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Section: 80.310 Experience and References (12 pages maximum not including attachments)	**Item:** 80.310 A/B/C/D Experience Narrative, Including Contract for Medicaid program clients, Letters of recommendation, and Previous Contract Termination
Applicable RFP Sections: N/A	**Maximum Item Points:** 100

Question

The applicant shall provide:

A. A narrative of its experience providing services to Medicaid populations in Hawaii and in other States. As part of this narrative, please indicate specific enrollment numbers if not provided elsewhere in Section 80.310. Also as part of this narrative the applicant may include experience of an affiliated company, a company with the same parent company as the applicant, and any subcontractors who will be providing direct services and that the applicant intends to use in the QUEST program;

B. A listing, in table format, of contracts for all Medicaid program clients (including those served by an affiliated company or a company with the same parent company as the applicant, and any subcontractors that are or have provided direct services and that the applicant intends to use in the QUEST program), past and present. This listing shall include the name, title, address, telephone number and e-mail address of the client and/or contract manager, the number of individuals the applicant has managed broken down by the type of membership (e.g. TANF and TANF related, foster children, aged, blind, disabled, etc.), and the number of years the applicant has been providing or had provided services for that program. In the interest of space, if the applicant has ten (10) or more contracts for the Medicaid programs that entail the provision of direct services, it is not necessary to include all contracts which do not entail direct service provision (e.g., administrative service arrangements);

C. Letters of recommendation that support the health plan's proposal. The health plan shall submit no more than ten (10) letters of recommendation. Letters of recommendation may be provided from: (1) member advocacy groups in the State or service region; (2) provider organizations in the State or service region; or (3) other persons or organizations that have had an opportunity to work with the health plan and can recommend their work in the QUEST program;

D. Information on: (1) whether or not any applicant contract (including those for an affiliate of the company, a company with the same parent company as the applicant, or any subcontractor that the applicant intends to use in the QUEST program to provide direct services) has been terminated or not renewed for non-performance or poor performance within the past five (5) years; and (2) whether the applicant (including an affiliate of the company, a company with the same parent company as the applicant or any subcontractor providing direct services) failed to complete a full contract term or self-terminated mid-contract. Please include information on the details of the termination, non-renewal, failure to complete a full contract term or self-termination;

The scores shall be based upon: This section shall be scored based upon:

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	A. The relevance of the experience in providing services to Medicaid enrollees in the State of Hawaii (experience in Hawaii shall be worth more points than experience providing services to Medicaid enrollees in another state); B. The relevance of the duration of the experience per Item #1 above (a longer duration of the experience shall be worth more points); and C. Whether or not a contract has been terminated or was not renewed due to non-performance or for poor performance.
Summary of Requirements	N/A
Response Considerations	1. Is the narrative clear, concise and convincing? Were concrete examples of the applicant's experience included in the narrative or was it general and vague? 2. Has the applicant had experience in providing services to Medicaid enrollees in the State of Hawaii? 3. How many years of relevant experience serving Medicaid enrollees in Hawaii or in other States does the applicant have? 4. Does the applicant have valuable letters of recommendation? Does their letters describe their performance well? 5. Does the applicant discuss any contract difficulties it has had and, if so, does the applicant offer a thorough explanation of how it handled these difficulties? 6. Remember that the RFP states that experience in Hawaii shall be worth more points than experience providing services to Medicaid enrollees in another state. 7. In addition, the duration of the experience per Item #5 above (a longer duration of the experience shall be worth more points).

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Section: 80.310 Experience and References (12 pages maximum not including attachments)	**Item:** 80.310 E. EQRO Evaluations
Applicable RFP Sections: N/A	**Maximum Item Points:** 30
Question	D. The applicant shall provide its most recent EQRO evaluations (July 2011) from the State of Hawaii. If the applicant is not currently providing services to Medical Assistance clients in the State of Hawaii, the applicant shall submit its most recent EQRO evaluation from at least two other states in which it has previously been or is currently operating. Note: this shall be cross-checked with references to ensure all EQROs have been submitted. The EQRO evaluations do not count towards the page limit.
Summary of Requirements	N/A
Response Considerations	1. Evaluate the EQRO report provided for the State of Hawaii. Is the health plan performing consistent with previous contractual requirements? 2. If the health plan did not submit State of Hawaii EQRO evaluation, how does their report describe their performance in another State? 3. To the extent that an EQRO report is negative, has the applicant shown any evidence that it has addressed the problems? (Check the narrative of experience to see if issues arising from a negative EQRO are addressed.) 4. What does the EQRO report tell us about member satisfaction with the applicant's plan? 5. How does the EQRO rate the applicant's quality monitoring plan? 6. What is the applicant's performance on quality and/or performance measures e.g. disease management programs or performance measures?

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Section: 80.310 Experience and References (12 pages maximum not including attachments)	**Item:** 80.310 F. EPSDT Measure for the Last 12 Months
Applicable RFP Sections: N/A	**Maximum Item Points:** 30
Question	E. EPSDT measures for the last twelve (12) month period from the State of Hawaii. If the applicant is not currently providing services to Medical Assistance clients in the State of Hawaii, the applicant shall submit its most recent EPSDT measures from at least two other states that it has previously or is currently operating. Please provide reference to the population reporting on and include geographic location and member demographics. The applicant shall indicate that measures were validated by an EQRO and provide the EQRO validation reports. Note: neither the EPSDT measures nor the EQRO validation reports count towards the page limit.
Summary of Requirements	N/A
Response Considerations	1. Does the applicant meet an 80% screening rate in Hawaii or any other State in which it operates? (Note: this is the federal standard.) 2. Are the EPSDT measures validated by an EQRO report? Is a validation report provided? 3. Does the applicant offer any narrative that it understands the importance of EPSDT and takes aggressive steps to increase its screening rate? (Note: a narrative is not required)

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Section: Provider Network (30 pages maximum ((includes Provider Services as well) not including attachments)	**Item:** 80.315.1-80.315.3 Provider Network Narrative/Required Providers/ Maps of Providers
Applicable RFP Sections: 40.200	**Maximum Item Points**: 150
Question	The applicant shall provide a narrative describing how it maintains its provider network serving Medicaid recipients in order to assure that all services are available to members. As part of this narrative, the applicant shall describe: A. In detail, how it will maintain its network to meets **all** required access standards required under this RFP, including, but not limited to, capacity standards (for acute care, primary care, and behavioral health) and geographic access requirements; B. How it monitors the provider network to ensure that access and availability standards are being met. As part of this description, please specifically address how the applicant ensures that acceptable appointment wait times are met and steps taken in the past, if any, in the past to address deficiencies in this area; C. How it will provide services when there are either no contracted providers or the number of providers fails to meet the minimum requirement; D. How it will recruit, retain, and incentivize providers in rural and other historically under-served areas to ensure access to care and services in these areas; E. Provide a summary of its PCP policies and procedures that includes information on choosing and selecting a PCP (including the PCP assignment process), describes who may serve as a PCP, referral to specialists, and describes who may serve as a PCP to members with chronic conditions; F. The provider network analysis for its Medicaid business in Hawaii. This analysis shall include: 1. The percent of PCPs who are Board certified; and 2. The percent of specialists who are Board certified in the specialty of their predominant practice. The applicant shall provide a listing of required providers and maps across the State of where their providers are in practice.
Summary of Requirements	• The health plan shall develop and maintain a provider network that is sufficient to ensure that all medically necessary covered QUEST services are accessible and available. At a minimum, the health plan shall have sufficient providers to ensure all access and appointment wait times defined in Sections 40.230 and 40.240 will be met. • Minimum requirements are established in the RFP for: • The types of providers (including behavioral health providers) that must be included in the health plan's network (Sections 40.220, 40.260, 40.270 and 40.280); • Wait times (Section 40.230); and

	• Geographic access standards (Section 40.240); • If the health plan's network is unable to provide medically necessary services to a particular member within its network or on the island of residence, the health plan shall adequately and timely provide these services out-of-network or transport the member to another island to access the service(s) for as long as it is unable to provide them on the island of residence (Section 41.100). • Quarterly, the health plan shall provide to the DHS a Provider Network Adequacy and Capacity Report that demonstrates that the health plan offers an appropriate range of preventive, primary care and specialty services that demonstrates that the provider network is adequate for the anticipated number of members for the service and that the network of providers is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. . • Each member shall have 10 days to select a qualified PCP or one will be assigned to him/her. The health plan shall allow specialists or other healthcare providers to serve as PCPs for members with chronic conditions when: o The member has selected a specialist with whom he or she has a historical relationship as his or her PCP; o The health plan has confirmed that the specialist agrees to assume the responsibilities of the PCP. Such confirmation may in writing, electronically or verbally; and o The health plan submits to the DHS prior to implementation a plan for monitoring their performance as PCPs.
Response Considerations	1. Does the applicant's plan for maintaining and improving on their network that gives you confidence that there is a solid network at this time and ongoing strategy for building on their current network? 2. When you review the GeoAccess maps, does the network seem to be sufficient to meet the needs of members living in remote or geographically diverse areas? 3. Does the applicant have specialists on islands other than Oahu? How about behavioral health providers? 4. Does the number of providers listed match the number of providers on the GeoAccess maps? 5. Did the applicant provide contract signature pages for contract verification if requested? 6. Does the applicant's description include information about how it maintains and continue to build on their network for all provider types: acute care, primary care, and behavioral health? 7. Does their provider network response indicate that the applicant has an understanding of potential problem areas and do the steps described to address these problem areas give you confidence they will be able to resolve issues? For example, is there a discussion of developing and improving their network in geographically remote areas? 8. If the applicant is already doing business in Hawaii, does the response rely on the existing network only? Does the applicant have a definitive plan for recruiting new providers and retaining and incentivizing their existing providers?

