Appendix K – Evaluation Tool

QUEST Integration (QI) Managed Care to Cover Medicaid and Other Eligible Individuals
RFP–MQD–2021-008

EVALUATION TOOL

Applicant: _____

Mandatory Proposal Elements

____ Proposal arrived by deadline

____ Only one proposal received

____ Proposal addresses all the provisions in RFP for Oahu and the Neighbor Islands

____ Transmittal Letter with all information completed:

____The transmittal letter shall be on official business letterhead and shall be signed by an individual authorized to legally bind the Health Plan.

____A statement indicating that the Health Plan is a corporation or other legal entity and is a properly licensed health plan in the state of Hawaii at the time of proposal submission. All Subcontractors shall be identified, and a statement included indicating the type and percentage of work to be performed by the prime Health Plan and each Subcontractor, as measured as a percentage of the Health Plan's anticipated budget for the contract. If Subcontractors will not be used for this Contract, a statement to this effect shall be included.

____A statement that the Health Plan has an established provider network to serve Medicaid Members in the state of Hawaii or will have a provider network to serve Medicaid Members in the state of Hawaii before the Commencement of Services.

____A copy of the Health Plan's registration to do business as a Health Plan in the state of Hawaii.

____A copy of the Health Plan's state of Hawaii General Excise Tax License.

____A statement that the Health Plan's Hawaii Compliance Express information is current and provide a copy of the Certificate of Vendor Compliance conducted no later than seven (7) days prior to proposal submission.

____A statement to certify that this proposal includes all amendments and addenda to this RFP issued by the issuing office. If no amendments or addenda have been issued, a statement to that effect shall be included.

____A statement attesting to the accuracy and truthfulness of all information contained in the Health Plan's responses to the RFP.

____A statement of affirmative action that the Health Plan does not discriminate in its employment practices with regard to race, color, creed, ancestry, age, marital status, arrest and court records, sex, including gender identity or expression, sexual orientation, religion, national origin, or mental or physical handicap, except as provided by law.

____A statement that no attempt has been made or will be made by the Health Plan to induce any other party to submit or refrain from submitting a proposal.

____A statement that the Health Plan read, understood, and is able and willing to comply with all provisions and requirements of this RFP.

____A statement that, if awarded the contract, the Health Plan's organization shall deliver the goods and services meeting or exceeding the specifications in the RFP and amendments.

____A certification by the person signing the Health Plan's proposal certifies that he/she is the person in the Health Plan's organization responsible for, or authorized to make, the offer firm and binding, and that he/she has not participated and shall not participate in any action contrary to the above conditions.

____A statement that the Health Plan will follow all applicable laws and rules regarding the procurement process, including, but not limited to, HRS §103F and HAR Title 3, Subtitle 11, §§143 and 148.

____A statement that the Health Plan understood that the terms of this RFP are self-contained and the Health Plan should not rely on information outside of this RFP in forming its proposal.

____A statement confirming the specific island(s) the Health Plan shall provide services to or whether the Health Plan shall provide services statewide (i.e., all islands).

____ Confidentiality

____ The proposals are government records subject to public inspection, unless protected by law, and may include information that the Health Plan feels is confidential or proprietary. If any page is marked "Confidential" or "Proprietary" in the Health Plan's proposal, an explanation to DHS of how substantial competitive harm would occur if the information is released. If DHS determines that it is confidential or proprietary, then the information will be excluded from disclosure to the public. By submitting a proposal, the Health Plan affirms its understanding that proposals are part of the procurement file and subject to public inspection under the current law governing information practices after execution of a contract by all parties pursuant to HAR §3-143-616.

____ Company Background and Experience

____The legal name of the Health Plan, including any names that the Health Plan has used or is using to do business under. Indicate the Health Plan's form of business, for example, corporation, non-profit corporation, partnership, etc.

____Federal and State Tax Identification Numbers.

____Address, telephone number and e-mail address of the Health Plan's headquarter office.

____Date the company was established and then began operations.

____Relationship to parent, affiliated and/or business entities and copies of management agreements with parent organizations.

____Organization chart of parent company and all Subcontractors.

____Detailed description of the Health Plan's organizational structure for this Contract, including an organizational chart that clearly displays the management structure, lines of responsibility, including dotted line responsibility, and authority for all operational areas of this Contract.

____Per §11.2.H.2.e a description of the proposed Health Coordination Team.

____Names, addresses, and contact information for all officers, directors, and partners.

____Provide copies of the Health Plan's articles of incorporation, bylaws, partnership agreements, or similar business entity documents, including any legal entity have an ownership interest of five (5) percent or more.

