

Technical Proposal Question & Answer

Issued on: May 18, 2012

For Request for Proposals RFP-MQD-2013-002

To Provide Behavioral Health Services For Medicaid Eligible Adults who have a Serious Mental Illness

Question #	RFP Section #	RFP Page #	Para-graph #	Question	Answer
1	20.100 21.200	11 18	N/A	The timeline in Section 20.100 indicates that proposals evaluation will occur between June 9 and June 21, 2012. Section 21.200 on page 18, however, allows bidders to submit proposals via the US Postal Service, which must be postmarked by June 8 and received by DHS within 10 days of the postmark, or by June 18. Please clarify how DHS will evaluate proposals that are received this late in the evaluation process.	DHS will evaluate the proposals in the allowable timeframe. Please note that DHS has fourteen (14) calendar days to evaluate proposals leaving us additional time over the ten (10) calendar days for receiving USPS mailed proposals.
2	20.200	11	N/A	Will DHS provide notes from the Orientation or a transcript?	No.
3	20.200	11	N/A	Can DHS provide a listing of the individuals/companies that attended the Orientation for purposes of possible partnering?	No.
4	20.900	18	n/a	The RFP requires salary and compensation information for the leadership teams of bidding entities. Will the state maintain salary information as confidential in order to prevent headhunting, poaching and other inappropriate use of information that is not public?	Please see section 20.900 for marking sections of the RFP confidential or proprietary. Please note that if the whole proposal is marked confidential or proprietary, then this request will not be granted.
5	30.340	28	2	The RFP states “Adults with a diagnosis and functional level that qualifies then as eligible for Adult Mental Health Division (AMHD) services will receive all mental health and substance abuse services through the DOH/AMHD system.” 1. What are the diagnostic and functional	1. DHS does not have access to the specific requirements for AMHD program. Please contact AMHD for this information. 2. No. Representative Payee, Supportive Employment and Transitional Housing may be provided by AMHD though this RFP allows

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				<p>eligibility criteria for AMHD services?</p> <p>2. Can a member be dually eligible for services from DOH/AMHD and CCS and what services from each system can they access?</p> <p>3. Are QExA members on Conditional Release automatically excluded from CCS services?</p>	<p>these services to be provided by the CCS program.</p> <p>3. Yes.</p>
6	30.500	28	1	<p>The RFP states “In such a case, the health plan shall be relieved of its responsibility for providing behavioral health services, but shall remain responsible for providing medical services.” Does DHS-MQD plan to provide any additional guidance on when the health plan is to pay for services in the emergency room or for ambulance transportation and when the BHO is to begin assuming responsibility for paying for the services? In many instances with this population, a member may be transported for treatment without an assurance that the treatment is solely related to a medical issue or behavioral health issue.</p>	<p>Any emergency department (ED) visit or hospitalization with a primary behavioral health diagnosis will be the responsibility of the BHO. The emergency transport will also be the responsibility of the BHO.</p>
7	30.600	31	n/a	<p>As part of the enrollment and determination process for BHO members, does the DHS process obtain member consent to share all medical information with providers and QExA plans, including substance use and chemical dependency treatment information?</p>	<p>No. This process is the responsibility of the BHO after enrollment. Substance abuse treatment and HIV status/treatment may have more stringent rules and regulations regarding the sharing of information,</p>

