Applicant Name:		
Section: 80.310 Experience and References (15 pages maximum not including attachments)		**Item:** 80.310 A-D Experience Narrative, Including Contract for Medicaid program clients, Letters of recommendation, and Previous Contract Termination
Applicable RFP Sections: N/A	**Maximum Item Points:** 90	**Score (0-5):**
Question	The applicant shall provide: A. A narrative of its experience providing services to Medicaid and Medicare populations in Hawaii and in other States. As part of this narrative, please indicate specific enrollment numbers. 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 Integration 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 Integration 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 Integration program. A letter should not be provided from anyone representing an individual or an organization with a financial conflict of interest to including board officers, directors, and other board members; 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 Integration 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;

Met	Not Met

Summary of Requirements	• 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); • The relevance of the duration of the experience per bullet point above (a longer duration of the experience shall be worth more points); • The relevance of letters of recommendation; and • Whether or not a contract has been terminated or was not renewed due to non-performance or for poor performance.

Applicant Name:		
Section: 80.310 Experience and References (15 pages maximum not including attachments)	**Item:** 80.310 E. EQRO Evaluations	
Applicable RFP Sections: N/A	**Maximum Item Points:** 20	**Score (0-5):**
Question	E. The health plan's most recent External Quality Review of Compliance with Standards evaluation issued September 2013 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;	
Met		**Not Met**
Summary of Requirements	• The EQRO compliance with standards evaluations shall be evaluated based upon its compliance with Federal regulations.	

Applicant Name:			
Section: 80.310 Experience and References (15 pages maximum not including attachments)		**Item:** 80.310 F. EPSDT Measure for the Last 12 Months	
Applicable RFP Sections: 41.100	**Maximum Item Points:** 20	**Score (0-5):**	
Question	F. EPSDT measures for the last twelve (12) month period submitted to the State of Hawaii on February 28, 2013 on a CMS 416. If the applicant is not currently providing services to Medical Assistance beneficiaries in the State of Hawaii, the applicant shall submit its most recent EPSDT measures from at least two other states provided on the CMS 416 that it has previously or is currently operating. Note: the EPSDT measures reports do count towards the page limit; and		
Met		**Not Met**	
Summary of Requirements	• EPSDT measures shall be evaluated based upon standards established by the State of Hawaii in Section 41.100.		

Applicant Name:		
Section: 80.310 Experience and References (15 pages maximum not including attachments)	**Item:** 80.310 G. HEDIS validation evaluations	
Applicable RFP Sections: N/A	**Maximum Item Points:** 20	**Score (0-5):**
Question	G. The health plan's most recent HEDIS® 2013 Compliance Audit™ (hereby called HEDIS validation evaluation) issued from the State of Hawaii with July or August 2013 on the front cover. If the applicant is not currently providing services to Medical Assistance beneficiaries in the State of Hawaii, the applicant shall submit its most recent validated performance measures from at least two other states. 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: the EQRO validation reports do not count towards the page limit.	
Met		**Not Met**
Summary of Requirements	• HEDIS validation measures shall be evaluated based upon 75th percentile for Medicaid nationally.	

Applicant Name:		
Section: Provider Network (32 pages maximum ((includes Provider Services as well) not including attachments)	**Item:** 80.315.1-80.315.4 Provider Network Narrative/Required Providers acute, primary care, and behavioral health Providers / Required LTSS Providers/ Maps of Providers	
Applicable RFP Sections: 40.200	**Maximum Item Points**: 100	**Rating (0-5):**

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, behavioral health, and long-term services and supports) 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 geographic access and 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. Steps the applicant will take to address provider shortages, especially with PCPs and specialist, for Medicaid populations;
E. 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;
F. How it will educate providers in a method that is provider-friendly;
G. The provider network analysis for its Medicaid business in Hawaii. This analysis shall include:
    1. The percent of PCPs who are Board certified;
    2. The percent of specialists who are Board certified in the specialty of their predominant practice; and
    3. The LTSS providers' abilities to adapt under new ACA regulations.