____The size and resources, including the gross revenues both in Hawaii and nationally, if applicable.

____Total current number of employees both in Hawaii and nationally, if applicable.

____Provide the following information for the Health Plan and any Subcontractors that are providing Covered Services. Information should be in order of most to least current. The Health Plan may exclude workers' compensation cases:

____ Using Table 12: 15.2.B, below, list pending or recent litigation within the past three (3) calendar years (2018 through 2020) against the Health Plan where the amount in controversy or the damages sought or awarded is $1 million or more and/or is due to the Health Plan's or Subcontractor's failure to provide timely, adequate, or quality Covered Services. The Litigation Events table is provided in Appendix I. The Health Plan shall complete all items in the table for each pending or recent litigation. Completed tables shall not be counted toward the Health Plan's total page limits.

Table 12: 15.2.B. Litigation Events

Disclosure of Pending or Recent Litigation	Vendor Details
Date litigation brought against Entity including case title and case ID	
Name of Entity (Health Plan or Subcontractor)	
Type of Contract and Contracting Entity (e.g., full risk managed care contract with State of Hawaii DHS, etc.)	
Describe nature of litigation, including action leading to the litigation.	
Indicate amount of damages sought or awarded.	
Does the pending or recent litigation have the potential to or will impair your organization's performance in a Hawaii Medicaid managed care Contract? Please explain if "yes."	
Indicate the status of the litigation.	
Indicate outcome of litigation, if resolved.	

____Any Securities Exchange Commission (SEC) filings discussing any pending or recent litigation.

____For the Health Plan, list and describe any confirmed PHI breaches within the past three (3) calendar years (2018 through 2020), both in and out of Hawaii that have occurred and the Health Plan's response to the breach (e.g., Member notification, payment of fines, free credit reporting, etc.). Do not include items excluded per 45 CFR §164.402. The Health Plan shall complete all items for each breach incident as detailed in Table 13: 15.2.B below. Completed tables shall not be counted toward the Health Plan's total page limits.

____Using the below table, list PHI breaches within the past three (3) calendar years (2018 through 2020). The PHI Breach Events table is listed in Appendix J. The Health Plan shall complete all items in the table for each PHI breach Information and in the order of most to least current.

Table 13: 15.2.B. PHI Breach Events

Date of Breach	Location of breach (State or States)	Did the breach result in the exposure of PHI?	Where did the exposure occur? (i.e. internal, Subcontractor, etc.)	How many Members' data were included in the breach?	How many total records of data were breached?	To what extent was the breached data seen or used?	What steps were taken to mitigate the breach?

____ The Health Plan shall provide evidence of its current NCQA accreditation status for Medicaid, including a copy of its current certificate of accreditation with a copy of the complete accreditation survey report, including scoring of each category, standard, and element levels, and recommendations, as presented via the NCQA Interactive Review Tool.

____Provide an attestation to whether the Health Plan has ever had its accreditation status (e.g., NCQA, URAC, or Accreditation Association for Ambulatory Health Care, etc.) in any state for any product line adjusted down, suspended, or revoked. If so, identify the state and product line and provide an explanation.

____Provide a listing of Medicaid managed care contracts both in and out of Hawaii held in the past (3) years for which the Health Plan has:

____Voluntarily terminated all or part of the contract under which it provided healthcare services as the licensed entity.

____Had such a contract partially or fully terminated before the contract end date, with or without cause.

____Describe the Health Plan's experience in operating a D-SNP including a description of the Health Plan's experience aligning administrative processes across Medicare and Medicaid to create a seamless system for dual eligible Members. Describe the Health Plan's experience using Medicare and Medicaid data to coordinate, track, and report on care provided across programs.

____Understanding of Healthcare in Hawaii

____A statement of understanding of the healthcare environment and challenges in Hawaii, the DHS Medicaid program, and the needs of Medicaid Members. This understanding shall address healthcare, geographic and cultural disparities in Hawaii.

____ Other Documentation

____The Proposal Application Identification form (Form SPO-H-200).

____The State of Hawaii DHS Proposal Letter.

____The Certification for Contracts, Grants, Loans and Cooperative Agreements form.

____The Disclosure Statement (CMS required) form.

____Disclosure Statement.

____The Disclosure Statement (Ownership) form.

____The Organization Structure and Financial Planning form.

____The Financial Planning form.

____The Controlling Interest form.

____The Background Check Information form.

____The Operational Certification Submission form.

____The Grievance and Appeal System form.

____Health Plan's Proof of Insurance.

____The Wage Certification form.

____The Standards of Conduct Declaration form.

____The State and Federal Tax Clearance certificates from the prime Health Plan and, upon request from subcontractors, as assurance that all federal and state tax liabilities have been paid and that there are no significant outstanding balances owed. A statement shall be included if certificates are not available at time of submission of proposal that the certificates will be submitted in compliance with §1.11;

____Proof of its current license to serve as a Health Plan in the State of Hawaii. A letter from the Insurance Division notifying the Health Plan of its license shall be acceptable "proof" for DHS.