	9. Does the response contain specific information related to how the applicant will monitor its networks, including unannounced visits and techniques to assure network providers are compliant with appointment wait times? 10. Does the response offer specific steps it will take, and has taken in the past, if there are deficiencies in this area? 11. Does the applicant suggest creative ways to assure compliance with access standards or ways that it will deal with gaps in its network?

Section: Provider Services (30 pages maximum ((includes Provider Network as well) not including attachments)	**Item:** 80.315.4-80.315.5 Availability of Provider Narrative/ Provider Services Narrative
Applicable RFP Sections: 40.250 and 40.600	**Maximum Item Points:** 50
Question	1. Availability of Providers Narrative The applicant shall describe how it will ensure that PCPs fulfill their responsibilities for supervising and coordinating care for all assigned members and include assurances that no PCP has too many members to fulfill their responsibilities. As part of this, the applicant shall describe how it will monitor the performance of specialists or other health care providers who are permitted to serve as a PCP to members with chronic conditions. 2. Provider Services Narrative – General Requirements The applicant shall provide a comprehensive explanation of how it intends to meet provider services requirements described below to include: A. A description of how the applicant will meet the timeframes associated with prior authorizations as described in Section 50.900; B. A description of how it will communicate fraud and abuse requirements to providers; C. A description of how it will process claims in a timely manner, as described in Section 60.310, as well as work with providers to assure that claims are processed timely; and D. A description of how it will assure that providers meet medically necessary requirements including, but not limited to, EPSDT screening and HEDIS measures.
Summary of Requirements	• The health plan shall have processes in place to assure that PCPs fulfill their requirements listed in Section 40.250. These responsibilities include supervising, coordinating, and providing all primary care to each assigned member. In addition, the PCP is responsible for coordinating and initiating referrals for specialty care (both in and out-of-network), maintaining continuity of each member's health care and maintaining the member's medical record that includes documentation of all services provided by the PCP as well as any specialty services. • The health plans shall work with their PCPs/providers to assure that EPSDT screening is completed within DHS established time limits and HEDIS scores are increased. • The health plan shall process prior authorizations within timeframes established in Section 50.900. • The health plan shall process claims in a timely manner (90% of clean claims within 30 days and 99% of clean claims within 90 days). Other Provider Services requirements: • The health plan shall educate providers on all QUEST program requirements. Training shall occur prior to the Date of Commencement of Services to Members (Section 20.100) and ongoing education sessions at least

	every six (6) months. • The health plan shall have a provider complaint, grievance and appeals process that provides for the timely and effective resolution of any disputes between the health plan and provider(s). • The health plan shall develop a provider manual, with specific criteria, that shall be made available to all providers. The health plan may provide an electronic version only (via link to the health plan's web-site or on a CD-ROM or other appropriate storage disc) unless the provider requests a hard copy. Updates to the electronic version of the manual shall be made immediately (not more than five (5) days following a change to it) and the health plan shall notify all providers, in writing, of any changes. • The health plan shall operate a toll-free provider call center to respond to provider questions comments, inquiries and requests for prior authorizations. The provider call center shall be fully staffed between the hours of 7:45am (H.S.T.) and 4:30pm (H.S.T.), Monday through Friday, excluding State holidays, and shall adhere to specific performance standards. • The health plan shall have a provider portal on its web-site that includes all pertinent provider information, such as the provider manual and sample provider contracts. The web-site shall have the functionality to allow providers to make inquiries and receive responses from the health plan.
Response Considerations	1. Does the applicant describe how it will ensure their PCPs are fulfilling their responsibilities? 2. Does the applicant describe how they will address assignment of PCP? Has the applicant factored in the reduction to 1 to 300 for PCP assignment (Section 40.250)? 3. Does the applicant describe how it will monitor the specialists serving as a PCP for members with chronic conditions? 4. Does the applicant describe how they will interact with their PCPs/providers to assure that EPSDT screening is completed within DHS established time limits? 5. Does the applicant describe how they will interact with providers to assure HEDIS scores are increased? 6. Does the applicant describe their process for assuring prior authorizations are implemented within timeframes established in Section 50.900? 7. Does the applicant describe their process for assuring claims are processed in a timely manner (90% of clean claims within 30 days and 99% of clean claims within 90 days)? Other Provider Services Requirements: 8. Does the applicant provide a comprehensive description that addresses all components of the question? 9. Does the applicant indicate the types of education sessions it will provide, the number of sessions and the timeframe and frequency for offering the sessions? 10. Does the applicant indicate how it will evaluate the effectiveness and appropriateness of the sessions offered? 11. Does the applicant provide an example of how it has handled provider non-compliance with provider agreement

	and program requirements? Does the applicant's example give you confidence that it can address noncompliance situations in QUEST in an appropriate and timely manner? 12. Does the applicant include a description of the provider grievance, complaints and appeals process? 13. Does the applicant provide a description of how it will update providers of major changes in the program? Does the description provide for timely dissemination of all major changes? 14. Do you have confidence from the description that the applicant has a good understanding of what is considered a major programmatic change? 15. Does the applicant provide a description of how it will train provider services staff responsible for manning the provider call-center? Does the description provide a comprehensive training plan that address initial training, ongoing refresher training and interim training when program updates and/or changes occur?

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Section: 80.320 Covered Benefits and Services (30 pages maximum)	**Item:** 80.320.1. Covered Benefits and Services Narrative
Applicable RFP Sections: 40.700	**Maximum Item Points:** 30 points

Question	The applicant shall describe: A. Its experience providing, on a capitated basis, the primary, acute care, and behavioral health covered benefits and services as described in Section 40.700. This description shall indicate: 1. The extent to which this experience is for a population comparable to that in the programs; 2. Which covered benefits and services the applicant does not have experience providing and how they intend to obtain the experience to provide these services; and 3. The proposal for providing the covered benefits and services required in this RFP, including whether or not the applicant intends to use a subcontractor and, if so, how the subcontractor will be monitored. B. Whether the applicant intends to provide additional services not required but allowed for in Section 40.700 and how it intends to provide these services; C. Its experience in providing services to members with special health care needs, including how it has identified such individuals and how it has provided needed services. In addition, the applicant shall describe how it intends to provide these services to its members in Hawaii; and D. Its competency serving the cultures in Hawaii and understanding the population served by the State's Medical Assistance program.
Summary of Requirements	1. The health plan shall be responsible for providing defined medically necessary primary, acute and behavioral health services to all eligible QUEST members. 2. The health plan shall assure that children under the age of 21 receive services defined in the QUEST Keiki benefit package. 3. The health plan shall assure that adults age 21 years and older receive services defined in the QUEST Adult benefit package.
Response Considerations	1. Does the applicant provide a comprehensive description of how it will approach delivering primary and acute care services and behavioral health services as described in Section 40.700 to the QUEST population? 2. Is the applicant's delivery approach appropriate to address the needs of the QUEST population? 3. Does the applicant's description include its previous experience? 4. Does the applicant indicate that there services it does not have experience providing? If yes, does the applicant indicate how it will compensate for this shortcoming? 5. Does the applicant indicate if it will use subcontractors to provide services? If it will use subcontractors, does it indicate how it will select and monitor subcontractors? Does the description indicate the qualifications/standards/criteria that will be used to select subcontractors? Does the applicant indicate the types

	of monitoring activities that will be used (i.e. reporting, onsite monitoring, member surveys and other feedback) and the frequency of these activities? Does the applicant indicate the measures that will be taken if a subcontractor is determined not to meet contract requirements? 6. Does the response give you confidence that the applicant is capable of competently providing the services that are required by the RFP and needed by QUEST members? 7. Does the applicant indicate if they intend to provide additional services not identified in Section 40.700 and how they intend to provide those services? 8. Does the applicant describe its experience in providing services for members with a special health care need? Does the applicant describe how they intend to provide these services to the QUEST population under this new program? 9. Does the applicant describe their competence in serving cultures in Hawaii? Does the applicant describe their understanding of the Medical Assistance program members that will be served under this contract?

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Section: 80.320 Covered Benefits and Services (30 pages maximum)	**Item:** 80.320.2 Behavioral Health Narrative
Applicable RFP Sections: 40.740.2	**Maximum Item Points:** 30
Question	The applicant shall describe its planned approach to providing behavioral health and substance abuse services as required in Section 40.740.2. Specifically describe how the following requirement will be implemented: A. Assessment of behavioral health needs; B. Assurance of case management within acuity levels; C. Assurance of medication refills for psychotropic medications; D. Prevention of unnecessary emergency room utilization and acute psychiatric hospitalizations; and E. Follow-up after acute psychiatric hospitalizations.
Summary of Requirements	• The health plan shall provide behavioral health services to their members that require these services. • The health plan shall provide both standard and additional behavioral health services.
Response Considerations	• Does the applicant describe how they will assess members for behavioral health needs (primarily their members requiring additional behavioral health services)? • Does the applicant describe the following: a. Assure case management is provided within established acuity levels? b. Assure medication refills for psychotropic medications for their members with a diagnosis of SPMI? c. Prevention of unnecessary emergency room visits and acute psychiatric hospitalization? d. Assure follow-up care after acute psychiatric hospitalization? • Does the response give you confidence that the applicant understands the concept of managing their members who require additional behavioral health services and will be capable of managing them?