The applicant shall provide a listing of acute, primary care, and behavioral health providers, required LTSS providers and maps across the State of where their providers are in practice.

Met	Not Met

Summary of Requirements	• Provision of the data required in Section 80.315; and • Other factors identified in Section 80.315. • Capability of applicant's provider network to provide the services set forth in the RFP in all areas applicant is bidding (i.e., Statewide or Oahu and one other island); • Sufficiency of provider network to meet the all service needs of its members to include acute, primary care, behavioral health and LTSS; • Comprehensiveness of the provider network to provide access to all required services as set forth in the RFP to include providers accepting new Medicaid beneficiaries; • Provider availability and geographic access, especially on the islands other than Oahu; • Applicants with signed contracts for LTSS instead of LOIs; • Provision of contract signature pages for contract verification if requested; and • Contains specific information related to monitoring its networks, including unannounced visits and techniques to assure network providers are compliant with appointment wait times.

Applicant Name:		
Section: Provider Services (32 pages maximum ((includes Provider Network as well) not including attachments)	**Item:** 80.315.5-80.315.6 Availability of Provider Narrative/ Provider Services Narrative	
Applicable RFP Sections: 40.250 and 40.600	**Maximum Item Points:** 50	**Rating (0-5):**

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 they will include service coordination as a mechanism to support the PCP in their requirements.

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 minimize administrative burden associated with prior authorizations as described in Section 40.650 and Section 50.900;
   B. A description of how it will assure providers are educated on health plan requirements as described in Section 40.610;
   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 improve on the EPSDT requirements and HEDIS measures.

Met	Not Met

Summary of Requirements	• Provision of the data required in Section 80.315; and • Other factors identified in Section 80.315. • Description of ensuring that PCPs fulfill their responsibilities for supervising and coordinating care for their members; • Description of addressing the assignment of PCP and meeting the 1 to 300 for PCP assignment; • Description of including service coordination to support the PCP; • Comprehensive description of decreasing administrative burden for prior authorizations; • Process to educate providers on health plan requirements to include EPSDT and HEDIS; and • Assure that claims are processed in a timely manner in accordance with Section 60.310.

Applicant Name:		
Section: 80.320 Covered Benefits and Services (18 pages maximum)	**Item:** 80.320.1. Covered Benefits and Services Narrative	
Applicable RFP Sections: 40.700	**Maximum Item Points:** 30 points	**Rating (0-5):**

Question	The applicant shall describe: A. Its experience providing, on a capitated basis, the primary, acute care, behavioral health, and LTSS 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. 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 C. Its competency serving the cultures in Hawaii and understanding the population served by the State's Medical Assistance program.

Met	**Not Met**

Met	Not Met

Summary of Requirements	• Answer all of the questions from Section 80.320; and • Other factors identified in Section 80.320. • Description of experience of providing covered benefits and services for a similar population.

Applicant Name:		
Section: 80.320 Covered Benefits and Services (18 pages maximum)	**Item:** 80.320.2 Long-Term Services and Supports (LTSS)	
Applicable RFP Sections: 40.740.3	**Maximum Item Points:** 30	**Rating (0-5):**
Question	The applicant shall describe its experience in providing LTSS as required in Section 40.740.3. Specifically describe how the following requirement will be implemented: A. Assessment of LTSS needs; B. Assurance of provision of choice when a member requires LTSS; C. Processes applicant has to minimize and decrease its acute waitlisted ICF/SNF members; and D. Processes applicant will use to determine appropriate HCBS for their members.	
Met		**Not Met**
Summary of Requirements	• Answer all of the questions from Section 80.320; and • Other factors identified in Section 80.320. • Description of provision of LTSS to include assessment, member choice of services, plans to minimize and decrease acute waitlisted ICF/SNF members, and appropriate use of HCBS.	

