragraph Member Education		Paragraph is amended by adding the following as the second sentence: <u>All instructional materials shall be provided in a manner and format that is easily understood.</u>
47	50.495, Section Interpretation Services	Section reads: The health plan shall provide interpretation services of information to any member who requests the service regardless of whether a member speaks a language that meets the threshold of a prevalent non-English language. In addition, the health plan shall provide sign language and TDD services to members with hearing impairments. The health plan shall notify	Section is deleted and amended to read: <u>The health plan shall provide oral interpretation services to individuals with limited English proficiency, sign language services and TDD services at no cost to the individual. The health plan shall notify its members and potential members of the availability of free interpretation services, sign language and TDD services, and inform them of how to access these services.</u>

#	RFP Section #	RFP Language	Amendment
		<p>its members of the availability of interpretation services, sign language and TDD services and inform them of how to access these services. There shall be no charge to the member for any interpretation, sign language or TDD services.</p>	<p><u>The health plan shall meet the following oral interpretation special requirements:</u></p> <ul style="list-style-type: none"> • <u>Offer oral interpretation services to individuals with limited English proficiency (LEP) regardless of whether the individual speaks a language that meets the threshold of a prevalent non-English language; and</u> • <u>Document the offer of an interpreter, and whether an individual declined or accepted the interpreter service; and</u> <p><u>The health plan is prohibited from requiring or suggesting that LEP individuals provide their own interpreters or utilize friends or family members.</u></p>
48	<p>50.440, Second sentence, first paragraph</p> <p>Member Handbook Requirements</p>	<p>Sentence reads:</p> <p>The health plan shall mail to all enrolled members a Member Handbook every year.</p>	<p>Sentence is amended to read. The section is amended by adding an additional sentence to provide clarification:</p> <p><u>Annually, the health plan shall mail to all enrolled members a Member Handbook every year to all enrolled members. The health plan may consolidate Member Handbooks to a family, including the parents and children (under the age of 19), as long as living in the same household.</u></p>
49	<p>50.440, Second paragraph, to the list of bullets, add the following as new bullet point #12</p>		<p>Bulleted list is amended by adding the following as a new bullet:</p> <ul style="list-style-type: none"> • <u>Information on how to obtain services that the health plan does not cover because of moral or religious objections, if applicable;</u>

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	Member Handbook Requirements		
50	50.440, Second paragraph, list of bullets, bullet point #14 Member Handbook Requirements	Bullet reads: <ul style="list-style-type: none"> • Information on how to obtain services when the member is out-of-state or off-island; 	Bullet is amended to read: <ul style="list-style-type: none"> • Information on services that are not provided by the health plan that the member may have access to (i.e., Early Intervention Program) and how to obtain these services <u>including transportation</u>;
51	50.440, Second paragraph, list of bullets, bullet point #1 in bullet point #25 Member Handbook Requirements	Bullet reads: <ul style="list-style-type: none"> ○ What constitutes an urgent and emergency medical condition, emergency services, and post-stabilization services and availability of a twenty-four (24) hour triage nurse; 	Bullet is amended to read: <ul style="list-style-type: none"> ○ What constitutes an urgent and emergency medical condition, emergency services, and post-stabilization services <u>in accordance with 42 CFR 422.113(c)</u>, and availability of a twenty-four (24) hour triage nurse;
52	50.440, Second paragraph, to the list of bullets, add to bullet point #6 in bullet point #26 Member Handbook Requirements	Bullet reads: <ul style="list-style-type: none"> ○ Notice that if the member files an appeal or a request for a state administrative hearing within the timeframes specified for filing, the member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member; and 	Bullet is amended to read: <ul style="list-style-type: none"> ○ Notice that if the member files an appeal or a request for a state administrative hearing within the timeframes specified for filing, the member may <u>request continuation of benefits as described in Section 51.155</u> and be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member; and
53	50.620, First paragraph, add the		Bulleted list is amended by adding the following as a new bullet:

#	RFP Section #	RFP Language	Amendment
	<p>following as new bullet point #3</p> <p>Prohibited Activities</p>		<ul style="list-style-type: none"> • <u>Distributing information that contains any assertion or statement (whether written or oral) that the health plan is endorsed by CMS, the Federal or State government, or DHS.</u>
54	<p>50.900, First paragraph</p> <p>Authorization of Services</p>	<p>Section reads:</p> <p>The health plan shall have in place written prior authorization/pre-certification policies and procedures for processing requests for initial and continuing authorization of services in a timely manner. As part of these prior authorization policies and procedures, the health plan shall have in effect mechanisms to: (1) ensure consistent application of review criteria for authorization decisions; and (2) consult with the requesting provider when appropriate. The health plan shall submit these policies and procedures to MQD for review and approval by the due date identified in Section 51.700, Readiness Review.</p>	<p>Section is amended to read:</p> <p>The health plan shall have in place written prior authorization/pre-certification policies and procedures for processing requests for initial and continuing authorization of services in a timely manner. <u>The member shall be able to request provision of a service.</u> As part of these prior authorization policies and procedures, the health plan shall have in effect mechanisms to: (1) ensure consistent application of review criteria for authorization decisions; and (2) consult with the requesting provider when appropriate. The health plan shall submit these policies and procedures to MQD for review and approval by the due date identified in Section 51.700, Readiness Review.</p>
55	<p>50.900, Second sentence, bullet #2, fifth paragraph</p> <p>Authorization of Services</p>	<p>Sentence reads:</p> <p>The health plan may extend the three (3) business day timeframe by an additional fourteen (14) calendar days if the member requests an extension, or if the health plan justifies to the DHS a need for additional information and the extension is in the member's interest.</p>	<p>Sentence is amended to read:</p> <p>The health plan may extend the three (3) business day timeframe by <u>up to</u> an additional fourteen (14) calendar days if the member requests an extension, or if the health plan justifies to the DHS a need for additional information and the extension is in the member's interest.</p>

#	RFP Section #	RFP Language	Amendment
56	51.125, Bullet point #2 of the fourth paragraph Grievance Process	Bullet reads: <ul style="list-style-type: none"> Convey a disposition, in writing, of the grievance resolution within thirty (30) days of the initial expression of dissatisfaction; and 	Bullet is amended to read: <ul style="list-style-type: none"> Convey a disposition, in writing, of the grievance resolution <u>as expeditiously as the member's health condition requires or within thirty (30) days of the initial expression of dissatisfaction whichever is earlier</u>; and
57	51.140, Bullet point #3 and #4 in the sixth paragraph of the section Expedited appeal process	Bullets read: <ul style="list-style-type: none"> Follow-up within two (2) days of the written notice; and Inform the member orally and in writing that they may file a grievance for the denial of the expedited process with the State with the health plan. 	Bullets are amended to read: <ul style="list-style-type: none"> Follow-up within two (2) days of the <u>with</u> a written notice; and Inform the member orally and in writing that they may file a grievance <u>with the health plan</u> for the denial of the expedited process with the State with the health plan.
58	51.145, Third paragraph State Administrative Hearing for Regular Appeals	Paragraph reads: The State shall reach its decision within ninety (90) days of the date the member filed the request for an administrative hearing with the State.	Paragraph is amended to read: The State shall reach its decision within ninety (90) days of the date the member filed the request for an administrative hearing with the State. <u>The disposition of the appeal at the State Administrative Hearing level shall take precedence over the health plan's decision of the appeal.</u>
59	51.165, Second bullet point in the first paragraph Notice of Action	Bullet reads: <ul style="list-style-type: none"> The reasons for the action; 	Bullet is amended to read: <ul style="list-style-type: none"> The reasons for the action <u>to include but not limited to changes in regulation, Federal or State law that require the action</u>;

#	RFP Section #	RFP Language	Amendment
60	51.165, Add the following as bullet points #6 and #7 in the first paragraph of the section Notice of Action		Bulleted list is amended by adding the following: <ul style="list-style-type: none"> • <u>Member may represent himself or use legal counsel or an authorized representative;</u> • <u>Circumstances under which a hearing will be granted when action is based upon change in Federal or State law, as applicable;</u>
61	51.310, Add the following as the second paragraph of the section General Requirements, Fraud & Abuse		Amend the section by adding the following as a new paragraph: <u>The health plan shall report to the Investigations Office (INVO) of the Benefit, Employment and Support Services Division (BESSD) any suspicion of recipient fraud. The reporting shall be done either through written notification or a telephone call to INVO Hotline.</u>
62	51.320, Title Reporting and Investigating Suspected Fraud and Abuse	Title reads: Reporting and Investigating Suspected Fraud and Abuse	Title is amended to read: Reporting and Investigating Suspected <u>Provider</u> Fraud and Abuse
63	51.510, Table, fifth row General Requirements, Reporting Requirements	Row reads: Provider Network/ Services FQHC or RHC Services Rendered Report- Annual 51.520.5 January 31 HCSB	Amend row to read: Provider Network/ Services FQHC or RHC Services Rendered Report- Annual 51.520.5 January 31 <u>May 31</u> HCSB

