

Amendment #5  
 Issued on: November 9, 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		Replace table in first paragraph with the table at the end of this document.
2	20.200, Third sentence, second paragraph	Sentence reads:  Applicants shall e-mail to QUESTRFP@medicaid.dhs.state.hi.us no later than 2:00 pm H.S.T on November 25, 2011 to receive the teleconference number.	Sentence is amended to read:  Applicants shall e-mail to QUESTRFP@medicaid.dhs.state.hi.us no later than 2:00 pm H.S.T on <del>November 25, 2011</del> <u>December 7, 2011</u> to receive the teleconference number.
3	20.300, Section  Submission of Written Questions		Insert the following as the fifth paragraph of the section:  <u>Questions on Clarification for Submission of Proposal- Version Two shall be submitted in the format that best addresses the applicants question to include the format provided in Appendix A, M, or N by 12:00 p.m. (H.S.T.) on the date identified in Section 20.100.</u>
4	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 subject to the benefit limits described in Section 40.710.1 (e.g., inpatient hospital and ambulatory surgical	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 subject to <del>the</del> <u>any</u> benefit limits described in Section 40.710.1 (e.g., inpatient hospital and

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		center).	ambulatory surgical center).
5	40.650, Fourth sentence, first paragraph  Web-site for Providers	Sentence reads:  In addition, the provider web-site shall have a real-time system to track utilization of limited member benefits.	Sentence is deleted:  <del>In addition, the provider web-site shall have a real-time system to track utilization of limited member benefits.</del>
6	40.710.1, Bullet points two and three  QUEST: QUEST Adult Benefit Package	Bullets read:  <ul style="list-style-type: none"> <li>• Ten (10) inpatient hospital days for medical and surgical care to include: <ul style="list-style-type: none"> <li>○ post-stabilization services,</li> <li>○ sterilization and hysterectomies,</li> <li>○ acute rehabilitation hospitals, or</li> <li>○ inpatient hospital psychiatric care;</li> </ul> </li> <li>• Twenty (20) outpatient medical or behavioral health visits. These visits include: <ul style="list-style-type: none"> <li>○ family planning</li> <li>○ home health,</li> <li>○ medical services related to dental needs,</li> <li>○ other practitioner services,</li> <li>○ physician services,</li> <li>○ podiatry,</li> <li>○ preventative services,</li> <li>○ smoking cessation,</li> <li>○ urgent care,</li> <li>○ vision, and hearing services, and</li> <li>○ behavioral health visits include: <ul style="list-style-type: none"> <li>▪ alcohol and substance abuse treatment,</li> <li>▪ medication management, <u>or</u></li> <li>▪ psychiatric or psychological</li> </ul> </li> </ul> </li> </ul>	Bullets are amended to read to include additional bullet (#3):  <ul style="list-style-type: none"> <li>• <del>Ten (10)</del> <u>Thirty (30)</u> inpatient hospital days for medical and surgical services; <u>however the number of covered days is subject to change. These services include:</u> <ul style="list-style-type: none"> <li>○ post-stabilization services,</li> <li>○ sterilization and hysterectomies, <u>or</u></li> <li>○ acute rehabilitation hospitals; <del>or</del></li> <li>○ <del>inpatient hospital psychiatric care;</del></li> </ul> </li> <li>• <u>Thirty (30) inpatient hospital days for behavioral health services; however the number of covered services is subject to change. These services include:</u> <ul style="list-style-type: none"> <li>○ <u>psychiatric services, and</u></li> <li>○ <u>substance abuse treatment services.</u></li> </ul> </li> <li>• <del>Twenty (20) or</del> <u>Outpatient medical or behavioral health visits; however, the number of covered outpatient visits is subject to change. These visits include:</u> <ul style="list-style-type: none"> <li>○ family planning</li> <li>○ home health,</li> <li>○ medical services related to dental needs,</li> <li>○ other practitioner services,</li> </ul> </li> </ul>