Applicant Name:			
Section: 80.320 Covered Benefits and Services (18 pages maximum)		**Item:** 80.320.3 Hospital Readmission within thirty (30) days	
Applicable RFP Sections: 40.910	**Maximum Item Points:** 30		**Rating (0-5):**
Question	The applicant shall detail how it intends to assure adequate discharge planning for members receiving acute care hospital services, perform follow-up on individuals discharged from acute care hospitals, assure follow-up with PCP, and minimize hospital readmissions.		
Met		**Not Met**	
Summary of Requirements	• Answer all of the questions from Section 80.320; and • Other factors identified in Section 80.320. • Processes to assure adequate discharge planning and decrease hospital readmissions within thirty (30) days.		

Applicant Name:		
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: 41.100	**Maximum Item Points:** 30	**Rating (0-5):**

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 physician who is not making the referral for follow-up services, as indicated; and C. The applicant shall provide a description of their processes (supported by statistics from its largest Medicaid contract) to increase the following: 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.

Met	**Not Met**

Summary of Requirements	• Answer all of the questions from Section 80.320; and • Other factors identified in Section 80.320. • Plan for assuring Hawaii's EPSDT plan is implemented.

Applicant Name:		
Section: 80.320 Covered Benefits and Services (18 pages maximum)	**Item:** 80.320.5 Transition of Care Narrative	
Applicable RFP Sections: 41.700	**Maximum Item Points:** 30	**Rating (0-5):**
Question	A. 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 health plans. 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 health plan. As part of this narrative, please provide specific examples.	
Met		**Not Met**
Summary of Requirements	• Answer all of the questions from Section 80.320; and • Other factors identified in Section 80.320. • Description of processes for transition of care for former and new members.	

Applicant Name:		
Section: Service Coordination System/Services Narrative (20 pages maximum)	**Item:** 80.325 Service Coordination System/Services Narrative	
Applicable RFP Sections: 40.800 and 40.900	**Maximum Item Points**: 150	**Rating (0-5):**

Question	The applicant shall provide a comprehensive description of its service coordination 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 these services. The applicant shall describe how it shall meet the requirements in RFP Section 40.800 – Self-Direction and RFP Section 40.900 – Service Coordination, Assessments, and Service Plans. At a minimum, the applicant shall describe and address: B. The organizational structure of its service coordination system; C. How the applicant identifies members who meet Special Health Care Needs (SHCN) as described in Sections 40.910.1 and 40.910.2; D. How the applicant shall monitor that service coordinators are meeting their responsibilities as described in Section 40.910; E. The applicant's processes to maintain a partnership between nurse and social worker service coordinators for members receiving LTSS; F. The applicant's processes to monitor the differing levels of service coordination and maintenance of case load ratios; G. How the service coordination system addresses coordination and follow-up of outpatient and inpatient care/service needs as well as coordination with, Medicare, DOH programs excluded from QI (i.e., DD/ID 1915(c) waiver), and other DHS programs (i.e., Child Welfare and Adult Protective Services); H. How the service coordinator addresses coordination of behavioral health services with CCS; I. The processes for monitoring emergency department utilization and informing members of options for urgent care, after-hours care, and twenty-four hour nurse line; J. The processes for assuring that service coordinators are adequately trained to meet member and RFP requirements; K. The mechanisms to ensure that the development and implementation of the member's service plan is monitored/evaluated for effectiveness, and is revised as frequently as the member's condition warrants;

	L. How the service plan is a person-centered document that analyzes the assessment and describes both the medical and social needs of the member; M. The processes for meeting self-direction requirements to include nurse delegation; and N. How the service coordination system is linked to the applicant's information system. This description shall include how the information system tracks service coordination activities and generate reports.