____Certificate of Compliance from the State of Hawaii, Department of Commerce and Consumer Affairs, Insurance Division.

____ Risk-based Capital

____The Health Plan shall provide the most recently completed risk- based capital report following the National Association of Insurance Commissioner's risk-based capital report instructions.

EVALUATION CRITERIA AND SCORING

The Health Plan's responses to the technical proposal will be evaluated in how responses address program requirements for Oahu and the Neighbor Islands. The Evaluation Categories and points are described in the table below.

Table 14: 16.5. Technical Evaluation and Points

Technical Proposal Evaluation Categories	RFP Evaluation Section	Maximum Points Possible
Evaluation Category 1 Care Delivery and Health Coordination (Section 3)	**Section 15.3.C.1**	**190**
Describe the Health Plan's unique approach to utilizing a multi-disciplinary team to provide primary care and behavioral health services across the continuum of HCS.	Question 15.3.C.1.a	50
Describe the Health Plan's experience and innovations to meet and monitor the behavioral health needs of members receiving HCS.	Question 15.3.C.1.b	40
Describe the Health Plan's experience with innovations for health coordination of LTSS.	Question 15.3.C.1.c	60
Describe the Health Plan's experience with innovations in providing health coordination for people experiencing homelessness or at risk of homelessness.	Question 15.3.C.1.d	40
Evaluation Category 2. Covered Benefits and Services (Section 4)	**Section 15.3.C.2**	**175**
Describe the Health Plan's experience and innovative approaches providing covered benefits and services, 1) addressing the needs of unique Hawaii populations; and 2) approaches to EPSDT.	Question 15.3.C.2.a	75

Technical Proposal Evaluation Categories	RFP Evaluation Section	Maximum Points Possible
Describe the Health Plan's experience, innovative strategies, and comprehensive approach to provide prevention and health promotion services.	Question 15.3.C.2.b	50
Describe any value-added services the Health Plan can offer.	Question 15.3.C.2.c	50
Evaluation Category 3. Quality, Utilization Management, and Administrative Requirements (Section 5)	**Section 15.3.C.3**	**70**
Describe the Health Plan's experience and innovative approach to 1) supporting and evaluating Providers in conducting quality improvement activities; 2) increasing rates of high value care and reducing variation; and 3) leveraging PIPs to support wide-scale adoption of successful practices.	Question 15.3.C.3.a	50
Utilization Management	Question 15.3.C.3.b	20
Evaluation Category 4. Health Plan Reporting and Encounter Data (Section 6)	**Section 15.3.C.4**	**50**
Describe the Health Plan's utilization of report and data to resolve issues.	Question 15.3.C.4.a	50
Evaluation Category 5. DHS and Health Plan Financial Responsibilities (Section 7)	**Section 15.3.C.5**	**125**
Incentive Strategies for Health Plan providers	Question 15.3.C.5.a	50
VBP	Question 15.3.C.5.b	50
Investing and incentivizing in primary care	Question 15.3.C.5.c	25

Technical Proposal Evaluation Categories	RFP Evaluation Section	Maximum Points Possible
Evaluation Category 6. Responsibilities and Requirements of DHS and Health Plans: Provider Networks, Provider Credentialing, Provider Contracts, and Other Functions for Providers (Section 8)	**Section 15.3.C.6**	**130**
Network Development Description for Individuals with Behavior Health and SUDs	Question 15.3.C.6.a.1	40
Network Development Description for LTSS	Question 15.3.C.6.a.2	40
Network Development Description on innovative methods to recruit and retain providers	Question 15.3.C.6.a.3	50
Evaluation Category 7. Responsibilities and Requirements of DHS and Health Plans: Eligibility, Enrollment, Disenrollment, Continuity of Care, and Grievance and Appeals (Section 9)	**Section 15.3.C.7**	**60**
Describe the Health Plan's innovative methods for communicating, including education and outreach, 1) identifying, developing, and distributing materials that will be of most use to Member populations; 2) innovative technologies the Health Plan will use to ensure high levels of QI Member engagement.	Question 15.3.C.7.a	60
Evaluation Category 8. Information Systems and Information Technology (Section 10)	**Section 15.3.C.8**	**50**

Technical Proposal Evaluation Categories	RFP Evaluation Section	Maximum Points Possible
Describe the Health Plan's compliance with expected functionality; timeline for implementing any unmet systems and supports requirements.	Question 15.3.C.8.a	50
Evaluation Category 9. Health Plan Personnel (Section 11)	**Section 15.3.C.9**	**50**
Describe the Health Plan's approach to staffing.	Question 15.3.C.9.a	50
Evaluation Category 10. Program Integrity (Section 12)	**Section 15.3.C.10**	**50**
Describe the Health Plan's Compliance Plan.	Question 15.3.C.10.a	50
Health Plan Proposes Statewide		**50**
Total Possible Points		**1,000**