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8	30.620	32	1	Paragraph needs clarification. If court ordered services are deemed not medically necessary by the BHO is the BHO responsible for continued payment of the services?	Yes. If the court orders treatment, the BHO is responsible for providing this service. Judges are not responsible for determining medical necessity.
9	30.620	33	n/a	The BHO will be responsible for payment for court-ordered services that are not medically necessary. Can Milliman and MQD confirm that the base data set and trends include all historic court-ordered treatment costs for those in the population that are receiving care as involuntary commitments?	<p>Milliman cannot confirm as they do not have an identifier of court-ordered services in the data nor do they have control totals or financials for these specific services.</p> <p>However, it has been the practice for the current CCS program to pay for all court-ordered treatment. Thereby, MQD is assuming that this practice is included in the underlying data and therefore the capitation rates.</p>
10	30.800	32	6	The RFP states “The BHO transition plan will be given to the QExA health plan in order to ensure continuity of care prior to disenrollment.” What constitutes the transition plan and how long is the transition period?	DHS has a transition of care (TOC) process that shall be utilized in transitioning members in and out of the BHO. The TOC with DHS health plan process will be provided to the BHO after contract award. The transition of care period for QExA is 180 days or until a health and functional assessment is completed.
11	40.100	34	5	The RFP states “The BHO shall be responsible for ensuring there are sufficient providers to provide the behavioral health services state-wide to meet the needs of the BHO’s members.” Does DHS-MQD have any expectations of the level of services to be provided on Moloka’i and Lana’i?	If members on the islands of Molokai or Lanai need services, then services shall be provided for these members. BHO staff does not need to reside on these islands for services to be provided to these members. Both Molokai and Lanai have Federally Qualified Health Centers (FQHC) that provide

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				<p>Does there have to be BHO staff residing on these two islands, or can staff be assigned to these two islands? Does there have to be a case management office location on these two islands?</p> <p>This subject is also referenced on page 81, where the RFP states “The BHO shall provide the full range of behavioral health services to its members Statewide.”</p>	<p>behavioral health services. The BHO may contract with these health centers for provision of services. In addition, the BHO may transport their members to other islands for receipt of services. Finally, telehealth may be utilized to supplement some services. The BHO shall propose ways to provide services to their members Statewide with approval from DHS.</p>
12	40.100	34		<p>The RFP states, “Once the service needs and coordination of care is established, the BHO shall ensure that its members have access to behavioral health providers.” This sentence suggests that, if members are receiving behavioral health services when they are referred to the BHO, those services might not continue until the initial BHO processes were completed, e.g., assessment and assignment of a case manager. Please clarify the intent of this statement.</p>	<p>If a new member of the BHO already is receiving services from a behavioral health provider, these services shall continue through coordinated transfer of care (see Section 41.200). If someone is not receiving services from a behavioral health provider or needs additional services, these should be identified through assessment and Individualized Treatment Plan (ITP) development.</p>
13	40.200	35	1	<p>The RFP states “Contracts shall, at a minimum, be for six months from the date an individual newly enrolls in the BHO and has an established and active relationship with a case manager. “ At the end of the six months, does the BHO have to re-contract with the case management agency, or can the member be transitioned to the BHO’s case management services at that point? Can the BHO</p>	<p>The BHO is required to have network adequacy and allow a choice of case management providers. The member may be transitioned to an in-network BHO case management at this time as long as it is in the best interest of the member. The BHO should be working with the member to educate and transition them over the six month period of time; this is why DHS has this transition timeframe.</p>

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				be working with the member to educate and transition him/her to the BHO?	
14	40.200	35	2	Please confirm that in this context, a care manager from an agency is a provider and not a BHO employee.	Care coordinator or case managers may be either a provider or a BHO employee or a combination of both. The BHO will need to determine how they intend to develop their system of delivery.
15	40.200	38	4	If the BHO intends to contract for psychosocial rehabilitation services and case management from community mental health agencies (i.e., providers), is that contract considered a sub-contract for purposes of requiring DHS approval?	No. These contracts would be provider contracts. However, contractually the BHO shall maintain responsibility for ensuring contracted agencies maintain compliance with the standards set forth for the Hawaii Medicaid Agency Programs.
16	40.210	36	Primary Bullet #4	What medical information (e.g. utilization) will the BHO receive from the QExA plans to ensure that care can be effectively coordinated and managed?	Examples include hospitalizations, emergency room utilization, physician visits (both primary and specialty care), medical diagnosis' and medication usage. The BHO can enter into business agreements with the QExA health plans. DHS-MQD may help facilitate coordination and sharing of information for the benefit of beneficiaries.
17	40.220	37	2 – 3 <sup>rd</sup> bullet point	The RFP states “The assessment tool shall be subject to approval by DHS.” What is the anticipated turnaround time for approval by DHS-MQD of not only this tool, but other materials as noted in the RFP, so that implementation/completion of projects is not unreasonably delayed? What should the BHO’s expected response time be for inquiries/decisions/approval from DHS-MQD?	Thirty to sixty days.