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		evaluation and treatment;	<ul style="list-style-type: none"> <li>○ physician services,</li> <li>○ podiatry,</li> <li>○ preventative services,</li> <li>○ smoking cessation,</li> <li>○ urgent care,</li> <li>○ vision and hearing services, and</li> <li>○ behavioral health <del>visits</del> <u>services include</u> <u>including</u>: <ul style="list-style-type: none"> <li>▪ alcohol and substance abuse treatment,</li> <li>▪ medication management, <del>or and</del></li> <li>▪ psychiatric or psychological evaluation and treatment;</li> </ul> </li> </ul>
7	40.710.1, Bullet point six  QUEST: QUEST Adult Benefit Package	<ul style="list-style-type: none"> <li>• Three (3) outpatient hospital procedures or ambulatory surgical center procedures to include but not limited to: <ul style="list-style-type: none"> <li>○ sleep laboratory services, and</li> <li>○ surgeries performed in a free-standing ambulatory surgery center (ASC) and hospital ASC;</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• <del>Three (3) Outpatient hospital procedures or ambulatory surgical center procedures; however</del> <u>the number of covered outpatient procedures is subject to change. These procedures</u> <del>to</del> <u>include but are not</u> limited to: <ul style="list-style-type: none"> <li>○ sleep laboratory services, and</li> <li>○ surgeries performed in a free-standing ambulatory surgery center (ASC) and hospital ASC;</li> </ul> </li> </ul>
8	40.720.1, Fifth and sixth bullet point in the first paragraph	<p>Bullets read:</p> <ul style="list-style-type: none"> <li>e. Ten (10) inpatient psychiatric hospital days. If all ten (10) psychiatric hospital days are used, the member may use available inpatient days from the base benefit package (thereby giving the member a minimum of ten (10) and a</li> </ul>	<p>Bullets are deleted:</p> <ul style="list-style-type: none"> <li><del>e. Ten (10) inpatient psychiatric hospital days. If all ten (10) psychiatric hospital days are used, the member may use available inpatient days from the base benefit package (thereby giving the member a minimum of ten (10) and a</del></li> </ul>

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		<p>maximum of twenty (20) inpatient psychiatric hospital days);</p> <p>f. Six (6) behavioral health outpatient visits (alcohol and substance abuse are included as part of behavioral health visits) to include but not limited to medication management, psychiatric or psychological evaluation and treatment, and methadone management. If all six (6) behavioral health outpatient visits are used, the member may use available outpatient visits from the base benefit package (thereby giving the member a minimum of six (6) and a maximum of twenty-six (26) behavioral health outpatient visits).</p>	<p><del>and a maximum of twenty (20) inpatient psychiatric hospital days);</del></p> <p><del>f. Six (6) behavioral health outpatient visits (alcohol and substance abuse are included as part of behavioral health visits) to include but not limited to medication management, psychiatric or psychological evaluation and treatment, and methadone management. If all six (6) behavioral health outpatient visits are used, the member may use available outpatient visits from the base benefit package (thereby giving the member a minimum of six (6) and a maximum of twenty-six (26) behavioral health outpatient visits).</del></p>
9	40.740.1.j, Section  Other Practitioner Services, Coverage Provisions for Primary and Acute Care Services	<p>Section reads:</p> <p>Other practitioner services include, but are not limited to: optometry services, certified nurse midwife services, licensed advanced practice registered nurse services (including family, pediatric, and psychiatric health specialists), and other medically necessary practitioner services provided by a licensed or certified healthcare provider to include behavioral health providers such as psychologists, marriage and family therapists, and mental health counselors.</p>	<p>Section is amended to read:</p> <p>Other practitioner services include, but are not limited to: <del>optometry services</del>, certified nurse midwife services, licensed advanced practice registered nurse services (including family, pediatric, and psychiatric health specialists), and other medically necessary practitioner services provided by a licensed or certified healthcare provider to include behavioral health providers such as psychologists, marriage and family therapists, and mental health counselors.</p>
10	40.740.1.y, Fourth sentence, second paragraph	<p>Sentence reads:</p> <p>An ophthalmologic exam with refraction is also</p>	<p>Sentence is deleted:</p> <p><del>An ophthalmologic exam with refraction is also</del></p>

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	Vision and Hearing Services, Coverage Provisions for Primary and Acute Care Services	an included service.	<del>an included service.</del>
11	40.751, Third and fourth bullet points on bulleted list in first paragraph  Services for Members with Special Health Care Needs (SHCNs)	Bullets read: <ul style="list-style-type: none"> <li>• Adults whose utilization of inpatient services have been used completely in accordance with Section 40.710.1; or</li> <li>• Adults who have utilized either half of their allowable medical or behavioral health visits in the first six (6) months of the benefit period in accordance with Section 40.710.1, or have utilized twelve (12) outpatient medical or behavioral health visits.</li> </ul>	Bullets are amended to read: <ul style="list-style-type: none"> <li>• Adults whose utilization <u>causes the member to be in the top one percent (1%) by utilization frequency and/or expenditures for any of the following:</u> <ul style="list-style-type: none"> <li>• <u>Outpatient medical visits;</u></li> <li>• <u>Outpatient behavioral health visits;</u></li> <li>• <u>Emergency room visits;</u></li> <li>• <u>Inpatient days;</u></li> <li>• <u>Prescription drugs; or</u></li> <li>• <u>Overall,</u></li> </ul> </li> <li><del>• of inpatient services have been used completely in accordance with Section 40.710.1; or</del></li> <li><del>• Adults who have utilized either half of their allowable medical or behavioral health visits in the first six (6) months of the benefit period in accordance with Section 40.710.1, or have utilized twelve (12) outpatient medical or behavioral health visits.</del></li> </ul>
12	50.490, Second sentence, first paragraph  Internet Presence/	Sentence reads:  This website shall incorporate a real-time system to track utilization of limited member benefits.	Sentence is deleted:  <del>This website shall incorporate a real-time system to track utilization of limited member benefits.</del>