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Section: 80.320 Covered Benefits and Services (30 pages maximum)	**Item:** 80.320.3 Prescription Drug Narrative
Applicable RFP Sections: 40.740.1.o	**Maximum Item Points:** 30

Question	The applicant shall detail how it intends to maximize generic prescribing, minimize use of brand-name prescriptions, manage prescription drug costs, and implement Section 346-59.9, HRS, Psychotropic medication law.
Summary of Requirements	• The health plan shall provide their members with medications that are medically necessary to optimize their member's condition to include medication management and patient counseling. • The health plan may develop a common formulary for their members to use. • Health plans are required to assure that members are not denied access to or have any limitations on antipsychotic medications and continuation of antidepressant and anti-anxiety medications. • Health plans shall have in effect processes to prevent prior authorization of medications to treat HIV or Hepatitis C or in need of transplant immunosuppressives.
Response Considerations	1. Does the applicant provide a comprehensive description of how they intend to assure a formulary that maximizes generic prescribing and minimizes unnecessary use of brand medications? 2. Does the applicant describe how they intend to manage their prescription drug costs? 3. Does the applicant describe their processes to assure no denial of access or limitations on antipsychotic, continuing antidepressant, or anti-anxiety medications? 4. Does the applicant describe their processes to assure no prior authorization of medications to treat HIV, Hepatitis C? 5. Does the applicant describe their process to assure no prior authorization for immunosuppressives for transplantation?

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Section: 80.320 Covered Benefits and Services (30 pages maximum)	**Item:** 80.320.4 Early and Periodic Screening Diagnosis and Treatment (EPSDT) Narrative
Applicable RFP Sections: 40.753	**Maximum Item Points:** 30
Question	The applicant shall describe: A. Its interactions with community partners including, but not limited to, The American Academy of Pediatrics - Hawaii Chapter or Hilopa'a Family to Family Health Information Center, to promote ESPDT awareness; B. The procedures it will follow to address the following situations: 1. A parent who is not adhering to periodicity schedules; and 2. A parent who is not following up with the children's referrals for diagnostic treatment services; and C. The applicant shall provide specific data from its largest Medicaid contract with documentation to verify the statistics on the: 1. Percentage of children who receive all screenings pursuant to the pediatric periodicity schedule; 2. Percentage of children identified for referral to follow-up services; and 3. Percentage of children so identified who actually receive follow-up services.
Summary of Requirements	• The health plan shall develop an EPSDT plan that includes written policies and procedures for outreach, informing, tracking, and following-up with members, families, and providers to ensure compliance with the periodicity schedules. • The EPSDT plan shall emphasize outreach and compliance monitoring for members under age twenty-one (21) years, taking into account the multi-lingual, multi-cultural nature of the member population, as well as other unique characteristics of this population. • The EPSDT plan shall include procedures for follow-up of missed appointments, including missed referral appointments for problems identified through EPSDT screens and exams. • The health plan shall also include procedures for referrals to the DHS contractor providing dental care coordination services for the Medicaid fee-for-service program for needed dental care. • The health plan shall submit documentation to the MQD regarding their EPSDT program on the CMS 416.
Response Considerations	1. Does the applicant address all required elements and offer a comprehensive approach to EPSDT? 2. Does the applicant describe their relationships with the community to promote ESPDT awareness? 3. Does the applicant describe how they will work with parents that are missing both periodicity schedule screening and follow-up referrals? 4. Does the applicant describe their methods to collect data for EPSDT? 5. Did the applicant provide any of this information addressing their EPSDT statistics? 6. Is the applicant tracking not only screens and members that have been referred but the children that have received follow-up services from the referrals?

Section: 80.320 Covered Benefits and Services (30 pages maximum)		**Item:** 80.320.5 Care Coordination/Case Management (CC/CM) System/Services Narrative
Applicable RFP Sections: 40.751 and 40.752		**Maximum Item Points:** 30
Question	The applicant shall provide a comprehensive description of its CC/CM system/services (either in Hawaii, another state, or its proposed CC/CM system/services for Hawaii), including policies and procedures as well as mechanisms developed for providing CC/CM system/services. The applicant shall describe how it shall meet the requirements in RFP Section 40.752 - Care Coordination/Case Management System, and RFP Section 40.751 - Services for Members with Special Health Care Needs (SHCNs). At a minimum, the applicant shall describe and address: A. The organizational structure of its CC/CM system and services including the staff to member caseload ratios; B. How the CC/CM system ensures that members, family/designated representatives, providers and health plan staff are informed about the availability of CC/CM services, how to make a referral for services, and how to access services during and after regular working hours; C. The needs assessment process including the criteria used to screen/identify members in need of CC/CM services; D. If the applicant elects to develop differing levels of CC/CM services, a description of the levels of services, the criteria to be used in determining what level of service a member will receive and how cases are prioritized; E. How the CC/CM system addresses coordination and follow-up of outpatient and inpatient care/service needs as well as referrals to, and coordination with, community-based resources/services that provide services that are not covered by the programs; F. The processes for monitoring emergency room utilization and informing members of options for urgent care, after-hours care, and twenty-four hour nurse line; G. The processes for receiving and sharing pertinent information, and interfacing with the member, the member's PCP and other relevant providers, and as appropriate, the member's family, and applicant departments, to promote continuity of care and coordination of services. In addition, discuss how the member and/or the member's family are involved in the process for decisions regarding care; H. The mechanisms to ensure that the implementation of the member's treatment plan is monitored/evaluated for effectiveness, and is revised as frequently as the member's condition warrants; I. The requirements for documentation of all CC/CM activities; J. The criteria for discontinuing CC/CM services; K. How the CC/CM system is linked to the applicant's information system. This description shall include how the	

	information system tracks CC/CM activities, support evaluation of the CC/CM system and generate reports; L. How the applicant will identify and manage its highest risk (top 1%) members; and M. How applicant CC/CM activities will be coordinated with and may be delegated to providers.
Summary of Requirements	• The health plan shall have CC/CM system/services that complies with the requirements in 42 CFR 438.208 and is subject to DHS approval. • At a minimum, the CC/CM system shall provide for: o Timely access and delivery of health care/services required by members; o Continuity of care for members; and o Coordination and integration care for of members. • The health plan shall assess all members with special health care needs (SHCN) within thirty (30) days of identification by the PCP or the health plan. • The health plan shall develop a treatment plan in conjunction with the member's PCP and the member. Once approved, the treatment plan shall be implemented.
Response Considerations	1. Does the description address all required elements and offer a comprehensive approach to care coordination/case management (CC/CM)? 2. Does the process include the staff to member caseload ratios? 3. Does the applicant describe how they will inform the members, family/designated representatives, providers and health plan staff about the availability of CC/CM services, how to make a referral for services, and how to access services during and after regular working hours? 4. Does the needs assessment process including the criteria used to screen/identify members in need of CC/CM services? 5. Does the applicant elect to develop differing levels of CC/CM services? 6. Does the applicant provide a description of the levels of services, the criteria to be used in determining what level of service a member will receive and how cases are prioritized? 7. Does the applicant describe how the CC/CM system addresses coordination and follow-up of outpatient and inpatient care/service needs as well as referrals to, and coordination with, community-based resources/services that provide services that are not covered by the programs? 8. Do the processes for monitoring emergency room utilization include informing members of options for urgent care, after-hours care, and twenty-four hour nurse line? 9. Do the processes for receiving and sharing pertinent information, and interfacing with the member, the member's PCP and other relevant providers, and as appropriate, the member's family, and applicant departments, to promote continuity of care and coordination of services? 10. Did the applicant discuss how the member and/or the member's family are involved in the process for decisions

	regarding care? 11. Does the applicant describe their mechanisms to ensure that the implementation of the member's treatment plan is monitored/evaluated for effectiveness, and is revised as frequently as the member's condition warrants? 12. Does the applicant describe how they will document all of the CC/CM activities? 13. Does the process describe the criteria for discontinuing CC/CM services? 14. Does the process describe how the CC/CM system is linked to the applicant's information system including support activities, evaluation and generation of reports? 15. Does the applicant describe how they will identify and manage its highest risk (top 1%) members? 16. Does the applicant describe how the CC/CM activities will be coordinated with and may be delegated to providers?