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				<p>This subject of DHS-MQD approval of tools/materials is also referenced on page 76, where the RFP states “Any materials prepared and distributed to BHO members shall be approved by DHS.”</p> <p>This subject is also discussed on page 111, where the RFP states “All written material including changes or revisions must be submitted to the DHS for prior approval before being distributed. The BHO shall also receive prior approval for any changes in written materials provided to the members before distribution to members.”</p>	
18	40.220	37	Paragraph 3, Bullet 2	Will MQD provide a list of existing clients and their case management providers such that the successful bidder will be able to effectively ensure continuity of care for CCS beneficiaries?	Yes.
19	40.220	38	2 – 8 <sup>th</sup> bullet point	The RFP states “A description of proposed caseload assignments for each CC/CM classification, as well as policies and procedures for providing CC/CM as they relate to the member’s needs” as a required description for the proposal. Is there an expectation of required member to CC/CM staffing ratios since there are now contractual requirements for face-to-face encounters? We realize that the RFP states for the	DHS expects for the offeror to describe their staffing ratios. This will be used in the evaluation of proposals. DHS has not determined ratios.

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				<p>bidder to tell DHS-MQD the proposed staffing, but will ratios be applied to judge appropriate staffing? If there are ratios, will the ratio be based on access to the CC/CM or to the entire treatment team, if the bidder uses a team concept of CC/CM, psychiatrist, APRN-Rx, medical director, etc.?</p> <p>This subject is also referenced on page 68, final paragraph, where the RFP states “The offer must include information on the number of FTE’s that will be used and that the designated staff is adequate to meet the requirements and functions of this RFP.”</p>	
20	40.220	39	4 (chart)	Please provide a breakout of the number of enrollees that typically fall within each service level	<p>The number of enrollees in each level of service currently is:</p> <p>Level 1 (lowest level)= 95</p> <p>Level 2=410</p> <p>Level 3=300</p> <p>Level 4=12</p>
21	40.230	40	1	Please clarify the requirement/definition of acute inpatient treatment and “alternative inpatient treatment” as referenced in RFP.	<p>Acute inpatient treatment is acute psychiatric hospitalization such as Kekela at Queens hospital. Alternative inpatient treatment is specialized residential treatment such as drug treatment obtained from Hina Mauka.</p>

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22	40.310	42	3	<p>The RFP states “The BHO shall ensure the provision of the following services . . .” and then lists 16 bullet points. Will the DHS-MQD provide a list of acceptable HCPCs and Revenue Codes for purposes of provider billing/payment that the BHO/providers shall use for consistency of the claims data and for programming the BHO’s claims adjudication system?</p> <p>This is also referenced on page 46, where the RFP states “Specify acceptable billing and coding requirements” as an item to be included in the provider contract template. The services are referenced in detail again on page 71-73.</p>	DHS can provide a list of HCPCS codes that DHS uses for behavioral health services to the BHO that is awarded a contract during readiness review, if requested. However, this list should be used as a reference only.
23	40.310	42	3	<p>The RFP states “The BHO shall ensure the provision of the following services...” The last 6 services (crisis services, interpretation services, transitional housing, representative payee, supported employment, peer specialist) are part of the AMHD service array. Will CCS members be considered dually eligible for AMHD services and be able to access these services via AMHD?</p>	No. These services shall be provided through the CCS program in accordance with this RFP.
24	40.310	42	n/a	<p>Given the small number of members and resultant small volume of total utilization that the BHO may represent compared to the total Hawaii health economy, will DHS provide assistance compelling key providers to contract with the BHO at</p>	DHS can provide support to the BHO awarded a contract to work with existing behavioral health providers. However, DHS cannot require that providers’ contract with the BHO or intervene in BHO/provider contracting.