Scoring

The evaluation team shall score proposals by reviewing the answers to the technical proposal. The evaluation team shall use a rating of 0 to 5 for each answer. The rating system is defined as follows:

Table 15: 16.6.A. Rating Methodology

Rating Score	Description
5	**Excellent.** The proposal response addresses the criterion in a clear and highly comprehensive manner. The proposal response meets the requirements and clearly adds significant value to the requirements listed in the RFP. Demonstrates expert level knowledge and understanding of the subject matter.
4	**Very Good.** The proposal response addresses the criterion in a highly comprehensive manner. The proposal response meets the requirements and may add some value to the requirements listed in the RFP. Demonstrates a strong knowledge and understanding of the subject matter, but not at the expert level.
3	**Good.** The proposal response addresses the criterion well. The proposal response clearly minimally meets the requirements. Demonstrates minimally adequate knowledge and understanding of the subject matter.
2	**Fair.** The proposal response addresses the criterion in a general manner. The proposal response may minimally meet the requirements and/or there no more than two concerning weaknesses. Ambiguously demonstrates minimally adequate knowledge and understanding of the subject matter.
1	**Poor.** The proposal response addresses the criterion in a general manner but there are concerning weaknesses. The proposal response may minimally meet the requirements and there is more than two concerning weakness. Ambiguously demonstrates some knowledge and understanding of the subject matter.
0	**Very Poor.** The proposal response fails to address the criterion or the criterion cannot be assessed due to missing or incomplete information, or because the response was overly ambiguous, conflicting, or confusing.

The Health Plan must receive, at minimum, a rating score of three (3) for each Evaluation Category or the Committee shall not make an award recommendation. Health Plans must receive a minimum score of seven hundred fifty (750) points, seventy-five (75) percent of the total available points to be considered responsive to the RFP. Proposals not meeting the total required points shall not be recommended to be awarded a contract.

The rating score (0-5) shall represent the corresponding conversion factor used to calculate the points awarded for each Evaluation Category as follows:

Table 16: 16.6.C. Conversion Factor

Rating Score	Conversion Factor
5	100%
4	88%
3	75%
2	50%
1	25%
0	0%

The total maximum number of points available for each Evaluation Category will be multiplied by the applicable conversion factor, based on the rating score given, to determine the number of points awarded for the Evaluation Category. The points awarded for each Evaluation Category shall by totaled to yield a final score.

Scoring will be based on the entire content of the proposal and the information as communicated to the Committee. The information contained in any part of the proposal may be evaluated by DHS with respect to any other scored section of the proposal. Lack of clarity and inconsistency in the proposal will impede effective communication of the content and may result in a lower score.

TECHNICAL PROPOSAL QUESTIONS

Total page limit excludes graphics, exhibits, flowcharts, diagrams, or other attachments.

Health Plan Name:	
Section: 15.3.C.1 Evaluation Category 1 - Care Delivery and Health Coordination (Section 3)	**Question:** 15.3.C.1.a - Care Delivery and Health Coordination requirements (Limit to five [5] pages)
Maximum Question Points: 50 points	**Rating (0-5):**
Question	a. Describe the Health Plan's unique approach to utilizing a multidisciplinary team to provide primary care and behavioral health services across the continuum of Health Coordination services, including how the Health Plan will engage the Members in their Health Action Plan, and how the Health Plan will implement and monitor the HAP.
Notes	

Health Plan Name:	
Section: 15.3.C.1 Evaluation Category 1 - Care Delivery and Health Coordination (Section 3)	**Question:** 15.3.C.1.b - Care Delivery and Health Coordination requirements (Limit to four [4] pages)
Maximum Question Points: 40 points	**Rating (0-5):**
Question	b. Describe the Health Plan experience and innovations to meet and monitor the behavioral health needs of the Members receiving Health Coordination services.
Notes	

Health Plan Name:	
Section: 15.3.C.1 Evaluation Category 1 - Care Delivery and Health Coordination (Section 3)	**Question:** 15.3.C.1.c - Care Delivery and Health Coordination requirements (Limit to seven [7] pages)
Maximum Question Points: 60 points	**Rating (0-5):**
Question	c. Describe the Health Plan's experience and innovations for Health Coordination of long-term services and supports (LTSS), including using person-centered outreach, engagement, and planning; empowering individual initiative, autonomy and independence in making life choices. The Health Plan's response shall address how it will support individual choice in designing and receiving LTSS and promote the Member's full access to their greater community, including opportunities to seek employment and work, engage in community life, and manage their own resources.
Notes	