Met	Not Met

Summary of Requirements	• Process for providing service coordination; • Staff functions, interactions, and internal coordination; • Staff level and case load ratios; • Plan for monitoring and coordinating needed clinical and other services to support the member in the community; • Description of the service coordination system's capabilities to address 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; • Description of the service coordinator's role in coordinating behavioral health services with the CCS program; • Process for monitoring utilization to include emergency department; • Training of service coordinators; • Process for identifying and managing its highest risk (top 2%) members; • Process for development of person-centered service planning; • Answer all of the questions from Section 80.325; and • Other factors identified in Section 80.325.

Applicant Name:		
Section: 80.330 Member Services (20 pages maximum)	**Item:** 80.330.1 Member Services Narrative- General Member Services	
Applicable RFP Sections: 50.220 and 50.400	**Maximum Item Points:** 40	**Score (0-5):**
Question	The applicant shall describe: E. How it will implement the member survey as described in Section 50.220; F. How it will help their members retain their Medicaid eligibility; G. 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; H. How it will assure interpretation services are available to members that speak a language other than English as their primary language; and I. How it will assure that members understand their role in verifying services that they received as required in Section 50.455.	

Met	**Not Met**

Summary of Requirements	• Answer all of the questions from Section 80.330; and • Other factors identified in Section 80.330. • Plan for conducting member survey; • Plan to support members in maintaining their Medicaid eligibility; • Plan for providing member services to include assuring members have access to written materials at 6.9 grade level; • Process for submitting all written materials to DHS for review/approval prior to use and distribution; • Procedures, including outreach to persons with limited literacy and those who speak languages other than English; and • Ability to provide services to members whose primary language is not English.

Applicant Name:		
Section: 80.330 Member Services (20 pages maximum)		**Item:** 80.330.2 Member Services Narrative- Toll-free Call Center and Twenty-Four Hour Nurse Line
Applicable RFP Sections: 50.480	**Maximum Item Points:** 30	**Score (0-5):**
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 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 shall do in the event those standards are not being met.	
Met		**Not Met**

Summary of Requirements	• Answer all of the questions from Section 80.330; and • Other factors identified in Section 80.330. • Plan for assuring that members have access to both a toll-free call center and 24-hour nurse line; • Process for monitoring call representatives' phone etiquette and accuracy of responses; • 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; • Description that the after-hours line provides a direct connection to the nurse advice line; • Description of any components of its operation that will have separate telephone numbers (e.g., transportation, etc.) and processes for monitoring and reporting on this call center activity; • Description of processes applicant has if the call center does not meet the performance standards for one or more periods; and • Description of training for call center staff.

Applicant Name:		
Section: 80.330 Member Services (20 pages maximum)	**Item:** 80.330.3 Member Grievance System Narrative	
Applicable RFP Sections: 51.100	**Maximum Item Points:** 30	**Score (0-5):**

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. A description of applicant's process to allow member to authorize another person represent their interest; C. A description of how applicant determines whether to accept an expedited appeal when requested by member or provider; D. A description of the training provided to staff who handle member grievances and appeals; and E. A description of how the applicant communicates their processes to their members.

Met	**Not Met**

Summary of Requirements	• Answer all of the questions from Section 80.330; and • Other factors identified in Section 80.330. • Description of applicant's grievance system as described in Section 51.100; and • Description of training for call center and grievance system staff.

Applicant Name:		
Section: 80.335 Quality Assessment and Performance Improvement (30 pages maximum)	**Item:** 80.335.1. QAPI Narrative- QAPI Program	
Applicable RFP Sections: 50.730	**Maximum Item Points:** 20 points	**Rating (0-5):**
Question	The applicant The applicant shall provide a comprehensive description of how it intends to conduct its QAPI program to ensure that all requirements in Section 50.730 are met. As part of this description, please include, at a minimum, the following information: A. 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. 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; o The licensed behavioral health care practitioner designated to be involved in the behavioral health care aspects of the QAPI Program; and o The individuals responsible for LTSS quality oversight. 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.	