Section: 80.320 Covered Benefits and Services (30 pages maximum)		**Item:** 80.320.6 Transition of Care Narrative
Applicable RFP Sections: 41.300		**Maximum Item Points:** 30
Question	The applicant shall describe how it will ensure that members transitioning into its health plan receive appropriate care, including how it will honor prior authorizations from a different QUEST health plan or a QExA health plan. The applicant shall also describe how it will coordinate with a new health plan when one of its member's transitions out of its health plan and into a different QUEST health plan or a QExA health plan. As part of this narrative, please provide specific examples.	
Summary of Requirements	**To the Health Plan** • The health plan shall provide continuation of such services for at least forty-five (45) days or until the member's medical needs have been assessed or reassessed by the PCP. • The health plan shall reimburse PCP services that the member may access during the forty-five (45) days prior to transition to their new PCP; even if the former PCP is not in the network of the new health plan. • In the event the member entering the health plan is in her second or third trimester of pregnancy and is receiving medically necessary covered prenatal services the day before enrollment, the health plan shall be responsible for providing continued access to the prenatal care provider (whether contract or non-contract) through the postpartum period. **From the Health Plan** • The former health plan shall remain responsible for the care and the cost of the inpatient services (as provided in Section 50.210) provided to the member, if hospitalized, until discharge or level of care changes, whichever occurs first. • The former health plan shall cooperate with the member and the new health plan when notified in transitioning the care of a member who is enrolling in a new health plan. • The former health plan shall submit transition of care information to DHS utilizing a format specified by DHS for transition to the new health plan within five (5) business days of the former health plan being notified of the transition. • The former health plan shall assure that the DHS or the new health plan has access to the member's medical records and any other vital information that the former health plan has to facilitate transition of care. The health plan shall develop transition of care policies and procedures that address all transition of care requirements in this RFP.	

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Response Considerations	1. How will the applicant accept and load new member prior authorization (PA), utilization, transportation manifests, and other enrollee information into its system? 2. Once loaded, how will the applicant use PA and other data to identify new members with recurring transportation and treatment needs? How will the applicant work to ensure that new members experience no interruptions in services (including in transportation) and their treatment? 3. Does the applicant discuss its coordination of care protocols for new members who are pregnant women? 4. Does the applicant explain which individual staff members/organization units have the express responsibility for transitioning members in hospitals who transition out of the applicant's health plan? Specifically, how will the health plan staff coordinate with the social workers and discharge planners at those facilities? 5. Regarding previously-authorized, medically necessary covered services for new members, does the applicant discuss how it will ensure that its systems do not allow either staff or system defaults to effectively impose new PA requests? 6. With which subcontractors will the applicant need to share PA and other data? Does the applicant have a plan for doing so – and for ensuring that the subcontractor uses the data to ensure that new members experience no interruptions of services or treatment? 7. Does the applicant provide a comprehensive description of how it will coordinate and work with the other health plan when a members transitions out? 8. Does the applicant provide specific examples that are relevant to the QUEST population?

Basis of Award(s) for QUEST RFP-MQD-2011-008

Section: 80.325 Member Services (18 pages maximum)	**Item:** 80.325.1 General Member Services Narrative
Applicable RFP Sections: 50.400 inclusive (excluding Section 50.480)	**Maximum Item Points:** 70

Question	The applicant shall describe: A. How it will review and update members' annually on changes to their member handbook; B. How it will ensure that all member information provided or sent to members is written at a grade school level of 6.9 or lower as described in Section 50.430; C. How it will assure interpretation services are available to members that speak a language other than English as their primary language; and D. How it will notify members of the availability of oral interpretation services as required in Section 50.495.
Summary of Requirements	• The health plan shall issue a new member enrollment packet within ten (10) days of receiving the notification of enrollment from the DHS. Section 50.200 lists the required contents of the packet. • The health plan shall convey information to members about their rights responsibilities, the role of PCPs, how to obtain care, what to do in an emergency or urgent medical situation, how to file a grievance or appeal, and how to report suspected fraud and abuse. The health plan shall educate it members (Section 50.420). The health plan may use interactive methods (e.g., telephone, internet, or face-to-face communications). • The health plan shall mail to all enrolled members a member handbook at least annually (the first to be included in the enrollment packet). The health plan shall update and re-print the member handbook at least annually, though the plan may request a waiver of the re-print requirement if there have been no changes. Section 50.440 outlines the requirements of the member handbook. • The health plan shall notify its members in writing and at least thirty (30) days in advance of any significant change(s) to the program information members have received. • The health plan shall produce a provider directory organized by island and then by provider type/specialty. The health plan shall mail a hard copy to its member as part of the member handbook packet as described in Section 50.400. Section 50.460 outlines the requirements of the provider directory. • The health plan shall issue a member identification (ID) card that includes their name, ID number, both effective and expiration date, PCP name and telephone number, Benefit or other limit (i.e., QUEST Keiki or QUEST Adult), and Third Party Liability (TPL) information (Section 50.470). • The health plan shall have a member portal on its website with accurate, up-to-date information about the health plan, services provided, the provider network (updated monthly), FAQs, and contact phone numbers and e-mail addresses. This portal shall include a real-time system to track utilization of limited member benefits. • The health plan shall develop member services policies and procedures that address all components of member services; Section 50.410 lists the required components.

Response Considerations	1. Does the applicant describe their process for reviewing and updating the members' annually on changes to their member handbook? 2. Does the applicant discuss how it will ensure that the content of the written materials will meet the reading level requirements (defined in Section 50.430)? 3. Does the applicant discuss how it will ensure that non-English versions of all written materials are translated correctly and are available in Tagalog, Chinese (traditional), Vietnamese and Korean? 4. Does the applicant discuss its process for submitting all written materials to DHS for review/approval prior to use and distribution? 5. Does the applicant discuss its update procedures, including outreach to persons with limited literacy and those who speak other languages? Other Member Services requirements: 6. Does the applicant describe a distribution process that is able to meet the required time-frames? Note that a more automated process is more likely to result in timely distribution. 7. Though not specifically asked, a thorough response might also include information on how the applicant will track down members when mail is returned. Does the plan indicate what follow-up that it plans to do? 8. Does the applicant discuss how it will provide member education to persons with limited literacy? How will the applicant identify these individuals and provide outreach to ensure that they understand their rights and responsibilities, the managed care system, etc.? 9. Does the applicant describe a reasonable process for maintaining up-to-date information in the provider directory? Specifically, does the applicant provide a persuasive description of how it will collect and maintain accurate information as to whether individual providers are accepting new patients? For example, applicants might issue regular requests for form updates via mail or on-line and/or have a verification process for information in the directory.

Basis of Award(s) for QUEST RFP-MQD-2011-008

Section: 80.345 Member Services (18 pages maximum)	**Item:** 80.325.2 Toll-free Call Center & 24-Hour Nurse Line
Applicable RFP Sections: 50.480	**Maximum Item Points: 60**

Question	The applicant shall provide a comprehensive description explaining how it will operate the required toll-free call center and nurse line. At a minimum, the applicant shall describe for both the call center and the nurse line: A. Its training curricula and schedule for training call center staff for both the call center and the nurse line, including ongoing training and training when program changes occur; B. How it will route calls among staff to ensure timely and accurate response to member inquiries, including procedures for referring the calls to supervisors or managers; C. How it will ensure that the telephone call center and nurse line staff can handle calls from non-English speaking callers and from members who are hearing impaired, including the number of hotline staff that are fluent in one of the State-identified prevalent non-English languages; and D. How it will monitor compliance with performance standards outlined in Section 50.480 and what it will do in the event they are not being met.
Summary of Requirements	• The health plan shall operate a toll-free call center to respond to member questions, comments and inquiries. The call center staff shall be trained to respond to member questions in all areas, including, but not limited to, covered services, the provider network, and non-emergency transportation (NET). • The call center shall be available on all islands that the health plans serves and be fully staffed between the hours of 7:45 a.m. (H.S.T.) and 4:30 p.m. (H.S.T.), Monday through Friday, excluding State holidays. • The health plan shall also have an ”after-hours” automated system or answering service, which shall provide callers with operating instructions on what to do in case of an emergency. The system shall also provide an option to talk directly to a nurse or other clinician and include a voice mailbox for members to leave messages. The health plan shall ensure that the voice mailbox has adequate capacity to receive all messages and that representatives return all calls by close of business the following business day. • The health plan shall have a twenty-four (24) hour, seven (7) day a week, toll-free nurse line available to members. The health plan may use the same number as is used for the call center or may develop a different phone number. Staff on the toll-free nurse line must be a registered nurse (R.N.), physician’s assistant, nurse practitioner, or medical doctor. The primary intent is through triage to decrease inappropriate utilization of emergency rooms and improve coordination and continuity of care with an individual's PCP. However, having the phone line staffed by someone who is also able to provide treatment as appropriate is encouraged. • Section 50.480 specifies the performance standards for the call center and the nurse advice lines. • The call centers shall provide both interpretation services for all languages as well as TDD services without any charge to members.
Response	1. Does the member services training curriculum cover all core program components (e.g., scope of coverage,