Health Plan Name:	
Section: 15.3.C.1 Evaluation Category 1 - Care Delivery and Health Coordination (Section 3)	**Question:** 15.3.C.1.d - Care Delivery and Health Coordination requirements (Limit four [4] pages)
Maximum Question Points: 40 points	**Rating (0-5):**
Question	d. Describe the Health Plan's experience and innovations in providing Health Coordination for people experiencing homelessness or at risk of homelessness. Include the Health Plan's experience and innovations coordination with community based homeless services organizations, and in providing Community Integration Services (CIS), Community Transition Services (CTS) or similar services.
Notes	

Health Plan Name:	
Section: 15.3.C.2 Evaluation Category 2 - Covered Benefits and Services (Section 4)	**Question:** 15.3.C.2.a - Covered Benefits and Services Requirements (Limit to eight [8] pages)
Maximum Question Points: 75 points	**Rating (0-5):**
Question	a. Describe the Health Plan's experience, innovative approaches providing covered benefits and services, as described in Section 4, Covered Benefits and Services. The response shall specifically include: 1) Addressing the needs of the unique populations of Hawaii, including Native Hawaiians and Hawaii residents from Micronesian Nations Under the Compact. 2) Approaches to providing EPSDT services.
Notes	

Health Plan Name:	
Section: 15.3.C.2 Evaluation Category 2 - Covered Benefits and Services (Section 4)	**Question:** 15.3.C.2.b - Covered Benefits and Services Requirements (Limit to five [5] pages)
Maximum Question Points: 50 points	**Rating (0-5):**
Question	b. Describe the Health Plan's experience, innovative strategies, and comprehensive approach to providing prevention and health promotion services such as lifestyle classes, self-management and education classes, and smoking cessation services, with emphasis on populations for whom standard outreach and engagement strategies are less effective.
Notes	

Health Plan Name:	
Section: 15.3.C.2 Evaluation Category 2 - Covered Benefits and Services (Section 4)	**Question:** 15.3.C.2.c - Covered Benefits and Services Requirements (Limit to five [5] pages)
Maximum Question Points: 50 points	**Rating (0-5):**
Question	c. Value-Added Services 1) The Health Plan may propose to offer Value-Added Services. For each service proposed, provide the following: a) Describe the service, including information on who is eligible to receive the service, and the proposed timeframe for implementation. b) Describe the expected impact in terms of cost savings, and perceived qualitative value of the service. c) Describe the Health Plan's proposed method(s) of outreach to increase awareness and utilization of the Value-Added Service.
Notes	

<table>
<tr><td colspan="3">Health Plan Name:</td></tr>
<tr><td colspan="2">Section: 15.3.C.3 Evaluation Category 3 - Quality, Utilization Management and Administrative Requirements (Section 5)</td><td>Question: 15.3.C.3.a - Quality, Utilization Management and Administrative Requirements (Limit to seven [7] pages)</td></tr>
<tr><td colspan="2">Maximum Question Points: 50 points</td><td>Rating (0-5):</td></tr>
<tr><td>Question</td><td colspan="2">a. The Health Plan shall describe its experience and proposed innovative approaches to the following:

1) Supporting and evaluating Providers in conducting quality improvement activities;
2) Increasing the rate of high value care and reducing variation from evidence-based standards; and
3) Leveraging Performance Improvement Projects (PIPs) to support wide-scale adoption of successful practices.</td></tr>
<tr><td colspan="3">Notes</td></tr>
<tr><td colspan="3"></td></tr>
</table>

Health Plan Name:	
Section: 15.3.C.3 Evaluation Category 3 - Quality, Utilization Management and Administrative Requirements (Section 5)	**Question:** 15.3.C.3.b - Quality, Utilization Management and Administrative Requirements (Limit to three [3] pages)
Maximum Question Points: 20 points	**Rating (0-5):**
Question	b. Utilization Management. The Health Plan shall: 1) Provide an attestation agreeing to collaborate with other Health Plans contracted with DHS in the development and implementation of an innovative and streamlined Utilization Management protocol for Providers. 2) Provide a workflow for Utilization Management that depicts the process from the initial receipt of a request to final disposition. (Workflow diagram not included in page limit) 3) Describe successful strategies the Health Plan has used to minimize Provider burden in seeking prior authorizations for services, and the extent to which each strategy has resulted in reduced Provider burden.
Notes	

Health Plan Name:	
Section: 15.3.C.4 Evaluation Category 4 - Health Plan Reporting and Encounter Data (Section 6)	**Question:** 15.3.C.4.a Health Plan Reporting and Encounter Data Requirements (Limit to five [5] pages)
Maximum Question Points: 50 points	**Rating (0-5):**
Question	a. The Health Plan shall describe one or more reports it has generated, either for internal purposes or for submission to DHS, that the Health Plan found to be instrumental in identifying and addressing an issue that impacted access to and/or quality of services provided to its Members or Providers. For each report included, briefly describe the issue identified, how it was resolved, and what data was reviewed to identify and ensure resolution of the issue.
Notes	