#	RFP Section #	RFP Language	Amendment
64	51.510, Table, 22 nd and 23 rd row General Requirements, Reporting Requirements	<p>Rows read:</p> <p>QAPI Program QAPI Program Report 51.550.2 March 1 HCSB</p> <p>QAPI Program PIP Report 51.550.3 March 1 HCSB</p>	<p>Amend rows to read:</p> <p>QAPI Program QAPI Program Report 51.550.2 March 1 <u>June 15</u> HCSB</p> <p>QAPI Program PIP Report 51.550.3 March 1 <u>July 1</u> HCSB</p>
65	51.510, Table, 24 th and 25 th row General Requirements, Reporting Requirements	<p>Rows read:</p> <p>UM/PA Prior Authorization Requests Denied/Deferred Report 51.560.1 April 30, July 31, October 31, January 31 HCSB</p> <p>UM/PA Report of Over-utilization and Under-utilization of Drugs 51.560.2 April 30, July 1, October 31, January 31 CSO</p>	<p>Amend rows to read:</p> <p>UM/PA Prior Authorization Requests Denied/Deferred Report 51.560.1 April 30, July 31, October 31, January 31 HCSB</p> <p>UM/PA Report of Over-utilization and Under-utilization of Drugs 51.560.2 April 30, July 31, October 31, January 31 CSO</p>

#	RFP Section #	RFP Language	Amendment
66	51.520.3, Title PCP Report	Title reads: PCP Report	Title is amended to read: PCP <u>Assignment</u> Report
67	51.520.7, Third bullet of fourth bullet in first paragraph Provider Complaints and Claims Report	Bullet reads: ○ The percentage of claims processed (at 14, 30, 60, and 90 days) after date of service for each month of the reporting quarter;	Bullet is amended to read: ○ The percentage of claims processed (at 14 , 30, 60 , and 90 days) after date of service for each month of the reporting quarter;
68	51.540.3, First paragraph, bulleted list Interpretation Services Report	Bulleted list reads: <ul style="list-style-type: none"> • The name and Medicaid ID number for each member to whom interpretation services was provided; • The date of the request; • The date provided; • The type of service including the language requested; and • The identification of the interpreter. 	Bulleted list is amended to read: <ul style="list-style-type: none"> • The name and Medicaid ID number for each member <u>individual</u> to whom interpretation services was provided; • <u>The primary language spoken by each LEP individual;</u> • The date of the request; • The date provided; • The type of <u>interpreter</u> service including the language requested provided; and • The identification name of the interpreter (<u>and agency, if applicable</u>).
69	51.550.3, First sentence Performance Improvement Projects (PIP) Report	Sentence reads: Annually, the health plan shall submit, on the DHS designated reporting form, two (2) <i>Performance Improvement Projects Reports</i> to the DHS and its EQRO. Each report shall document a clearly defined study question, and well-defined indicators (both of which may be selected by the DHS).	Sentence is amended to read: Annually, the health plan shall submit, on the DHS designated reporting form, two (2) <i>Performance Improvement Projects Reports</i> to the DHS and its EQRO. Each report shall document a clearly defined study question, and well-defined indicators (both of which may be selected by the DHS).