Considerations	provider network, disease management/care coordination, grievance/appeals, etc.)? 2. Does the applicant discuss on-going monitoring for re-training of call center representatives for both the member services and the nurse advice line? Also, what ongoing clinical education/training does the provider plan for the nurse advice line staff? 3. Does the applicant discuss how it addresses or plans to address industry-wide concerns about attrition rates among call center staff? 4. If the applicant plans to use call center representatives who serve other programs, does the applicant explain how it will train these staff members so that they will be familiar with QUEST? 5. For both the member services and the nurse advice line, how will the applicant monitor call representatives' phone etiquette and accuracy of responses? Examples might include random telephone monitoring of service line and use of recorded calls. 6. For both the member services and the nurse advice line, is the process of routing/transferring calls sufficiently automated such that the applicant will be able to handle the volume of calls? 7. Does the applicant's narrative include a description of how calls from non-English-speaking members will be routed to ensure accurate and timely responses? Does the process make sense and seem workable? 8. For both the member services and the nurse advice line, does the applicant have bilingual or multi-lingual staff? Have they made a commitment to ensuring they have enough translators (e.g. might pay people more if they speak multiple languages)? 9. For both the member services and the nurse advice line, does the applicant have a relay services or other Telecommunications for the Deaf (TDD) operator? 10. Is it clear from the description of after-hours procedures that members will be informed of what to do in the case of an emergency and that there is a process to ensure that callers who have left a message receive a return call be the next business day? 11. Does the after-hours line provide a direct connection to the nurse advice line? 12. If the applicant plans to use a call center that will also serve other programs, does the applicant discuss how it will "segregate" the QUEST calls for monitoring and reporting purposes? 13. Does the applicant demonstrate that it can effectively monitor the phone line(s) to ensure compliance with the timeliness and other performance standards? 14. Though not requested, does the applicant discuss its minimum ratios either for (a) telephone lines:members or (b) operators:members? 15. Has the applicant discussed its capacity to adapt to surges in call activity? Also, how will the applicant address the typical spike in call volumes on Mondays and the business days following state holidays? 16. Does the applicant discuss which if any components of its operation will have separate phone numbers (e.g.,

	transportation, etc.)? How will the applicant monitor and report on this call activity? 17. Does the applicant describe what it will do if it does not meet the performance standards for one or more periods?

Basis of Award(s) for QUEST RFP-MQD-2011-008

Section: 80.325 Member Services (18 pages maximum)	**Item:** 80.325.3 Member Grievance System Narrative
Applicable RFP Sections: 51.100	**Maximum Item Points: 70**
Question	The applicant shall provide a narrative describing the member grievance system it is currently using in Hawaii or another state. In your narrative, please provide: A. A description of how the applicant determines a grievance to include but not limited to customer service calls or calls to other health plan personnel; B. An explanation of how member grievances and appeals are tracked and trended; C. A description of the training provided to staff who handle member grievances and appeals; D. A description of how staff performance and operational processes are monitored and adapted to ensure compliance with member grievance system requirements to include but not limited to meeting required timeframes identified in Section 51.100.
Summary of Requirements	• The health plan shall have a formal grievance system that is consistent with the RFP and 42 CFR Part 438, Subpart F. • The member grievance system shall include an inquiry process, a grievance process and appeals process. • The health plan's grievance system shall provide information to members on accessing to the State's administrative hearing system. • The health plan shall require that members exhaust its internal grievance system prior to accessing the State's administrative hearing system. • The health plan shall have policies and procedures that describe its member grievance system. • The health plan shall help their members complete forms, provide interpreter services, and have access to TTY/TDD.
Response Considerations	1. Does the health plan describe its process for determining a grievance? For calls that come into the call center or to other health plan personnel, what becomes a grievance? 2. Does the health plan describe how they train their staff on identifying grievances? 3. Does the health plan describe how they track and trend their member grievances and appeals? 4. Does the health plan describe staff training on handling both member grievances and appeals? 5. Does the health plan include their processes for assuring that timelines are met in the grievance/appeals process? 6. Do the processes sound reasonable? Do the processes that are describe seem sound? 7. Does the health plan describe their monitoring to assure compliant with RFP and CFR? 8. Does the monitoring include staff oversight?

Basis of Award(s) for QUEST RFP-MQD-2011-008

Section: 80.330 QAPI (36 pages maximum)		**Item:** 80.330.1 QAPI Program Narrative
Applicable RFP Sections: 50.730		**Maximum Item Points:** 10
Question	The applicant shall provide the following information relative to its QAPI program: A. A description of the governing body accountable for providing organizational governance of the applicant's QAPI Program, a description of the governing body's responsibilities, a description of how it exercises these responsibilities, and the frequency of meetings; B. A description of the committee/group responsible for developing, implementing and overseeing QAPI Program activities/operations including: 1. A description of the committee's specific functions/ responsibilities, how it exercises these responsibilities, and the frequency of its meetings; 2. A description of the composition/membership of this committee including information on: o The chairperson(s) – including title(s), and for physicians, provide specialty; o Physician membership - including the total number and types of specialties represented; o The physician designated to have substantial involvement in the QAPI Program; and o The licensed behavioral health care practitioner designated to be involved in the behavioral health care aspects of the QAPI Program. 3. The applicant's staff membership – including names and position titles. C. A description of how the applicant ensures that practitioners participate in the QAPI program through planning, design, implementation and/or review; and D. A description of how the applicant makes information about the QAPI program available to its practitioners and members, including a description of the QAPI program and a report on the organization's progress in meeting its goals.	
Summary of Requirements	The health plan must have an ongoing QAPI program that consists of systematic internal processes and mechanisms used for monitoring and evaluation of the impact and effectiveness of the care/services it provides. The health plan shall use the principles of continuous quality improvement throughout the process, from developing, implementing, monitoring, and evaluating the QAPI program to identifying and addressing opportunities for improvement. The health plan shall comply with NCQA Standards/Guidelines as well as with the QAPI Program standards established by the DHS.	
Response Considerations	1. Is the QAPI program described NCQA compliant? 2. Are all required program activities included in the description? 3. Does the applicant appear to have allocated sufficient staff and resources to its QAPI program and to quality management? 4. If the applicant mentions delegating any QAPI program activities does the description of how they will retain	

	ultimate responsibility ensure that they will do so? 5. Do the members of the governing body have the appropriate expertise and experience? Is it clear from the description of how the governing body exercises its responsibility that the body will be effective? Is the meeting frequency often enough to ensure that ongoing monitoring and quality improvement activities occur in a timely manner? 6. Do the members of the committee/group responsible for developing, implementing and overseeing QAPI program activities and operations have the appropriate and requisite experience to perform the job? Does the description of the committee's functions and responsibilities give assurances that the job will be done as required? Does the committee meet frequently enough to ensure that ongoing monitoring and quality improvement activities occur in a timely manner? 7. Does the applicant effectively describe how it will ensure that practitioners participate in the QAPI program at all levels? 8. Does the applicant describe multiple methods of providing information about the QAPI program to its providers and members? Examples might include provider and member education activities, newsletters, inclusion in the member handbook and provider manuals.

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Section: 80.330 QAPI (36 pages maximum)		**Item:** 80.350.2 General Provisions
Applicable RFP Sections: 50.720 Quality Management		**Maximum Item Points:** 10
Question	The applicant shall describe: A. How it will address, evaluate, and review both the quality of clinical care and the quality of non-clinical aspects of service such as availability, accessibility, coordination and continuity of care; B. The methodology to review the entire range of care provided to all demographic groups, care settings (inpatient, ambulatory, home) and types of services (preventive, primary, specialty care, including behavioral health care) to ensure quality, member safety, and appropriateness of care/services in pursuit of opportunities for improvement on an ongoing basis; and C. The methodology and mechanisms to implement corrective actions as well as monitor and evaluate the effectiveness of corrective action plans.	
Summary of Requirements	The health plan is responsible for providing quality care that is (1) accessible and efficient, (2) provided in the appropriate setting, (3) provided according to professionally accepted standards and, (4) provided in a coordinated and continuous rather than an episodic manner.	
Response Considerations	1. Does the applicant provide a comprehensive description of how it will evaluate and review the quality of clinical care and how it will work to continually improve? Does this description make sense? 2. Does the description seem appropriate and reasonable for the QUEST population? 3. Does the applicant provide a comprehensive description of how it will ensure quality of care in non-clinical aspects, including ensuring the availability of providers and services, the accessibility of provider and services, and ensuring that the services are provided in a coordinated manner? Does this description make sense? 4. Does the applicant demonstrate that it knows how to provide high quality care in the most appropriate setting? 5. Does the response describe how members, providers and other stakeholders will be included in quality improvement activities? 6. Does the applicant describe comprehensive, logical methodologies to review the entire range of care as required in Question B? Do these methodologies make sense? Does the description include how quality will be assured for behavioral health members? 7. Does the description indicate how opportunities for improvement are identified and strategies for improvement are implemented?	

Basis of Award(s) for QUEST RFP-MQD-2011-008

Section: 80.330 QAPI (36 pages maximum)		**Item:** 80.330.3 Value-Based Purchasing
Applicable RFP Sections: 50.550 Value-Driven Health Care		**Maximum Item Points:** 30
Question	A. The applicant shall describe its experience with value-based purchasing (VBP) to incentivize quality and efficiency of care and improve overall health outcomes; and B. The applicant shall describe how it will implement VBP in the QUEST program, to include supporting the health home model.	
Summary of Requirements	Value-driven health care means aligning payment with quality and efficiency. This payment reform may include but not be limited to different reimbursement strategies such as fee for service with incentives for performance, capitation payment to providers with assigned responsibility for patient care, or a hybrid. Measures used shall be evidence-based and validated. Value-driven health care can occur through reimbursement mechanisms for physicians, hospitals, and other health care providers.	
Response Considerations	1. Does the applicant provide a description of value-based purchasing consistent with Section 50.500? 2. Does the applicant describe any experience with VBP? 3. Is the applicants experience consistent with Section 50.500? 4. Does the applicant describe offering VBP for several provider types? 5. Does the applicant describe how they will implement VBP in the QUEST program? 6. Does the applicant describe that their VBP project will be consistent with DHS' health home program? 7. Is the applicant using models developed by external organizations such as NCQA?	