<table>
<tr><td colspan="3">Health Plan Name:</td></tr>
<tr><td colspan="2">Section: 15.3.C.5 Evaluation Category 5 - DHS and Health Plan Financial Responsibilities (Section 7)</td><td>Question: 15.3.C.5.a - DHS and Health Plan Financial Responsibilities Requirements (Limit to five [5] pages)</td></tr>
<tr><td colspan="2">Maximum Question Points: 50 points</td><td>Rating (0-5):</td></tr>
<tr><td>Question</td><td colspan="2">a. Incentive Strategies for Health Plan providers

1) The Health Plan shall describe incentive strategies including the Health Plan’s approach for aligning its provider incentive strategies with DHS incentive strategies. The description shall include the Health Plan’s experience and innovative approaches to support providers in diverse geographies in achieving these goals with respect to two provider types from the following list:

a. Primary care providers;
b. Community Health Centers
c. Hospitals (Including Critical Access Hospitals);
d. Behavioral health providers (Mental Health and SUD);
e. LTSS providers, or
f. Other Specialists.</td></tr>
<tr><td colspan="3">Notes</td></tr>
<tr><td colspan="3"></td></tr>
</table>

<table>
<tr><td colspan="3">Health Plan Name:</td></tr>
<tr><td colspan="2">Section: 15.3.C.5 Evaluation Category 5 - DHS and Health Plan Financial Responsibilities (Section 7)</td><td>Question: 15.3.C.5.b - DHS and Health Plan Financial Responsibilities Requirements (Limit to five [5] pages)</td></tr>
<tr><td colspan="2">Maximum Question Points: 50 points</td><td>Rating (0-5):</td></tr>
<tr><td>Question</td><td colspan="2">b. Value-based Payment

1) The Health Plan shall describe its approach to ensure payments to providers are increasingly focused on population health, appropriateness of care and other measures related to value. The Health Plan’s response should address the following:
a) The Health Plan’s strategy for developing APMs that mature along the LAN continuum over the course of the Contract.
b) The Health Plan’s utilization of VBP strategies for two of the following provider types. The Health Plan shall choose two different provider types than for their response to the above 15.3.E.2:
i) Primary care providers;
ii) Community Health Centers
iii) Hospitals (Including Critical Access Hospitals);
iv) Behavioral health providers (Mental Health and SUD);
v) LTSS providers, or
vi) Other Specialists.</td></tr>
<tr><td colspan="3">Notes</td></tr>
<tr><td colspan="3"></td></tr>
</table>

Health Plan Name:	
Section: 15.3.C.5 Evaluation Category 5 - DHS and Health Plan Financial Responsibilities (Section 7)	**Question:** 15.3.C.5.c - DHS and Health Plan Financial Responsibilities Requirements (Limit to three [3] pages)
Maximum Question Points: 25 points	**Rating (0-5):**
Question	c. The Health Plan's specific approach to increase investment in, incentivization of, and medical spend on primary care providers in support of advancing primary care.
Notes	

Health Plan Name:	
Section: 15.3.C.6 Evaluation Category 6 - Responsibilities and Requirements of DHS and Health Plans: Provider Networks; Provider Credentialing; Provider Contracts; and Other Functions for Providers (Section 8)	**Question:** 15.3.C.6.a.1 - Responsibilities and Requirements of DHS and Health Plans: Provider Networks; Provider Credentialing; Provider Contracts; and Other Functions for Providers Requirements (Limit to four [4] pages)
Maximum Question Points: 40 points	**Rating (0-5):**
Question	a. The Health Plan shall describe its proposed network development strategy, including addressing workforce shortages, to meet all contract requirements and allow for timely availability and access to a continuum of physical health, behavioral health, and LTSS providers. In addition to overall strategy, the Health Plan's response shall specifically address the following: 1) Methods to develop a Provider network that sufficiently addresses the needs of individuals with mental health and/or SUDs, and individuals with co- morbid physical and behavioral health conditions.
Notes	

Health Plan Name:	
Section: 15.3.C.6 Evaluation Category 6 - Responsibilities and Requirements of DHS and Health Plans: Provider Networks; Provider Credentialing; Provider Contracts; and Other Functions for Providers (Section 8)	**Question:** 15.3.C.6.a.2 - Responsibilities and Requirements of DHS and Health Plans: Provider Networks; Provider Credentialing; Provider Contracts; and Other Functions for Providers Requirements (Limit to four [4] pages)
Maximum Question Points: 40 points	**Rating (0-5):**
Question	a. The Health Plan shall describe its proposed network development strategy, including addressing workforce shortages, to meet all contract requirements and allow for timely availability and access to a continuum of physical health, behavioral health, and LTSS providers. In addition to overall strategy, the Health Plan's response shall specifically address the following: 2) How the Health Plan will develop a Provider network that sufficiently addresses LTSS including HCBS.
Notes	