#	RFP Section #	RFP Language	Amendment
70	60.210 Childhood Immunization	<p>Section reads: <u>Childhood Immunizations (20%)</u></p> <p>A health plan shall be eligible for a performance incentive payment if the health plan's performance:</p> <ul style="list-style-type: none"> • Is at or exceeds the HEDIS Medicaid 75th percentile rate for the measure of Combination 2 under the Childhood Immunization Status measures. 	<p>Section is amended to read: <u>Childhood Immunizations (20%)</u></p> <p>A health plan shall be eligible for a performance incentive payment if the health plan's performance:</p> <ul style="list-style-type: none"> • Is at or exceeds the <u>HEDIS Medicaid 50th percentile rate in year one and HEDIS Medicaid 75th percentile rate in year two</u> for the measure of Combination 2 under the Childhood Immunization Status measures.
71	60.220 Plan All-Cause Readmissions	<p>Section reads: <u>Plan All-Cause Readmissions (30%)</u></p> <p>A health plan shall be eligible for a performance incentive payment if the health plan's performance:</p> <ul style="list-style-type: none"> • Meets or exceeds the HEDIS 50th percentile rate in year one and 75th percentile rate in year two for the measure of Plan All-Cause Readmissions 	<p>Section is deleted and replaced with the following: <u>Plan All-Cause Readmissions (30%)</u></p> <p>A health plan shall be eligible for a performance incentive payment if the health plan's performance:</p> <ul style="list-style-type: none"> • Meets or exceeds the HEDIS 50th percentile rate in year one and 75th percentile rate in year two for the measure of Plan All-Cause Readmissions <p><u>Chlamydia Screening (20%)</u></p> <p><u>A health plan shall be eligible for a performance incentive payment if the health plan's performance:</u></p> <ul style="list-style-type: none"> <u>• Meets or exceeds the HEDIS Medicaid 75th percentile rate for the measure of Chlamydia Screening.</u>

#	RFP Section #	RFP Language	Amendment
72	60.230 Controlling High Blood Pressure	Section reads: <u>Controlling High Blood Pressure (15%)</u> A health plan shall be eligible for a performance incentive payment if the health plan's performance: <ul style="list-style-type: none"> Meets or exceeds the HEDIS Medicaid 75th percentile rate for the measure of Controlling High Blood Pressure. 	Section is amended to read: <u>Controlling High Blood Pressure (1520%)</u> A health plan shall be eligible for a performance incentive payment if the health plan's performance: <ul style="list-style-type: none"> Meets or exceeds the HEDIS Medicaid <u>50th percentile rate in year one and 75th percentile rate in year two</u> for the measure of Controlling High Blood Pressure.
73	60.240 Third bullet of the second bullet in the paragraph Comprehensive Diabetes Care	Bullet reads: Systolic and Diastolic BP Levels (<130/ 80).	Bullet is amended to read: Systolic and Diastolic BP Levels (< 130/80 <u>140/90</u>).
74	60.250 Getting Needed Care	Section reads: <u>Getting Needed Care (15%)</u> A health plan shall be eligible for a performance incentive payment if the health plan's performance: <ul style="list-style-type: none"> Meets or exceeds the CAHPS Medicaid 75th percentile rate for the measure of 'Getting Needed Care' in the CAHPS Survey. 	Section is amended to read: <u>Getting Needed Care (1520%)</u> A health plan shall be eligible for a performance incentive payment if the health plan's performance: <ul style="list-style-type: none"> Meets or exceeds the CAHPS Medicaid <u>50th percentile rate in year one and 75th percentile rate in year two</u> for the measure of 'Getting Needed Care' in the CAHPS Survey.

#	RFP Section #	RFP Language	Amendment
75	60.310, Third sentence, first paragraph Provider and Subcontractor Reimbursement	Sentence reads: Health plans shall allow no less than a one-year filing deadline for providers to submit claims.	Sentence is deleted: Health plans shall allow no less than a one-year filing deadline for providers to submit claims.
76	60.310, Second sentence, ninth paragraph Provider and Subcontractor Reimbursement	Sentence reads: The health plans shall allow providers at least one-hundred and eighty (180) days to submit claims for reimbursement.	Sentence is amended to read: The health plans shall allow providers at least one-hundred and eighty (180) days <u>one year</u> to submit claims for reimbursement.
77	60.310, Tenth paragraph Provider and Subcontractor Reimbursement		Paragraph is amended by adding the following as the second sentence: <u>The date of receipt is the date the agency receives the claim, as indicated by its date stamp on the claim and the date of payment is the date of the check or other form of payment.</u>
78	70.100, First sentence in the first paragraph Contract Documents	Sentence reads: The following documents form an integral part of the contract between the health plan and the DHS (hereafter collectively referred to as “the Contract”):	Sentence is amended to read: The following documents form an integral part of the <u>written</u> contract between the health plan and the DHS (hereafter collectively referred to as “the Contract”):
79	70.400 Subcontractor		Amend section by adding the following as the third bullet in the sixth paragraph: <ul style="list-style-type: none"> • <u>Provide information regarding member rights</u>