Basis of Award(s) for QUEST RFP-MQD-2011-008

Section: 80.330 QAPI (36 pages maximum)		**Item:** 80.330.4 Performance Measures
Applicable RFP Sections: 50.770 Performance Measures		**Maximum Item Points:** 20
Question	The applicant shall: A. Describe its policies and procedures relating to meeting HEDIS performance measures requirements; and B. Provide HEDIS measures for the last two (2), twelve (12) month periods from the State of Hawaii. If the applicant is not currently providing services to Medical Assistance clients in the State of Hawaii, the applicant shall submit its most recent HEDIS measures from at least two other states that it has previously or is currently operating. Please provide reference to the population reporting on to include geographic location and member demographics. The applicant shall indicate which measures were validated by an EQRO or NCQA certified compliance auditor and provide the validation reports. Note: the HEDIS measures and the validation reports do not count towards the page limit.	
Summary of Requirements	Both clinical (i.e., comprehensive diabetes care measures, cardiovascular disease measures) and utilization measures (i.e., emergency department visits, hospital readmissions) are included. • HEDIS measures - a set of HEDIS measures (both clinical and utilization measures) is required from the health plan each year. DHS shall provide a list of the HEDIS performance measures at the end of the calendar year for the next years required measures. • Utilization dashboard - the health plan shall supply information that may include hospital admissions and readmissions, call center statistics, provider network, member demographics, etc. DHS shall provide a list of the measures and a format for submission. • EPSDT data - the health plan shall report EPSDT information utilizing the CMS 416 format. This report includes information on EPSDT participation, percentage of children identified for referral, percentage of children receiving follow-up services in a timely manner, etc.	
Response Considerations	1. Does the applicant demonstrate an understanding of the requirements in the Section? 2. Does the applicant provide a comprehensive description of how it will meet the requirements and not just state that it will meet the requirements? 3. Does the applicant indicate how it will select appropriate measures? Does the process seem reasonable and appropriate? 4. Does the applicant provide HEDIS measures for the last two (2), twelve (12) month periods for all Medicaid programs the applicant was serving during that time period? Thought not asked, a bonus would be if the applicant provides an explanation as to why the identified HEDIS measures were selected and the rationale seems reasonable and logical 5. Do the selected HEDIS measures seem appropriate for the target population?	

Basis of Award(s) for QUEST RFP-MQD-2011-008

Section: 80.330 QAPI (36 pages maximum)		**Item:** 80.330.5 Delegation of QAPI Program Activities
Applicable RFP Sections: 50.730 QAPI Program		**Maximum Item Points:** 10
Question	The applicant shall provide a narrative describing the functions of all activities it intends to delegate, a list of proposed delegates and its plan to monitor the delegated function.	
Summary of Requirements	Contingent upon approval from the DHS, the health plan may be permitted to delegate certain QAPI Program activities and functions. The health plan shall request to delegate QAPI Program activities and functions. However, the health plan shall remain responsible for the QAPI Program, even if portions are delegated to other entities. Any delegation of functions requires: • A written delegation agreement between the delegated organization and the health plan, describing the responsibilities of the delegation and the health plan; and • Policies and procedures detailing the health plan's process for evaluating and monitoring the delegated organization's performance. At a minimum, the following shall be completed by the health plan: o Prior to execution of the delegation agreement there shall be provisions for a site visit and evaluation of the delegated organization's ability to perform the delegated activities; and o An annual on-site visit and/or documentation/record reviews to monitor/evaluate the quality of the delegated organization's assigned processes; and o Evaluation of the content and frequency of reports from the delegated organization.	
Response Considerations	1. Does the applicant intend to delegate any of the functions of their QAPI? 2. If so, does the applicant describe all activities it intends to delegate? 3. Does the applicant identity a list of proposed delegates? 4. Does the applicant describe its plan to monitor the delegated function? 5. Does the description that the applicant provide assurances that these functions will be performed consistently with the standards identified in the RFP?	

Basis of Award(s) for QUEST RFP-MQD-2011-008

Section: 80.330 QAPI (36 pages maximum)		**Item:** 80.330.6 Medical Records Standards
Applicable RFP Sections: 50.740, 70.500		**Maximum Item Points:** 10
Question	The applicant shall provide a narrative explaining how it maintains medical records and assures appropriate record retention and how it monitors provider compliance with its policies.	
Summary of Requirements	The health plan shall establish medical records standards as well as a record review system to assess and assure conformity with standards. These standards shall be consistent with the minimum standards established by the DHS. In addition, the health plan is required to facilitate the transfer of the member's medical records (or copies) to the new PCP within 7 business days from receipt of any request and shall comply with medical records retention requirements in 70.500 which state that medical records must be maintained for 7 years from the last date of entry in the records. For minors, records must be maintained for 7 years from the age of majority. In addition the health plan shall require that providers adhere to specific medical records requirement	
Response Considerations	1. Does the applicant require that the medical record be maintained by the PCP? 2. Do the standards described address all required elements? 3. Does the applicant describe a comprehensive monitoring policy to assure record retention? 4. Does the applicant provide a description of how it assures provider compliance with its policies in this area? Examples might include random medical record check and reminders of policies in provider updates and training. 5. Does the applicant describe how it will educate providers about the medical records standards?	

Basis of Award(s) for QUEST RFP-MQD-2011-008

Section: 80.330 QAPI (36 pages maximum)		**Item:** 80.330.7 Practice Guidelines
Applicable RFP Sections: 50.760		**Maximum Item Points:** 20
Question	The applicant shall indicate the practice guidelines it will select for use as part of its QAPI program. For each guideline, also include: A. The rationale for its relevance to the QUEST population; B. The measures the applicant will take to increase compliance with practice guidelines and how compliance with practice guidelines will be monitored; and C. The process for developing, updating and disseminating practice guidelines to providers.	
Summary of Requirements	The health plan is required to have two (2) clinical practice guidelines for medical conditions (such as asthma, diabetes mellitus, and pregnancy/high risk pregnancy) and at least two (2) for behavioral health conditions (such as depression and ADHD). The health plan may adopt practice guidelines in other areas. All practice guidelines must be: (1) relevant to the membership, (2) based on valid and reliable clinical evidence or a consensus of healthcare professionals in a particular field, (3) adopted in consultation with in-network providers, (4) reviewed and updated periodically as appropriate, (5) disseminated to all affected providers and to members (upon request), and (6) ensure that decisions for utilization management, member education, coverage of services and other areas to which the guidelines apply are consistent with the guidelines.	
Response Considerations	1. Does the applicant describe its rationale for adopting the practice guidelines? Does the rationale seem reasonable? Are the guidelines relevant to the QUEST population? 2. Has the applicant provided a comprehensive description of how it will increase compliance with practice guidelines? 3. Has the applicant demonstrated it will monitor compliance with practice guidelines and provided specific examples of the monitoring? 4. Has the applicant provided a comprehensive description of how it will develop, update and disseminate practice guidelines to providers? Are specific examples provided? Examples might include: provider education classes, provider updates, use of provider portal on the web site. 5. Does the applicant indicate how it will monitor provider compliance with practice guidelines? 6. Does the process for developing and updating include providers of different specialties as appropriate? 7. Are these guidelines updated at a frequency that gives you assurances they will be up-to-date?	

Basis of Award(s) for QUEST RFP-MQD-2011-008

Section: 80.330 QAPI (36 pages maximum)		**Item:** 80.330.8 Disease Management Programs Narrative
Applicable RFP Sections: 40.802		**Maximum Item Points:** 30
Question	The applicant shall provide: A. A description of its disease management program policies and procedures and mechanisms to assist members and practitioners in managing chronic conditions; B. A description of how the applicant will administer the required disease management programs for two of the conditions listed in Section 40.802; and C. Quantitative data on health improvement of members in two disease management programs the applicant is currently operating in Hawaii or another state.	
Summary of Requirements	The health plan shall have disease management programs for asthma and diabetes. The health plan shall select at least two (2) other programs from the following: congestive heart failure, hypertension, high-risk pregnancy, or obesity management. In addition, the health plan may request approval from DHS to change the two (2) other programs based upon member needs after providing services for the first year of the contract. The health plan shall develop policies and procedures for its disease management programs.	
Response Considerations	1. Does the applicant describe its policies and procedures for its disease management programs? 2. Does the applicant describe mechanisms that assist the member and providers in managing chronic conditions? Do the mechanisms seem practical and effective? 3. Does the applicant describe how they will administer the asthma and diabetes disease management programs? 4. Does the applicant correlate the policies and procedures with actual disease management programs for asthma and diabetes? 5. Has the applicant provided quantitative data on health improvement of members through use of disease management programs? In Hawaii or another State?	