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	Web-Site		
13	50.510, Third sentence, first paragraph  Background, Value-Driven Health Care	Sentence reads:  Measures used shall be evidence-based and validated.	Sentence is amended to read:  Measures used shall be evidence-based and validated <del>;</del> , <u>and DHS may require that certain measures are included in value-driven health care contracts, as applicable, based upon providers' scope of services.</u>
14	50.520, First sentence, third paragraph  Primary Care Providers, Value-Driven Health Care	Sentence reads:  A medical home shall receive increased reimbursement compared to a practice that does not meet the criteria to be a medical home, and there shall be two levels of medical homes with higher payment to the Platinum level compared to the Gold level:	Sentence is amended to read:  A medical home shall receive increased reimbursement compared to a practice that does not meet the criteria to be a medical home, and there shall be two levels of medical homes with higher payment to the <del>Platinum</del> <u>Level 2 Medical Home</u> compared to the <del>Gold</del> <u>Level 3 Medical Home</u> :
15	50.520, Second sentence, third paragraph  Primary Care Providers, Value-Driven Health Care	Sentence reads:  <u>Platinum Level Medical Home</u> : To be considered a first tier medical home, a provider/practice must meet all elements for each of the domains of patient centered, accessible, comprehensive, and coordinated; and must meet three elements for each for the domains of evidence-based and performance measurement; plus meet the Office of the National Coordinator requirements for meaningful use of an electronic health record.	Sentence is amended to read with an additional sentence added:  <del>Platinum</del> <u>Level 2 Medical Home</u> : To be considered a <del>first tier</del> <u>Level 2</u> medical home, a provider/practice must meet all elements for each of the domains of patient centered, accessible, comprehensive, and coordinated; and must meet three elements for each for the domains of evidence-based and performance measurement; plus meet the Office of the National Coordinator requirements for meaningful use of an electronic health record <u>that includes exchanging</u>

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			<u>vaccination information with the Department of Health. Health plans must participate in health information exchange.</u>
16	50.520, Third and fourth sentences, third paragraph  Primary Care Providers, Value-Driven Health Care	Sentences read:  <u>Gold Level Medical Home</u> : To be considered a second tier medical home, a provider/practice must meet three elements for each of the domains of patient centered, accessible, comprehensive, and coordinated; and must meet two elements for each for the domains of evidence-based and performance measurement. NCQA recognition for the patient-centered medical home shall deem a provider/practice as a second tier medical home.	Sentences are amended to read:  <del>Gold</del> <u>Level 3 Medical Home</u> : To be considered a <del>second—tier</del> <u>Level 3</u> medical home, a provider/practice must meet three elements for each of the domains of patient centered, accessible, comprehensive, and coordinated; and must meet two elements for each for the domains of evidence-based and performance measurement. NCQA recognition for the patient-centered medical home shall deem a provider/practice as a <del>second—tier</del> <u>Level 3</u> medical home.
17	50.550, Second sentence  Value-Driven Health Care Schedule, Value-Driven Health Care	Sentence reads:  The health plans shall incorporate the measures selected for financial incentives, as appropriate, into the provider contracts.	Sentence is amended to read:  The health plans shall incorporate <u>at a minimum</u> the measures <del>selected for financial incentives</del> <u>specified by DHS, as appropriate applicable</u> , into the provider contracts.
18	51.560.3 Fourth bullet point in section  Report of Over-Utilization and Under-Utilization of	Bullet reads:  <ul style="list-style-type: none"> <li>• Increased utilization: The number and percent of adult members with utilization greater than twelve (12) outpatient visits and those that have fully utilized their inpatient benefits.</li> </ul>	Bullet is amended:  <ul style="list-style-type: none"> <li>• <u>Increased utilization: The number and percent of adult members</u> <del>with utilization greater than twelve (12) outpatient visits and those that have fully utilized their inpatient</del></li> </ul>