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				Medicaid FFS rates?	
25	40.320	43-44	1-7	<p>The RFP discusses the responsibilities of the BHO for provider credentialing, recredentialing, and other certification. Does the DHS-MQD have expectations that the BHO will credential and ensure licensure for all CCS providers through its credentialing process? If a provider has not been credentialed through the BHO’s process or does not have a contract with the BHO, will DHS-MQD expect the BHO to pay the non-participating/non-contracted provider if the provider is credentialed and in good-standing with Medicaid? How will DHS-MQD notify the BHO that the non-participating/non-contracted provider is credentialed and in good-standing with Medicaid? Will payments be at the same rate or at an out-of-network rate?</p> <p>The RFP also states, “The BHO will follow the most current NCQA credentialing standard.” How will compliance with this standard be validated?</p> <p>This topic is also referenced on page 48, number 43, where the RFP states “Require that the provider complies with all credentialing and re-credentialing activities.”</p>	<p>DHS shall review the BHO’s credentialing policies and procedures to assure that they meet NCQA guidelines and are not cumbersome for providers in the community. DHS will work with the BHO to assure that providers are compensated while going through the credentialing process.</p> <p>Compliance with NCQA guidelines will be measured through DHS’ External Quality Review Organization (EQRO).</p>

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26	40.330	44	1.1	If the BHO has existing Medicaid contracts with behavioral health providers for covered CCS services, does it have to amend contracts to specifically reference CCS as per RFP section 40.330?	Yes.
27	40.330	47	No. 32	<p>The RFP states that the provider contract shall include “Require that providers offer access to interpretation services for members that have a Limited English Proficiency (LEP) at no cost to the member, and to document the offer and provision of interpreter services to the same extent as the BHO under the Contract.” Will DHS-MQD reimburse the BHO or the provider for interpretation services that are utilized? If so, how should the services be documented and submitted for payment?</p> <p>This subject of interpretation services is also referenced in the RFP on page 76, where it states “The BHO shall provide oral interpretation services to individuals with Limited English Proficiency (LEP), sign language services, and TDD services at no cost to the individual.”</p>	Not directly. This should be paid by the BHO and viewed as part of its capitation payment (this is an anticipated administrative expense).
28	40.350	52	3	The RFP states “The BHO shall submit the availability of providers policies and procedures as required in Section 51.300, Readiness Review.” However, the Readiness Review Table with the	See #5 in Amendment #1.

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				Documents, RFP Section, and Due Date on page 112 does not include this requirement. Is this an error in the table? If it should be included in the table, what is the due date?	
29	40.400	58	n/a	Has DHS confirmed that the current authorization processes in place under the current are fully compliant with MHPAEA (Federal Mental Health Parity) as the non-quantitative treatment limits (e.g., utilization management) are substantially similar to those processes in place by the QExA health plans? If in the course of the contract it is determined that the authorization criteria and processes must change, will DHS commit to adjusting capitation rates accordingly?	<p>These requirements are consistent with mental health parity. In addition, DHS will review the BHO's policies and procedures to assure that they are not more restrictive than those provided by either the QUEST or QExA health plans.</p> <p>DHS shall adjust capitation rates annually unless DHS requires more frequent rebasing. In addition, DHS will assure that capitation rates are actuarially sound.</p>
30	40.400	59	3	The RFP states "As the BHO has authority to authorize direct services to its members, it shall refrain from provision of direct services or otherwise engage in activities that would constitute a conflict of interest." Does this language exclude the BHO from providing PSR, IOP, or other FFS as a direct provider of services for payment? If so, how does the BHO ensure consistency of medication management or other behavioral health treatment to members on the neighbor islands or Oahu? The current BHO transports psychiatrists into Kauai and Hilo and Maui due to the lack of psychiatrists or APRN-Rx's willing to accept CCS	<p>Yes.</p> <p>Through contracting with a provider in the community.</p> <p>It is the responsibility of the BHO to assure providers will see their members. This includes flying providers to neighbor islands.</p>