Basis of Award(s) for QUEST RFP-MQD-2011-008

Section: 80.335 UMP & Authorization of Services (8 pages maximum)		**Item:** 80.335.A UMP Narrative
Applicable RFP Sections: 50.800		**Maximum Item Points:** 10
Pages Reviewed:		**Rating (0-5):**
Question	The applicant shall provide a narrative describing its UMP. This narrative shall include: A. A description of the committee responsible for the UMP as well as its functions and responsibilities, and how it exercises these responsibilities; B. A description of how it detects, monitors and evaluates under-utilization, over-utilization and inappropriate utilization of services as well as processes to address opportunities for improvement; C. A discussion of strategies to improve health care quality and reduce cost by preventing unnecessary hospital readmissions and by decreasing inappropriate emergency department utilization; and D. A discussion of any special issues in applying UM guidelines for behavioral health services.	
Summary of Requirements	The health plan is required to have a UMP that includes structured, systematic processes that employ objective evidenced-based criteria to ensure that utilization decisions regarding medical necessity and appropriateness are made in a fair, impartial and consistent manner by qualified licensed healthcare professionals. Practitioners with appropriate clinical experience shall be involved in developing, adopting and reviewing criteria. The required activities should include: (1) prior authorizations/pre-certifications, (2) concurrent reviews, (3) retrospective reviews, (4) discharge planning, (5) case management and (6) pharmacy management. In addition, the health plan's UMP shall include mechanisms to detect under-, over- and inappropriate utilization. The health plan shall perform: (1) routine, systematic monitoring of relevant utilization data, (2) routine analysis of data collected to identify causes of inappropriate utilization patterns, (3) implementation of appropriate interventions to correct any patterns of potential or actual under- or over-utilization, and (4) systematic measurement of the effectiveness of interventions aimed at achieving appropriate utilization. The health plan shall evaluate and analyze practitioner's practice patterns and produce and distribute provider profiles. In addition, the health plan shall provide feedback to providers when specific utilization concerns are identified.	
Response Considerations	1. Does the applicant provide a description of the committee responsible for the UMP and do the individuals on the committee have the appropriate experience? Are the functions and responsibilities clearly defined? 2. Are practitioners involved in the UMP? 3. Does the applicant describe how it will detect, monitor and evaluate under-utilization, over-utilization and inappropriate utilization of services? Do the activities give you confidence that the applicant has solid	

	processes in place? Do they describe activities such as systematic monitoring and routine analysis of utilization patterns and data? 4. Does the applicant provide a solid description of how it will intervene to correct and/or address potential or actual under- or over-utilization? 5. Has the applicant identified any unique and creative strategies for utilization management? A bonus would be if they have produced quantifiable results in reducing costs and improving care using these strategies. 6. Does the applicant describe any special issues in applying UM guidelines for behavioral health and long-term care services and how these special issues will be addressed? 7. Does the applicant provide a discussion of provider profiling activities and include information on feedback?

Basis of Award(s) for QUEST RFP-MQD-2011-008

Section: 80.335 UMP & Authorization of Services (prior authorization)		**Item:** 80.335.B Authorization of Services (PA) Narrative
Applicable RFP Sections: 50.900		**Maximum Item Points:** 10
Question	The applicant shall provide a narrative describing its PA program. This narrative shall, at a minimum, provide the following: A. A description of the PA process, including how PAs will be applied for members requiring out-of-network services or services for conditions that threaten the member's life or health; B. A description of how it will ensure that services are not arbitrarily or inappropriately denied or reduced in amount, duration or scope; and C. A description of how it will ensure consistent application of review criteria.	
Summary of Requirements	The health plan shall have mechanisms to (1) ensure consistent application of review criteria for authorization decisions and (2) consult with the requesting provider when appropriate. The health plan shall (1) ensure that all prior authorization decisions are made by a healthcare professional that has appropriate clinical expertise, (2) not arbitrarily deny or reduce the required scope of services solely because of the diagnosis, type of illness or condition and (3) not require prior authorization of emergency services. The health plan must meet timeframes detailed in Section 50.900.	
Response Considerations	1. Does the applicant provide a comprehensive description of its PA process? 2. Does the applicant describe how PAs will be applied for members requiring out-of-network services or services for conditions that threaten the member's life or health? 3. Does the process ensure for continuity of care, particularly for members with special health care needs and those who transition to and from institutional placement? 4. Is it clear that the applicant has solid policies and procedures in place to ensure that services are not arbitrarily or inappropriately denied or reduced in amount, duration or scope? 5. Does the applicant describe activities that will ensure the consistent application of review criteria?	

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Section: 80.340 General Administrative Requirements (12 pages maximum not including attachments)	**Item:** 80.340.1. General Administrative Requirements Narrative – Fraud and Abuse
Applicable RFP Sections: 51.300	**Maximum Item Points:** 20 points
Question	The applicant shall: A. Provide a comprehensive description of how it shall detect, investigate, and communicate fraud and abuse to DHS as described in Section 51.300; and B. Continually improve and modify their fraud and abuse detection processes.
Summary of Requirements	• The health plan shall have a system in place to prevent, detect, investigate and report all known or suspected cases of fraud and abuse. • The health plan shall develop a written fraud and abuse compliance plan that meets prescribed requirements.
Response Considerations	1. Does the applicant provide a comprehensive description detailing how it will prevent, detect, investigate and report to the State in order to guard against fraud and abuse in the administration and delivery of QUEST services? 2. Does the applicant include a description of an effective written fraud and abuse compliance plan that meets the requirements specified in Section 51.330? 3. As part of the description, does the applicant provide specific examples of how it will educate providers, members and staff about fraud and abuse? Examples might include, information in provider updates, in—house updates for staff, etc. 4. Does the applicant provide include proactive mechanisms for detecting fraud—does it identify multiple avenues for fraud detection (i.e., member calls, analyzing claims, follow-up on referrals)? 5. Does the applicant have a process in place to verify with members the delivery of services as claimed (i.e., explanation of benefits)? 6. Does the applicant provide a description of specific activities geared toward preventing fraud and abuse? Examples might include claim edits and provider profiling. 7. Is it clear from the applicant's description that it understands the contract requirements and that it has a workable process to provide adequate protections for the QUEST population?

Section: 80.340 General Administrative Requirements (18 pages maximum not including attachments)	**Item:** 80.340.2 Organization Charts and Narrative on Organization Charts 80.340.3 Organization and Staffing Table
Applicable RFP Sections: 51.400	**Maximum Item Points:** 20
Question	80.340.2 Organization Charts (Attachment) and Narrative on Organization Charts The applicant shall provide organization chart(s) and a brief narrative explaining its organizational structure, including: (1) whether it intends to use subcontractors for activities and functions and, if so, how it will manage and monitor them; and (2) how it will ensure coordination and collaboration among staff located in the State of Hawaii and those in the Continental United States. 80.340.3 Organization and Staffing Table In a table format, the applicant shall describe its current or proposed staffing that includes the number of full-time equivalents (FTEs) for all positions described in the table in Section 51.410. Adequacy of proposed staff shall be judged based on an enrollment of approximately 20,000 members.
Summary of Requirements	• The health plan shall have organizational, management and administrative systems capable of fulfilling all contract requirements. • The health plan shall have sufficient, qualified staff to fulfill the required contract requirements. • The health plan must have a significant presence in the State of Hawaii, therefore, certain positions are required to be filled by individuals residing and working full-time in the State.
Response Considerations	80.365.2 1. Does the organizational chart address, at a minimum, the required staff listed in the table in Section 51.410 of the contract? 2. Are reporting structures clear, logical and appropriate for the QUEST program? 3. Is the organizational chart comprehensive and logical to address QUEST program requirements? 4. Does it demonstrate an effective operation to meet the requirements of the contract? 5. Does the applicant indicate if it will use subcontractors? If yes, does it indicate how it will select and monitor the subcontractor? Does the description indicate the qualifications/standards/criteria that will be used to select subcontractors? Does the applicant indicate the types of monitoring activities that will be used (i.e. reporting, onsite monitoring, member surveys and other feedback) and the frequency of these activities? 6. Does the applicant indicate the measures that will be taken if a subcontractor is determined not to meet contract

	requirements? 80.365.3 1. Does the applicant provide a table that addresses, at a minimum, the required staff prescribed in the table in section 51.410? 2. Are the FTEs per position clear and appropriate to meet contract standards? 3. Is the staffing level sufficient to meet the requirements of the contract and to properly administer a program with a maximum of 20,000 members? 4. In keeping with the table in section 51.410, does the applicant indicate staff based in Hawaii vs. those in the continental United States? Are all positions that are required to be in Hawaii identified as such?

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Section: 80.340 General Administrative Requirements (18 pages maximum not including attachments)		**Item:** 80.340.4 General Administrative Requirements Narrative – Reporting Requirements
Applicable RFP Sections: 51.500		**Maximum Item Points:** 20
Question	The applicant shall describe its internal systems or processes to: A. Gather data to meet reporting requirements; B. Compile and review data for consistency and accuracy prior to submitting to DHS; C. Submit reports to DHS in a timely manner; and D. Develop corrective action plans (CAP), as needed, to improve health plan processes.	
Summary of Requirements	The health plan shall submit to the DHS all requested reports in the time frames identified in Section 51.500. In addition, the health plan shall comply with all additional requests from the DHS, or its designee, for additional data, information and reports. In the event the health plan is under a corrective action plan (CAP), the health plan may be required to submit certain reports more frequently than stated in Section 51.500.	
Response Considerations	1. Is the applicant response consistent with the reporting requirements specified in Section 51.580? 2. Does the applicant describe the processes effectively to gather data and meet reporting requirements? 3. Does the applicant have a process for reviewing the data, prior to submitting to DHS, for consistency and accuracy? Does this process sound effective? 4. Does the applicant have a process to submit their reports to DHS in a timely manner? 5. Does the applicant describe their process for developing CAPs as needed when requested by DHS? Does this process sound like it will improve health plan processes?	