Met	Not Met

Summary of Requirements	• Answers all questions from Sections 80.335 and 80.340. • Other factors identified in Sections 80.335 and 80.340. • Description of 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; • Use of the principles of continuous quality improvement throughout the process, from developing, implementing, monitoring, and evaluating the QAPI program to identify and address opportunities for improvement; • Provision of 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; • Members of the governing body have the appropriate expertise and experience and the description of how the

	governing body exercises its responsibility is effective; • QAPI meets frequently enough to ensure that ongoing monitoring and quality improvement activities occur in a timely manner; • 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 as described in Section 50.730; and • Description of the committee's functions and responsibilities give assurances that the QAPI is effective.

Applicant Name:		
Section: 80.335 Quality Assessment and Performance Improvement (30 pages maximum)	**Item:** 80.335.2. QAPI Narrative- General Provisions	
Applicable RFP Sections: 50.720	**Maximum Item Points:** 20	**Rating (0-5):**
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, nursing facility) and types of services (preventive, primary, specialty care, behavioral health care, and LTSS) 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.	
Met	**Not Met**	

Summary of Requirements	• Answer all of the questions from Sections 80.335 and 80.340; and • Other factors identified in Sections 80.335 and 80.340. • Provision of a comprehensive description of how applicant 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; and • Process that ensures continuity of care, particularly for members with special health care needs, those receiving LTSS, and those who transition to and from institutional placement.

Applicant Name:		
Section: 80.335 Quality Assessment and Performance Improvement (30 pages maximum)	**Item:** 80.335.3. QAPI Narrative- Value-Based Purchasing	
Applicable RFP Sections: 50.500	**Maximum Item Points:** 30	**Rating (0-5):**
Question	A. The applicant shall describe its experience in linking provider reimbursement to improved performance or aligning payment with quality and efficiency; B. The applicant shall describe its VBP reimbursement methodologies for primary care providers (PCP) and hospitals; and C. The applicant shall describe its medical home model.	
Met		**Not Met**
Summary of Requirements	• Answer all of the questions from Sections 80.335 and 80.340; and • Other factors identified in Sections 80.335 and 80.340. • Description of value-based purchasing is consistent with requirements established in Section 50.500; • Reimbursement is aligned with improved performance and quality and efficiency; and • Description of provider-types receiving value-based purchasing.	

Applicant Name:		
Section: 80.335 Quality Assessment and Performance Improvement (30 pages maximum)	**Item:** 80.335.4. QAPI Narrative- Performance Measures	
Applicable RFP Sections: 50.770	**Maximum Item Points:** 20 points	**Rating (0-5):**
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.	

Met	**Not Met**

Summary of Requirements	• Answer all of the questions from Sections 80.335 and 80.340; and • Other factors identified in Sections 80.335 and 80.340. • Processes comply with NCQA Standards/Guidelines as well as with the QAPI Program standards established by the DHS; and • Description of processes for meeting HEDIS measures.

Applicant Name:		
Section: 80.335 Quality Assessment and Performance Improvement (30 pages maximum)	**Item:** 80.335.5. Disease Management (DM) Programs Narrative	
Applicable RFP Sections: 41.320	**Maximum Item Points:** 20 points	**Rating (0-5):**
Question	The applicant shall provide: O. A description of how the applicant will identify members who may benefit from the required disease management programs for two of the conditions listed in Section 41.320; and P. Quantitative data on health improvement/outcomes of members in two disease management programs the applicant is currently operating in Hawaii or another State.	
Met		**Not Met**
Summary of Requirements	• Answer all of the questions from Sections 80.335 and 80.340; and • Other factors identified in Sections 80.335 and 80.340. • Description of mechanisms that assist the member and providers in managing chronic conditions that are practical and effective; and • Correlation of policies and procedures with actual disease management programs.	