#	RFP Section #	RFP Language	Amendment
	Agreements		<u>and processes regarding the Member Grievance System found in Section 51.100;</u>
80	70.800 Conflict of Interest		Section is amended by adding the following as the second paragraph to the section: <u>The health plan shall not contract with the State of Hawaii unless safeguards at least equal to Federal safeguards (41 USC 423, section 27) are in place.</u>
81	71.200, Sentence three, first paragraph Term of the Contract	Sentence reads: Unless terminated, the contract shall be extended without the necessity of re-bidding, for not more than four (4) additional twelve (12) month periods or parts thereof, only upon mutual agreement of the parties in writing, at least sixty (60) days prior to expiration of the contract term, provided that the contract price for the extended period shall remain the same or lower than the initial bid price or as adjusted in accordance with the contract price adjustment provision herein.	Sentence is amended to read. The section is amended by adding an additional sentence to provide clarification: Unless terminated, the contract shall be extended without the necessity of re-bidding, for not more than four (4) additional twelve (12) month periods or parts thereof, only upon mutual agreement of the parties in writing. at least sixty (60) days prior to expiration of the contract term. , provided that the contract price for the extended period shall remain the same or lower than the initial bid price or as adjusted in accordance with the contract price adjustment provision herein. <u>Future rates shall be set in accordance with Section 90.400.</u>
82	71.610, First sentence of the first paragraph Termination for Default	Sentence reads: The failure of the health plan to comply with any term, condition, or provision of the contract shall constitute default by the health plan.	Sentence is amended to read: The failure of the health plan to comply with any term, condition, or provision of the contract <u>or applicable requirements in Sections 1932, 1903(m) and 1905(t) of the Social Security Act</u> shall constitute default by the health plan.

#	RFP Section #	RFP Language	Amendment
83	71.700, Sixth paragraph Confidentiality of Information	Paragraph reads: The health plan shall notify the State within two (2) business days of discovery of the breach of confidentiality. In addition, the health plan shall provide to the State a written report of the investigation and resultant mitigation of the breach within thirty (30) business days of the discovery of the breach. All breaches of confidential information relating to Medicaid enrollees, as health plan members, shall be reported to the MQD. The actual requirements found in this section shall be detailed in all provider and subcontractor agreements.	Paragraph is amended to read: <u>All breaches of confidential information relating to Medicaid enrollees, as health plan members, shall be reported to the MQD.</u> The health plan shall notify the State <u>MQD</u> within two (2) business days of discovery <u>following actual knowledge of the a</u> breach of confidentiality, <u>including any use or disclosure of confidential information, any breach of Unsecured PHI, and any Security Incident (as defined in HIPAA regulations) of which the health plan becomes aware with respect to PHI in the custody of the health plan.</u> In addition, the health plan shall provide to the State <u>MQD</u> with a written report of the investigation and resultant <u>breach efforts</u> within thirty (30) business days of the discovery of the breach. <u>The health plan shall work with MQD to ensure that the breach has been mitigated and reporting requirements, if any, or complied with.</u> All breaches of confidential information relating to Medicaid enrollees, as health plan members, shall be reported to the MQD. The actual requirements found in this section shall be detailed in all provider and subcontractor agreements.
84	71.800, Second sentence of the first paragraph Audit Requirements	Sentence reads: The DHS may inspect and audit any records of the health plan and its subcontractors or providers.	Sentence is amended to read: The DHS <u>or the DHHS</u> may inspect and audit any records of the health plan and its subcontractors or providers.

#	RFP Section #	RFP Language	Amendment
85	72.230, First sentence in the first paragraph Special Rules for Temporary Management	Sentence reads: The sanction of temporary management may be imposed by the State if it finds that:	Sentence is amended to read: The sanction of temporary management may be imposed by the State, <u>as allowed or required by 42 CFR 438.706</u> , if it finds that:
86	72.230 Special Rules for Temporary Management		Section is amended by adding the following as the third paragraph: <u>The State may not terminate temporary management until it determines that the health plan can ensure that the sanctioned behavior will not recur.</u>
87	72.320, Bullet point #6 Compliance with other Federal and State Laws	Bullet reads: <ul style="list-style-type: none"> • applicable standards, orders or regulations issued pursuant to the Clean Air Act (42 U.S.C. Section 7401, <u>et seq.</u>) and the Federal Water Pollution Control Act, as amended (33 U.S.C. Section 1251, <u>et seq.</u>); 	Bullet is amended to read: <ul style="list-style-type: none"> • <u>all</u> applicable standards, orders or regulations issued pursuant to <u>under section 306 of the Clean Air Act (42 U.S.C. Section 7401, et seq.) (42 USC 1857 (h)), section 508 of the Clean Water Act (33 USC 1368), Executive Order 11738, and Environmental Protection Agency regulations (40 CFR part 15) and the Federal Water Pollution Control Act, as amended (33 U.S.C. Section 1251, et seq.);</u>
88	72.320 Compliance with other Federal and State Laws		Amended the bulleted list to add the following after bullet point #5: <ul style="list-style-type: none"> • <u>Education Amendments of 1972 (regarding education programs and activities);</u> • <u>Copeland Anti-Kickback Act;</u> • <u>Davis-Bacon Act;</u>