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				members and a shortage of providers to provide services to the neighbor islands. On Oahu and the neighbor islands, there are some CCS members who have been denied services due to their instability and disruption to provider offices, commercial member profitability and treatment environment, homelessness and hygiene issues, etc. The current BHO provides services to these CCS members when no other providers will.	
31	40.400	59		The RFP states, "Service authorization decisions not reached within the timeframes specified above and in accordance with the DHS policy guidance shall constitute a denial." Please clarify member appeal rights in the context of this type of denial.	Appeal rights need to be offered to the member in these situations consistent with Section 40.500.
32	40.370.1	55	3	The RFP states "The <u>health</u> shall maintain documentation of the education and training provided in addition to reporting the recovered amounts as income or revenues." Should the word "health" be replaced with "BHO?"	Yes. See #3 in Amendment #1.
33	40.610	67	1	Can the Medical Director be part time?	Yes. However, at least a 0.5 FTE. See #4 in Amendment #1.
34	40.610	67	1	Does the Medical Director need to be an employee of the BHO or may he/she be a contractor?	This person may be a contractor as long as there is no conflict of interest (i.e., also performing services for DHS).

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35	40.700	69	3	The RFP states “Capitation payments for members enrolled/disenrolled on dates other than the first or last day of the month shall be prorated on a daily basis based on the number of days in a month.” Can DHS-MQD give an example of the proration calculation and how it will apply to the number of members enrolled/disenrolled on dates other than the first or last day of the month? Is this a majority of the days in the month method (i.e. > 15 days for a full month, <= 14 days for half-month) or is this calculation on a truly prorated daily basis (member loses eligibility on day 4; the BHO is paid the PMPM rate prorated for 3 days of eligibility?) Is there another number of days used for full- or half-month payment?	It is pro-rated by the day. If the member is disenrolled on the fourth (4 <sup>th</sup> ) day of the month, then capitation payments are paid prorated for the first three (3) days of the month.
36	40.810	71	1	Is the BHO allowed to have Preferred brands and non-preferred brands?	The BHO must comply with Hawaii State law regarding psychotropic medication coverage. The BHO can have preferred and non-preferred brand name medications except as required under Hawaii State law.
37	40.810	71	1	Can the BHO use quantity limits on prescription drugs?	See #36. For chronic medications, the quantity limit on dispensed supply shall be no less than a one-month supply. There shall not be a limit on the number of prescriptions, although medication management and reconciliation is encouraged.
38	40.810	71	1	Can the BHO implement age limits on drugs?	See #36. Age limits shall not be more restrictive than FDA approval.

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39	40.810	71	1	Can the BHO use Channel Management on prescription drugs? i.e. Can there be a Variable Fee Schedule based on where the prescription is filled?	Contracting between the BHO and pharmacies is between those two parties but shall comply with any applicable state and federal law. The BHO must ensure access for its members to prescription medications.
40	40.810	71	1	Can the BHO require members to use mail order for management drugs?	The BHO may offer mail order medications to their members, but may not make this a requirement.
41	50.110	84	1	Is a separate BHO membership card required? Will the enrolled member have a Medicaid ID?	Yes. Yes.
42	50.500	92	2	Will MQD be providing additional information on the performance incentives that will be included under the contract? If so, when can the offerors expect the updated information? If not, should offerors respond to the examples listed in Section 50.500? Will MQD entertain additional suggested measures and incentives from the offerors?	Yes. No definitive timeframe is established. Yes. Yes.
43	50.630	93	4	Will the BHO bear the cost of the patient satisfaction surveys issued by DHS?	If DHS requires the BHO to conduct quality of life surveys as part of their quality program, these surveys will be paid for by the BHO.  If DHS conducts overall satisfaction surveys of members and providers, the cost of these surveys will be paid for by DHS.
44	50.730	95	4	The RFP states “DHS <u>shall</u> also share information among <u>BHOs</u> to promote transparency and sharing of benchmarks/best practices. DHS <u>shall</u> publicly report measures in formats such as a consumer	At this time, behavioral health services are provided by QUEST health plans. MQD shall provide public reporting on information from the CCS program compared with the QUEST health