Applicant Name:		
Section: 80.340 Utilization Management Program and Authorization of Services (10 pages maximum)	**Item:** 80.340.1 Utilization Management Program (UMP) Narrative	
Applicable RFP Sections: 50.800	**Maximum Item Points:** 20 points	**Rating (0-5):**
Question	The applicant shall provide a narrative describing its Utilization Management Program (UMP) including: A. A description of the UMP performs requirements as described in Section 50.800 to include but not limited to prior authorization/pre-certification, concurrent review, and discharge planning; B. A description of how it detects, monitors and evaluates under-utilization, over-utilization and inappropriate utilization of services as well as the 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 LTSS.	
Met		**Not Met**

Summary of Requirements	• Answer all of the questions from Sections 80.335 and 80.340; and • Other factors identified in Sections 80.335 and 80.340. • Description of detecting, monitoring and evaluating under-utilization, over-utilization and inappropriate utilization of services; • Describes activities such as systematic monitoring and routine analysis of utilization patterns and data; • Description of intervention to correct and/or address potential or actual under- or over-utilization; and • Identification of unique and creative strategies for utilization management that produce quantifiable results in reducing costs and improving care using these strategies.

Applicant Name:			
Section: 80.340 Utilization Management Program and Authorization of Services (10 pages maximum)		**Item:** 80.340.2 UMP and Authorization of Services- Prior Authorization (PA)	
Applicable RFP Sections: 50.900	**Maximum Item Points:** 20 points		**Rating (0-5):**
Question	A. A description of the qualified licensed health care professionals and medical director in the PA process; B. A description of how it will ensure that utilization review is performed in a fair, impartial, and consistent manner for medical, behavioral health, and LTSS services; C. A description of how the applicant will ensure that evidenced-based criteria are applied; and D. How the administrative burden on providers will be minimized.		
Met		**Not Met**	
Summary of Requirements	• Answer all of the questions from Sections 80.335 and 80.340; and • Other factors identified in Sections 80.335 and 80.340. • Provision of a comprehensive description of its prior authorization (PA) process; • Description of qualified licensed health care professional and medical director in PA process; • Description of policies and procedures to ensure that utilization review is performed in a fair, impartial, and consistent manner for all services; and • Use of evidenced-based criteria in PA process.		

Applicant Name:		
Section: 80.345 Health Plan Administrative Requirements (20 pages maximum)		**Item:** 80.345.1. Health Plan Administrative Requirements Narrative- Fraud and Abuse
Applicable RFP Sections: 51.300	**Maximum Item Points:** 30 points	**Rating (0-5):**
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; B. Continually improve and modify their fraud and abuse detection processes; and C. Ensure that no providers terminated from Medicaid or Medicare is reimbursed for services.	

Met	**Not Met**

Summary of Requirements	• Answer all of the questions from Section 80.345; and • Other factors identified in Section 80.345. • Comprehensive description of details for preventing, detecting, investigating and reporting to the State in order to guard against fraud and abuse in the administration and delivery of QUEST Integration services; • Provision of specific examples of educating providers, members and staff about fraud and abuse; • Provision of proactive mechanisms for detecting fraud; • Process in place to verify with members the delivery of services as claimed (i.e., explanation of benefits); and • Process for assuring that providers who have been terminated from providing services to Medicare and Medicaid are not reimbursed.

Applicant Name:		
Section: 80.345 Health Plan Administrative Requirements (20 pages maximum)		**Item:** 80.345.2. Health Plan Administrative Attachment and Requirements Narrative- Organization Charts (Attachment) and Narrative on Organization Charts
Applicable RFP Sections: 51.400	**Maximum Item Points:** 20	**Rating (0-5):**
Question	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. Note: the organizational chart(s) do not count towards the page limit.	

Met	**Not Met**

Summary of Requirements	• Answer all of the questions from Section 80.345; and • Other factors identified in Section 80.345. • Provision of an organizational chart that addresses, at a minimum, the required staff listed in the table in Section 51.410 of the contract; and • Staffing structure that demonstrates an effective operation to meet the requirements of the contract and to properly administer a program with a minimum of 20,000 members.