#	RFP Section #	RFP Language	Amendment
			<ul style="list-style-type: none"> • <u>Debarment and Suspension;</u>
89	80.230, Bullet point #I Attachment: Other Documentation	Bullet reads: The Financial Performance form;	Bullet is deleted and all other bullets are renumbered following it: The Financial Performance form;
90	80.310, Title Experience and References	Title reads: Experience and References (12 pages maximum not including attachments)	Title is amended to read: Experience and References (12 pages maximum not including attachments <u>B, C, E, and F below</u>)
91	80.315.2, Bullet point K, third paragraph Attachment: Required Providers (not included in page maximum)	Bullet reads: K. Behavioral health providers;	Bullet is amended to read: K. Behavioral health providers (<u>as described in Section 40.220</u>);
92	100.400, Table, second paragraph Technical Proposal Evaluation		Replace table in second paragraph with the table at the end of this document.
93	Appendix C, Fifth paragraph Gain Share Program	Paragraph reads: Total Revenue is the sum of all capitation payments made to each health plan during the fiscal year.	Paragraph is amended to read: Total Revenue is the sum of all capitation payments <u>expected to be made</u> to each health plan during <u>for</u> the fiscal year.
94	Appendix M		Insert Appendix M as included at the end of this document

100.400 Technical Proposal Evaluation
 Table in second paragraph of the section

Section/Title	Total Points Possible	Points Needed to Pass
80.310 Experience and References	160	120
A. Narrative- experience in Hawaii	100*	
B. Contract for Medicaid program clients		
C. Letters of recommendation		
D. Information about termination, non-renewal, etc.		
E. EQRO evaluations	30	
F. EPSDT measures	30	
80.315 Provider Network and Services	200	150
80.315.1 Provider Network Narrative	150*	
80.315.2 Attachment: Required Providers		
80.315.3 Attachment: Maps of Providers		
80.315.4 Availability of Providers Narrative	50*	
80.315.5 Provider Services Narrative		
*The allotted points for these sections are evaluated together and are not divided evenly between the subsections.		
80.320 Covered Benefits and Services	180	135
80.320.1 Covered Benefits and Services Narrative	30	
80.320.2 Behavioral Health Narrative	30	
80.320.3 Prescription Drug Narrative	30	
80.320.4 EPSDT Narrative	30	
80.320.5 Care Coordination/Case Management System/Services Narrative	30	
80.320.6 Transition of Care Narrative	30	
80.325 Member Services	200	150
80.325.1 General Member Services	70	
80.325.2 Toll-free Call Center and Twenty-Four Hour Nurse Line	60	
80.325.3 Member Grievance System	70	
80.330 Quality Assessment and Performance Improvement (QAPI)/ Utilization Management	160	120
80.330.1 QAPI program	10	

Section/Title	Total Points Possible	Points Needed to Pass
80.330.2 General Provisions	10	
80.330.3 Value-Based Purchasing	30	
80.330.4 Performance Measures	20	
80.330.5 Delegation of QAPI Program Activities	10	
80.330.6 Medical Records Standards	10	
80.330.7 Practice Guidelines	20	
80.330.8 Disease Management	30	
80.335.1 Utilization Management Program (UMP) Narrative	10	
80.335.2 UMP and Authorization of Services	10	
80.340 Health Plan Administrative Requirements	100	75
80.340.1 Fraud and Abuse	20	
80.340.2 Narrative and Organization Charts	10	
80.340.3 Organization and Staffing Tables	10	
80.340.4 Reporting Requirements	20	
80.340.5 Encounter Data Reporting Requirements	10	
80.340.6 Information Technology	10	
80.340.7 Third Party Liability	20	
Total	1,000	750

Appendix M
Written Questions on Amendment #1
Format for QUEST RFP

Applicant Name	Date Submitted	Question #	# (first column of list of amendments)	Question