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				guide, public report, or otherwise, on MQD's website." Who does "BHOs" refer to in this context? Also, with the use of the word "shall" as opposed to the word "may," does this indicate that the DHS-MQD is under a mandate to produce a public report with measures for monitoring performance?	plans.  DHS is not under a mandate, but believes in transparency within our programs.
45	50.810	104	n/a	Will DHS require the BHO to adopt ICD-10 standards during the term of the contract? Have administrative costs been included in the administrative capitation rates to facilitate the required systems change?	When ICD-10 is implemented as a Federal requirement, DHS will require that the BHO participate in its requirements. DHS is unable to determine administrative costs associated with ICD-10 at this time to determine if additional costs will be added for ICD-10 implementation. However, conversion to ICD-10 will be a necessary business expense for any healthcare entity that seeks to continue to operate.
46	51.220	110	3	The RFP lists the required languages (English, Ilocano, Vietnamese, Chinese [Traditional], and Korean in which all member materials must be produced in writing and made available to the CCS member. Because the materials must be approved by DHS-MQD before production, is there a recommended number of each document that must be produced in each language, realizing that CCS members with individual language needs will change over the contract period? Or, can the BHO	The BHO needs to have these materials available for members as they need them. DHS will not provide a specific number to be printed. The BHO may maintain in electronic format and publish as needed or publish a specific amount. This is up to the BHO.

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				maintain these written materials in an electronic format and publish hardcopy versions when requested?	
47	60.700	120 - 121	all	Can you confirm that no specific state licensure is required other than meeting the HMO solvency/bond requirements?	The DHS cannot confirm that no other State license is required in addition to the one required under section 60.700. Throughout the RFP, there are other licensure requirements (e.g., tax, professional, etc.). Also, noting the relevancy to your question, DHS was recently informed by the Department of Commerce and Consumer Affairs (DCCA), Insurance Division (ID) that they were asked if offerors to an RFP (which DHS believes to be this RFP based on its description by the ID), require an insurance license to provide the services outlined in the RFP for the State. The ID agreed to inform the DHS of their decision once issued. The DHS will provide this information as a follow-up to this question after it receives the ID's decision.
48	70.100	141	n/a	Will respondents be provided with editable versions (e.g. Microsoft Word) of the Proposal Application Identification form and the required documentation in Appendix B?	No.
49	70.200	142	Last bullet	RFP states "If the use of subcontractor(s) is proposed, a statement from each subcontractor must be appended to the transmittal letter signed by an individual authorized to legally bind the	Yes. This is the correct interpretation. Offerors should provide a statement from each subcontractor in instances where joint or multiple organizations are bidding on the contract (as

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				subcontractor and stating the general scope of work to be performed by the subcontractor(s).” We are interpreting this to refer to a BHO that might be submitting a joint proposal (i.e.: two independent organizations). We will be the sole bidder however we have numerous subcontractors. For example, we will have subcontractors such as our PBM, transportation vendor, interpreter services and claims payment/clearing house contractors in addition to an entire network of direct BH service providers. We do not believe that DHS is requesting each of these entities to be appended to the transmittal letter. Are we correct in this assumption?	described in Section 10.400).
50	70.600	147		Can the current BHO provide letters of intent from new providers that may not have signed a contract by the time the proposal is submitted but which would be available to deliver services by the Commencement of Services date?	We would not consider the current vendor of the CCS program to be a BHO. Those who submit proposals should submit provider letters of intent for any provider that they intend on contracting with prior to Commencement of Services for Members.
51	80.200	151		This section indicates that there will be two (2) base capitation rates, one to cover services delivered to members and the other is the administrative Per Member Per Month fee of \$382.50. Please confirm that the BHO is at risk for the cost of care over and above the capitation rates specified on page one (1) of CCS Data Book and	There are two (2) per member per month base rates one for each age cohort. Each of those base rates include a component that is directly tied to services provided to members and an administration/case management component. The BHO is responsible for costs in excess of the base rate which includes both components, subject to the risk sharing