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Section: 80.340 General Administrative Requirements (18 pages maximum not including attachments)		**Item:** 80.340.5 General Administrative Requirements Narrative – Encounter Data Reporting Requirements
Applicable RFP Sections: 51.580		**Maximum Item Points:** 10
Question	A. The applicant shall describe how it will ensure that all encounter data requirements are met and that encounter data is submitted to the State in a timely and accurate manner as described in Section 51.580. As part of this description, please provide a narrative of how you prepare encounter data reports and how you assure accuracy. B. Please provide a narrative on what trend analysis you perform on your encounter data.	
Summary of Requirements	The health plan shall submit timely, accurate and complete encounter data to MQD once per month.	
Response Considerations	1. Is the applicant's response consistent with the reporting requirements specified in Section 51.580? 2. Does the applicant's response indicate who prepares encounter data reports, the process for generating data to be included in reports, and the process used to validate reports? 3. How does the applicant ensure timeliness and completeness of reports? 4. Does the applicant describe the type of trend analysis that is performed on the encounter data and the frequency with which the analysis occurs? 5. Does the applicant indicate how the results of trend analysis will be used for program improvement?	

Section: 80.340 General Administrative Requirements (18 pages maximum not including attachments)	**Item:** 80.340.6 Health Plan Administrative Requirements Narrative-Information Technology
Applicable RFP Sections: 51.200	**Maximum Item Points:** 10

Question

A. The applicant shall provide a description of its information systems environment, including:

1. Details on the systems which will be used to perform the key functions ("key production systems") noted in Sections 51.220, 51.300, 51.580, 60.110 and 60.310. At a minimum include:
   - System name and version,
   - Number of users,
   - Who maintains the system and from what location,
   - The location of the data center where the system is housed,
   - Whether the system is currently in use or being implemented (if the system is being implemented, please indicate the expected go-live date), and
   - Major system functionality.
2. How these key production systems are designed to *interoperate*: (a) how identical or closely related data elements in different systems are named, formatted and maintained; (b) data element update/refresh methods and frequency/periodicity; and (c) how data is exchanged between key production systems (i.e. how these systems are "interfaced" to facilitate work processes within your organization).
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 electronic prior authorizations.
4. An explanation of how it will ensure that its systems can interface with the DHS systems and how it will institute processes to insure the validity and completeness of the data submitted to the DHS.

As part of its response, the applicant should support the narrative with diagrams that illustrate (a) point-to-point interfaces, (b) information flows, (c) internal controls and (d) the networking arrangement (AKA "network diagram") associated with the information systems profiled. These diagrams should provide insight into how its systems will be organized and how they will interact with DHS systems for the purposes of exchanging Information and automating and/or facilitating specific functions associated with this contract.

B. The applicant shall provide a description of how it will ensure confidentiality of member information in accordance with professional ethics, state and federal laws, including HIPAA compliance provisions.

C. The applicant shall provide a description of its disaster planning and recovery operations policies and

	procedures.
Summary of Requirements	Section 51.210 - General Requirements: The health plan shall have information management systems that enable it to meet the DHS requirements, state and federal reporting requirements, all other contract requirements and any other applicable state and federal laws, rules and regulations, including HIPAA. Section 51.220 - Expected Functionality: The DHS expects health plan information systems to facilitate and to integrate the following essential health plan case management and coordination of care functions: (1) member health status assessments, (2) determination of the optimal mix of health care services needed to improve the health status of said members, (3) coordination and oversight of the delivery of said services, and (4) the analysis and reporting of service utilization and outcomes data required to manage these functions effectively. The health plan shall have a suite of properly interfaced, readily accessible yet secured information systems that enable the efficient execution of the aforementioned functions. Section 51.230 - Method of Data Exchange with MQD: The MQD Secure File Transfer (SFT) server is the source of all file transfers between MQD and trading partners, including health plans. The SFT server allows the MQD and the health plan to securely transfer member, provider, and encounter data via the internet. The question is aimed at obtaining insight from each applicant on the architecture and capabilities of its information systems. Section 51.240: The health plan is required to comply with HIPAA. Section 72.300: The health plan is required to comply with all applicable federal and state laws as it relates to disclosure of confidential information. Section 51.270: The health plan shall have in place disaster planning and recovery operations appropriate for the health plan industry, and comply with all applicable federal and state laws relating to security and recovery of confidential information and electronic data.

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Response Considerations	1. In response to the System Profile question, does the applicant address each item, (a) through (f): a. System name and version, b. Number of users, c. Who maintains the system and from what location, d. The location of the data center where the system is housed, e. Whether the system is currently in use or being implemented (if being implemented, did the applicant indicate the expected go-live date), and f. Major system functionality. 2. In response to the production system interoperability question, does the applicant address Items (a) through (c): (a) How identical or closely related data elements in different systems are named, formatted and maintained; (b) Data element update/refresh methods and frequency/periodicity; and (c) How data is exchanged between key production systems. 3. In response to the system accessibility question, does the applicant address different types of access mechanisms and different types of users, i.e. how thorough is their explanation: (a) Access mechanisms – office LAN, wireless, desktop/laptop, phone, etc. (b) Different types of users – office-based vs. mobile/field-based staff (c) Different types of functions/applications – what can be accessed, and how (d) Security – how security can vary across all of the systems mentioned, and how the plan intends to achieve it 4. In response to the interface and data validation and completeness question, does the applicant elaborate sufficiently on: (a) Each key interface/data exchange: Providers, Enrollment/Membership, Payments, Encounters (b) Data validation/completeness methods, policies and procedures and technologies 5. Does the applicant identify specific requirements that it cannot meet at the time it submitted its proposal, and does it elaborate on the time and effort investment required to meet said requirements? Alternatively, does the applicant make it clear in its response that presently it can meet all of the requirements? 6. Does the applicant discuss any innovative approaches to any of the requirements that you would consider to be "value adding" to the program?

	7. Do any attachments/diagrams/supporting documents (if provided) provide insight into how the vendor's Systems will be organized and how they will interact with DHS/MQD systems for the purposes of exchanging Information and automating and/or enabling specific functions associated with DHS/MQD, as required in the contract? 8. Is the applicant's response complete, or are there gaps in the responses, e.g. does the applicant address HIPAA but not germane state laws and regulations in its response? 9. Does the applicant demonstrate an understanding of each requirement and any critical underlying issue(s), e.g. the risk of not incorporating access management and security controls into its IT environment? 10. Does the applicant identify specific requirements that it cannot meet at the time it submitted its proposal, and does it elaborate on the time and effort investment required to meet said requirements? Alternatively, does the applicant make it clear in its response that presently it can meet all of the requirements? 11. Does the applicant discuss any innovative approaches to any of the requirements that you would consider to be "value adding" to the program? 12. Is the applicant's response complete or are there gaps in the responses, e.g. does the applicant address availability assurance technologies but not business continuity policies and procedures in its response? 13. Does the applicant demonstrate an understanding of each requirement and any critical underlying issue(s), e.g. the need for system availability, particularly for critical systems functions, and the value of ensuring the maximum levels of system availability subject to financial and other considerations? 14. Does the applicant identify specific requirements that it cannot meet at the time it submitted its proposal, and does it elaborate on the time and effort investment required to meet said requirements? Alternatively, does the applicant make it clear in its response that presently it can meet all of the requirements?

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Section: 80.340 Financial Responsibilities (18 pages maximum not including attachments)		**Item:** 80.340.7 Financial Responsibilities Narrative- Third Party Liability
Applicable RFP Sections: 60.400		**Maximum Item Points:** 20
Question	The applicant shall describe how it will coordinate health care benefits with other coverages, its methods for obtaining reimbursement from other liable third parties, and how it will fulfill all requirements as detailed in Section 60.400	
Summary of Requirements	60.420 (DHS responsibilities): (1) coordinating and recovery of accident and workers' compensation subrogation benefits, (2) collecting and providing member TPL information to the health plan via the daily TPL roster, (3) conducting TPL audits every 6 months to ensure TPL responsibilities are being completed by the health plan. 60.400 (health plan responsibilities, in part): (1) coordinating health benefits with other coverages, (2) seeking reimbursement from other liable third parties, (3) reporting accidents incurring medical and medically related dental expense in excess of $500 to the DHS, (4) informing the DHS of TPL information uncovered during the course of normal business operations at least every thirty (30) days, (5) and developing procedures for determining when to pursue TPL recovery.	
Response Considerations	1. Does the applicant provide a sufficient description on pay and chase procedures such that you feel confident it understands how to operationalize the activities? 2. Does the applicant describe a clear methodology for obtaining reimbursement from other liable third parties? 3. Does the applicant describe how it will cost avoid health insurance plans' accident and worker's compensation benefits, as well as for members receiving motor vehicle liability coverage through the Hawaii Joint Underwriting Plan (HJUP)? 4. Does the applicant describe a thorough process for notifying the DHS about TPL information uncovered during the course of normal business operations? 5. Does the applicant describe a process for determining when recovery would not be cost-effective and what types of documentation it will provide to the DHS in these instances? 6. Does the applicant describe its process for reporting accident cases incurring medical and medically related dental expenditures in excess of $500 to the DHS?	