Health Plan Name:	
Section: 15.3.C.6 Evaluation Category 6 - Responsibilities and Requirements of DHS and Health Plans: Provider Networks; Provider Credentialing; Provider Contracts; and Other Functions for Providers (Section 8)	**Question:** 15.3.C.6.a.3 - Responsibilities and Requirements of DHS and Health Plans: Provider Networks; Provider Credentialing; Provider Contracts; and Other Functions for Providers Requirements (Limit to six [6] pages)
Maximum Question Points: 50 points	**Rating (0-5):**
Question	a. The Health Plan shall describe its proposed network development strategy, including addressing workforce shortages, to meet all contract requirements and allow for timely availability and access to a continuum of physical health, behavioral health, and LTSS providers. In addition to overall strategy, the Health Plan's response shall specifically address the following: 3) Innovative contracting methods or strategies the Health Plan will implement to recruit and retain providers, including specialists, in rural and underserved areas on island(s) the Health Plans will serve. The Health Plan shall include a statement to confirm collaboration with other Health Plans on the expanded use of Telehealth to address access to services and workforce shortages.
Notes	

<table>
<tr><td colspan="3">Health Plan Name:</td></tr>
<tr><td colspan="2">Section: 15.3.C.7 Evaluation Category 7 – Responsibilities and Requirements of DHS and Health Plans: Eligibility, Enrollment, Disenrollment, continuity of Care, and Grievance and Appeals (Section 9)</td><td>Question: 15.3.C.7.a Responsibilities and Requirements of DHS and Health Plans: Eligibility, Enrollment, Disenrollment, continuity of Care, and Grievance and Appeals Requirements (Limit to five [5] pages)</td></tr>
<tr><td colspan="2">Maximum Question Points: 60 points</td><td>Rating (0-5):</td></tr>
<tr><td>Question</td><td colspan="2">a. Describe innovative methods for communicating, including education and outreach, with the Members as follows:
1) Approach to identifying, developing, and distributing materials that will be of most use to the Member populations, and efforts the Health Plan proposes to target distribution to specific populations as appropriate. The Health Plan shall describe its methods of using culturally appropriate communications to meet the diverse needs and communication preferences of the Members, including but not limited to individuals with diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity.

2) Describe innovative technologies the Health Plan will use to ensure high levels of QI Member engagement, as methods to educate the Members and advance their own involvement in their healthcare, and to communicate information specific to individual health conditions. The response should address the Health Plan’s experience in deploying technologies and identifying the populations to which the technologies would best apply.</td></tr>
<tr><td colspan="3">Notes</td></tr>
<tr><td colspan="3"></td></tr>
</table>

Health Plan Name:		
Section: 15.3.C.8 Evaluation Category 8 – Information Systems and Information Technology (Section 10)		**Question:** 15.3.C.8.a - Information Systems and Information Technology Requirements (Limit to five [5] pages)
Maximum Question Points: 50 points		**Rating (0-5):**
Question	a. The Health Plan shall describe its current state of compliance with the requirements set for in §10.2.C. Further, the Health Plan shall describe it approach and timeline for implementing any unmet systems and supports requirements, as applicable.	
Notes		

Health Plan Name:	
Section: 15.3.C.9 Evaluation Category 9 - Health Plan Personnel (Section 11)	**Question:** 15.3.C.9.a - Health Plan Personnel Requirements (Limit to five [5] pages)
Maximum Question Points: 50 points	**Rating (0-5):**
Question	a. Describe the Health Plan's proposed approach to staffing the Contract, including the following information at a minimum: 1) Description of how the organizational structure provides solutions for meeting programmatic goals specific to Hawaii's Medicaid program, the Members, providers, and other stakeholders. 2) Summary of mandated QI personnel for which resumes are requested in §11.2, including recruitment timelines and activities for which individuals have not been identified at the time of the proposal. Describe contingency plans should those positions continue to remain open after Contract Award.
Notes	

<table>
<tr><td colspan="3">Health Plan Name:</td></tr>
<tr><td colspan="2">Section: 15.3.C.10 Evaluation Category 10 Program Integrity (Section 12)</td><td>Question: 15.3.C.10.a - Program Integrity Requirements (Limit to five [5] pages)</td></tr>
<tr><td colspan="2">Maximum Question Points: 50 points</td><td>Rating (0-5):</td></tr>
<tr><td>Question</td><td colspan="2">a. The Health Plan shall describe its proposed Compliance Plan, including but not limited to the following:

1) The Health Plan’s FWA detection/prevention program activities for employees, caregivers and providers, including reporting and follow-up, continuous monitoring of compliance, identification and reporting of issues to all required parties, and ongoing training.

2) A description of the Compliance Committee including Compliance Officer and Special Investigation Unit, and how the Heath Plan works with DHS and Hawaii’s MFCU.