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To Provide Behavioral Health Services For Medicaid Eligible Adults who have a Serious Mental Illness

Question #	RFP Section #	RFP Page #	Para-graph #	Question	Answer
				CY Cap Rates.pdf with the exception of the specific services identified in 80.200.	program detailed in Appendix G.
52	80.300	152	1	If the BHO subcontracts the CM costs with an external BH Provider, will the costs be counted as medical expense or be covered under the CM/Admin expense?	CM costs will be covered as a CM/Admin expense. We expect financials will separate this service from the medical expenses. We will review these costs during future rate setting and determine if these costs should be separated from the admin component, so they should be tracked separately but not included with medical costs.
53	90.500	154		Please clarify the evaluation of sub-areas and assignment of weighted points. For example, Section 90.540 Organization and Staffing is worth 10 points. If a specific proposal receives 4 weighted points on this section, does that mean that the proposal will receive a score of 40 for this section?	No. Scores will range from 0-5. The weighted section score in this case will be less than the maximum of 10 points.
54	Data Book			What was the brand discount, generic basis for unit costs and dispensing fee during the 2008 period used to create the rates? Please provide the data in pre-rollback for Nations Bank pricing definitions.	At this time we do not have access to that information. If it can be obtained it will be shared as an addendum to the data book.
55	Exhibit 1b Exhibit 2b	2-3 2-3	n/a	Some of the drugs on this list are not behavioral health drugs. Are drugs used to treat HIV conditions, hematoloicals, or IV antibiotic therapy included as a cost to the per diem?	The drugs included in these exhibits were provided by the BHO as part of their contract. We are not aware of the specific reasons for certain drugs provided as part of this program. At this time all those drug costs have been included in the developed capitation rate.

Technical Proposal Question & Answer

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56	Exhibit 1b Exhibit 2b	2-3 2-3	n/a	It appears that some medications noted may be used for “Off-label” treatment of behavioral health conditions. If this is so, what reference is used and what body of evidence is required to validate an appropriate behavioral health indications?	Plans are expected to treat the behavioral health conditions in an appropriate and cost effective manner.
57	Exhibit 1b Exhibit 2b	2 -3 2-3	n/a	Some of the drugs on this list are not behavioral health drugs. If a patient is admitted for a behavioral health condition and that patient has a medical co-morbidity and takes non-behavioral health medication for that condition, is that included as a cost to the per diem?	To the extent that the medical co-morbidity is part of a separate claim we would expect that to be covered by the QExA plan. Costs included in the rate development were based on services paid for by the BHO. We have assumed that appropriate allocation of costs between the MCOs and BHO were performed.
58	Exhibit 1b Exhibit 2b	2 -3 2-3	n/a	Is, or can, a drug formulary be used? If yes, who manages that formulary? Must brand name behavioral drugs be included in a formulary?	See #36. The BHO must meet State law related to provision of psychotropic medications. State law prohibits denial of brand drugs for certain behavioral health conditions. The BHO can determine who manages their formulary.
59	N/A			Does DHS have a preferred page limit for the proposal response?	No. However, DHS is expecting that all proposals answer the question posed without providing superfluous information.
60	N/A	1	N/A	The RFP Interest Form is not available through the link on this page ( <a href="http://www.hawaii.gov/rfps103f/">http://www.hawaii.gov/rfps103f/</a> ). Can DHS please provide a workable link or the form prior to the May 18, 2012 deadline for submission of the Notice of Intent to Propose?	See attached form below.  See #1 of Amendment #1.

**Notification to State Agency of Interest in Responding to an RFP**

RFP Number and Title: \_\_\_\_\_  
Organization or Individual: \_\_\_\_\_

Contact Person Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
E-mail Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_  
Fax Number: \_\_\_\_\_

Mailing Address

Street Address or PO Box \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Please provide to the agency contact person listed in the Request for Proposals (RFP).