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	Services, Utilization Management Reports	The average cost spent for members with increased utilization;	<u>medical/surgical benefits, and the number and percent of adult members that have fully utilized their inpatient behavioral health benefits. For inpatient days exceeding the limit, provide: diagnosis, number of days, and what payment would have been if covered.</u>
19	60.310, Third paragraph  Provider and Subcontractor Reimbursement, Health Plan Responsibilities	Paragraph reads:  Subject to CMS approval, the health plan may contract with FQHCs and RHCs using an alternative payment methodology in lieu of full PPS reimbursement. The alternative payment methodology would need to be mutually agreed upon by the health plan and provider and reviewed and approved by the Department. In such an arrangement, the FQHC/RHC chooses to assume risk and the Department shall not be required to reimburse the difference between the amount the FQHC receives from the health plan under the alternative payment methodology and the amount the health plan would have received under PPS.	Paragraph is deleted and replaced with the following:  <del>Subject to CMS approval, the health plan may contract with FQHCs and RHCs using an alternative payment methodology in lieu of full PPS reimbursement. The alternative payment methodology would need to be mutually agreed upon by the health plan and provider and reviewed and approved by the Department. In such an arrangement, the FQHC/RHC chooses to assume risk and the Department shall not be required to reimburse the difference between the amount the FQHC receives from the health plan under the alternative payment methodology and the amount the health plan would have received under PPS.</del>  <u>The health plan shall reimburse non-contracted FQHCs and RHCs at rates no less than the Medicaid fee schedule. The health plan shall reimburse contracted FQHCs or RHCs for PPS eligible services at the PPS rate provided annually by the DHS.</u>

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20	71.200, Second sentence, first paragraph  Term of the Contract	Sentence reads:  The contract is for the initial term from the date of commencement of services to members as specified in Section 20.100 to December 31, 2013.	Sentence is amended to read:  The contract is for the initial term from the date of commencement of services to members as specified in Section 20.100 to <del>December 31, 2013</del> <u>December 31, 2014</u> .
21	80.340.6, Third bullet in first bullet in first paragraph  Health Plan Administrative Requirements Narrative-Information Technology	Bullet reads:  3. How these systems can be accessed by health plan users (for instance, can field-based case managers access case management information via portable devices such as laptops) to facilitate work, promote efficiencies and deliver services at the point of care, including how it will make available to providers in real time members' utilization of limited benefits.	Bullet is amended to read:  3. How these systems can be accessed by health plan users (for instance, can field-based case managers access case management information via portable devices such as laptops) to facilitate work, promote efficiencies and deliver services at the point of care, including how it will make available to providers <u>electronic prior authorizations</u> <del>in real time members' utilization of limited</del> <u>benefits</u> .

20.100 RFP Timeline

Table in first paragraph of the section

Issue RFP	August 8, 2011
Orientation	August 15, 2011
Submission of Technical Proposal Questions	August 22, 2011
Notice of Intent to Propose	August 29, 2011
Responses to Technical Proposal Questions	September 14, 2011
Submission of Questions on Amendments	September 16, 2011
Responses to Questions on Amendments	September 23, 2011
Submission of Questions on Clarification for Submission of a Proposal	September 26, 2011
Responses to Questions on Clarification for Submission of a Proposal	September 30, 2011
Submission of Questions on Clarification for Submission of a Proposal- Second Version	November 14, 2011

<u>Responses to Questions on Clarification for Submission of a Proposal- Second Version</u>	<u>November 17, 2011</u>
Proposal Due Date	<del>November 18, 2011</del> <u>December 2, 2011</u>
Proposal Evaluation Period	<del>November 19 to December 22, 2011</del> <u>December 3, 2011 to January 16, 2012</u>
Issue Proposed Capitation Rates with Supporting Documentation	<del>November 18, 2011</del> <u>December 2, 2011</u>
Proposed Capitation Rates Orientation	<del>November 29, 2011</del> <u>December 9, 2011</u>
Submission of Proposed Capitation Rate Questions	<del>December 1, 2011</del> <u>December 14, 2011</u>
Written Responses to Proposed Capitation Rate Questions	<del>December 14, 2011</del> <u>January 4, 2012</u>
Issue Final Capitation Rates	<del>December 14, 2011</del> <u>January 4, 2012</u>
Capitation Rate Meeting with Applicants to discuss Final Capitation Rates	<del>December 19, 2011</del> <u>January 9, 2012</u>
Contract Award	<del>December 23, 2011</del> <u>January 17, 2012</u>
Contract Effective Date	<del>January 16, 2012</del> <u>January 31, 2012</u>
Commencement of Services to Members	<u>May 1, 2012-July 1, 2012</u>
Commencement of Quality Portion of Auto-Assignment	<u>January 1, 2014</u>