3) Proposed innovations for analyzing and reporting data in the program integrity area. Provide at least one example of successful innovation implemented.</td></tr>
<tr><td colspan="3">Notes</td></tr>
<tr><td colspan="3"></td></tr>
</table>

SCORE SHEET

Technical Proposal Evaluation Categories	RFP Evaluation Section	Maximum Points Possible	Health Plan Score	Health Plan Points
Evaluation Category 1 Care Delivery and Health Coordination (Section 3)	**Section 15.3.C.1**	**190**		
Describe the Health Plan's unique approach to utilizing a multi-disciplinary team to provide primary care and behavioral health services across the continuum of HCS.	Question 15.3.C.1.a	50		
Describe the Health Plan's experience and innovations to meet and monitor the behavioral health needs of members receiving HCS.	Question 15.3.C.1.b	40		
Describe the Health Plan's experience with innovations for health coordination of LTSS.	Question 15.3.C.1.c	60		
Describe the Health Plan's experience with innovations in providing health coordination for people experiencing homelessness or at risk of homelessness.	Question 15.3.C.1.d	40		
Evaluation Category 2. Covered Benefits and Services (Section 4)	**Section 15.3.C.2**	**175**		
Describe the Health Plan's experience and innovative approaches providing covered benefits and services, 1) addressing the needs of unique Hawaii populations; and 2) approaches to EPSDT.	Question 15.3.C.2.a	75		
Describe the Health Plan's experience, innovative strategies, and comprehensive approach to provide prevention and health promotion services.	Question 15.3.C.2.b	50		

Technical Proposal Evaluation Categories	RFP Evaluation Section	Maximum Points Possible	Health Plan Score	Health Plan Points
Describe any value-added services the Health Plan can offer.	Question 15.3.C.2.c	50		
Evaluation Category 3. Quality, Utilization Management, and Administrative Requirements (Section 5)	**Section 15.3.C.3**	**70**		
Describe the Health Plan's experience and innovative approach to 1) supporting and evaluating Providers in conducting quality improvement activities; 2) increasing rates of high value care and reducing variation; and 3) leveraging PIPs to support wide-scale adoption of successful practices.	Question 15.3.C.3.a	50		
Utilization Management	Question 15.3.C.3.b	20		
Evaluation Category 4. Health Plan Reporting and Encounter Data (Section 6)	**Section 15.3.C.4**	**50**		
Describe the Health Plan's utilization of report and data to resolve issues.	Question 15.3.C.4.a	50		
Evaluation Category 5. DHS and Health Plan Financial Responsibilities (Section 7)	**Section 15.3.C.5**	**125**		
Incentive Strategies for Health Plan providers	Question 15.3.C.5.a	50		
VBP	Question 15.3.C.5.b	50		
Investing and incentivizing in primary care	Question 15.3.C.5.c	25		

Technical Proposal Evaluation Categories	RFP Evaluation Section	Maximum Points Possible	Health Plan Score	Health Plan Points
Evaluation Category 6. Responsibilities and Requirements of DHS and Health Plans: Provider Networks, Provider Credentialing, Provider Contracts, and Other Functions for Providers (Section 8)	**Section 15.3.C.6**	**130**		
Network Development Description for Individuals with Behavior Health and SUDs	Question 15.3.C.6.a.1	40		
Network Development Description for LTSS	Question 15.3.C.6.a.2	40		
Network Development Description on innovative methods to recruit and retain providers	Question 15.3.C.6.a.3	50		
Evaluation Category 7. Responsibilities and Requirements of DHS and Health Plans: Eligibility, Enrollment, Disenrollment, Continuity of Care, and Grievance and Appeals (Section 9)	**Section 15.3.C.7**	**60**		
Describe the Health Plan's innovative methods for communicating, including education and outreach, 1) identifying, developing, and distributing materials that will be of most use to Member populations; 2) innovative technologies the Health Plan will use to ensure high levels of QI Member engagement.	Question 15.3.C.7.a	60		
Evaluation Category 8. Information Systems and Information Technology (Section 10)	**Section 15.3.C.8**	**50**		

Technical Proposal Evaluation Categories	RFP Evaluation Section	Maximum Points Possible	Health Plan Score	Health Plan Points
Describe the Health Plan's compliance with expected functionality; timeline for implementing any unmet systems and supports requirements.	Question 15.3.C.8.a	50		
Evaluation Category 9. Health Plan Personnel (Section 11)	**Section 15.3.C.9**	**50**		
Describe the Health Plan's approach to staffing.	Question 15.3.C.9.a	50		
Evaluation Category 10. Program Integrity (Section 12)	**Section 15.3.C.10**	**50**		
Describe the Health Plan's Compliance Plan.	Question 15.3.C.10.a	50		
Health Plan Proposes Statewide		**50**		
Total Possible Points		**1,000**		