Applicant Name:		
Section: 80.345 Health Plan Administrative Requirements (20 pages maximum)		**Item:** 80.345.3. Health Plan Administrative Requirements Narrative- Organization and Staffing Table
Applicable RFP Sections: 51.400	**Maximum Item Points:** 20	**Rating (0-5):**
Question	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.	

Met	**Not Met**

Summary of Requirements	• Answer all of the questions from Section 80.345; and • Other factors identified in Section 80.345. • Provision of an organizational chart that addresses, at a minimum, the required staff listed in the table in Section 51.410 of the contract; and • Staffing structure that demonstrates an effective operation to meet the requirements of the contract and to properly administer a program with a minimum of 20,000 members.

Applicant Name:		
Section: 80.345 Health Plan Administrative Requirements (20 pages maximum)		**Item:** 80.345.4. Health Plan Administrative Requirements Narrative- Reporting Requirements
Applicable RFP Sections: 51.500	**Maximum Item Points:** 20 points	**Rating (0-5):**
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.	

Met	**Not Met**

Summary of Requirements	• Answer all of the questions from Sections 80.345; and • Other factors identified in Sections 80.345. • Process for reviewing the data in reports, prior to submitting to DHS, for consistency and accuracy; and • Process to submit reports to DHS in a timely manner.

Applicant Name:		
Section: 80.345 Health Plan Administrative Requirements (20 pages maximum)		**Item:** 80.345.5. Health Plan Administrative Requirements Narrative- Encounter Data Reporting Requirements
Applicable RFP Sections: 51.580	**Maximum Item Points:** 20 points	**Rating (0-5):**

Question	Q. 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. R. Please provide a narrative on what trend analysis you perform on your encounter data.

Met	**Not Met**

Summary of Requirements	• Answer all of the questions from Sections 80.345; and • Other factors identified in Sections 80.345. • Description of process regarding preparation of encounter data reports, the process for generating data to be included in reports, and the process used to validate reports.

Applicant Name:		
Section: 80.345 Health Plan Administrative Requirements (20 pages maximum)	**Item:** 80.345.6. Health Plan Administrative Requirements Narrative- Information Technology	
Applicable RFP Sections: 31.400 and 51.200	**Maximum Item Points:** 20 points	**Rating (0-5):**

Question

The applicant shall provide:

A. A description of its information systems environment including:

E. Details on the systems that 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);
- Its ability to receive different rate codes and contract types; 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.
5. Compliance with the National Correct Coding Initiative, readiness for ICD-10, and capability for health information exchange.

As part of its response, the applicant shall 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 shall 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. A description of how it shall ensure confidentiality of member information in accordance with professional ethics, state and federal laws, including HIPAA compliance provisions; and C. A description of its disaster planning and recovery operations policies and procedures both for operations and for member care.

Met	Not Met

Summary of Requirements	• Answer all of the questions from Sections 80.345; and • Other factors identified in Sections 80.345. • Attachments/diagrams/supporting documents (if provided) of information system provides insight into how the vendor's systems will be organized; and • Process to 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.

Applicant Name:		
Section: 80.345 Health Plan Administrative Requirements (20 pages maximum)		**Item:** 80.345.7. Health Plan Administrative Requirements Narrative- Third Party Liability
Applicable RFP Sections: 60.400	**Maximum Item Points:** 20 points	**Rating (0-5):**
Question	The applicant shall describe how it will coordinate health care benefits with other coverage, its methods for obtaining reimbursement from other liable third parties, and how it will fulfill all requirements as detailed in Section 60.400.	
Met		**Not Met**
Summary of Requirements	• Answer all of the questions from Sections 80.345; and • Other factors identified in Sections 80.345. • Description of a clear methodology for obtaining reimbursement from other liable third parties.	