STATE OF HAWAII

Department of Human Services

REQUEST FOR PROPOSAL (RFP)

QUEST Integration (QI)
Managed Care to Cover Medicaid and Other Eligible Individuals

RFP–MQD–2014-005

Med-QUEST Division

State of Hawaii
Department of Human Services
Med-QUEST Division
Health Care Services Branch

Request for Proposals

RFP-MQD-2014-005

QUEST Integration (QI)
Managed Care to Cover Medicaid and Other Eligible Individuals

August 5, 2013

Note: It is the applicant's responsibility to check the public procurement notice website, the request for proposal website, or to contact the RFP point-of contact identified in the RFP for any addenda issued to this RFP. If this RFP was downloaded from the public website, each applicant must provide contact information to the RFP contact person for this RFP. For your convenience, you may download the RFP Interest Form found in Appendix C, complete and e-mail or mail to the RFP contact person. The State shall not be responsible for any incomplete proposal submitted as a result of missing addenda, attachments or other information regarding the RFP.

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SECTION 10 ADMINISTRATIVE OVERVIEW

10.100 Purpose of the Request for Proposals

This Request for Proposals (RFP) solicits participation by qualified and properly licensed health plans at the time of proposal submission to provide improved access and enhanced quality healthcare services to eligible Medicaid members for medically necessary medical, behavioral health, and long-term services and supports. The services shall be provided in a managed care environment with reimbursement to qualifying health plans based on fully risk-based capitated rates. The Department of Human Services (DHS) reserves the right to add new eligible groups and benefits and to negotiate different or new rates including any such changes. Services to health plan members under the contracts awarded shall commence on the date identified in Section 20.100.

Applicants are advised that the entire RFP, any addenda, and the corresponding proposal shall be part of the contract with the successful applicants.

The DHS reserves the right to modify, amend, change, add or delete any requirements in this RFP and the documentation library to serve the best interest of the State. If significant amendments are made to the RFP, the applicants shall be provided at least ten working days or with sufficient time to submit their proposals.

10.200 Authority for Issuance of RFP

This RFP is issued under the authority of Title XIX of the Social Security Act, 42 USC Section 1396, et. seq. as amended, the implementing regulations issued under the authority thereof, Section 346-14 of the Hawaii Revised Statutes (HRS), and the provisions of the Chapter 103F, HRS. All applicants are charged with presumptive knowledge of all requirements cited by these authorities, and submission of a valid executed proposal by any applicant shall constitute admission of such knowledge on the part of such applicant. Failure to comply with any requirement may result in the rejection of the proposal. The DHS reserves the right to reject any or all proposals received or to cancel this RFP, according to the best interest of the State.

10.300 Issuing Officer

This RFP is issued by the State of Hawaii, DHS. The Issuing Officer is within the DHS and is the sole point of contact from the date of release of this RFP until the selection of a successful applicant. The Issuing Officer is:

Jon Fujii
Department of Human Services/Med-QUEST Division
601 Kamokila Boulevard, Suite 506A
Kapolei, Hawaii 96707
Telephone: (808) 692-8083

10.400 Use of Subcontractors

In the event of a proposal submitted jointly or by multiple organizations, one organization shall be designated as the prime applicant and shall have responsibility for not less than forty percent (40%) of the work to be performed. The project leader shall be an employee of the prime applicant. All other participants shall be designated as subcontractors. Subcontractors shall be identified by name and by a description of the services/functions they will be performing. The prime applicant shall be wholly responsible for the entire performance whether subcontractors are used. The prime applicant shall sign the contract with the DHS.

10.500 Campaign Contributions by State and County Contractors

Pursuant to section 11-355, HRS, campaign contributions are prohibited from specified State or county government contractors during the term of the contract if the contractors are paid with funds appropriated by a legislative body. For more information, refer to the Campaign Spending Commission webpage (www.hawaii.gov/campaign).

10.600 Organization of the RFP

This RFP is composed of 10 sections plus appendices:

- Section 10 – Administrative Overview – Provides general information on the purpose of the RFP, the authorities relating to the issuance of the RFP, the use of subcontractors and the organization of the RFP.
- Section 20 – RFP Schedule and Requirements - Provides information on the rules and schedules for procurement.

- Section 30 – Background and DHS Responsibilities – Describes the current populations receiving medical assistance and the role of the DHS.
- Section 40 – Provisions of Services – Health Plan Responsibilities – Provides information on the provider network requirements, the medical, behavioral health, and long-term services and supports, and the service coordination system requirements to be provided under the contract.
- Section 50 – Health Plan Administrative Requirements – Provides information on the enrollment and disenrollment of members, member services, value-based purchasing, marketing and advertising, quality management, utilization management requirements, information systems, health plan personnel, and reporting requirements.
- Section 60 – Financial Responsibilities – Provides information on health plan reimbursement, provider reimbursement, incentives, and third party liability.
- Section 70 – Special Terms and Conditions – Describes the terms and conditions under which the work shall be performed.
- Section 80 – Technical Proposal – Defines the required format of the technical proposal and the minimum information to be provided in the proposal.
- Section 90 – Proposed Capitation Rates – Defines the methodology that the DHS uses for setting capitation rates.
- Section 100 – Evaluation and Selection – Defines the evaluation criteria and explains the evaluation process.

Various appendices are included to support the information presented in Sections 10 through 100.

SECTION 20 RFP SCHEDULE AND REQUIREMENTS

20.100 RFP Timeline

The delivery schedule set forth herein represents the DHS' best estimate of the schedule that will be followed. If a component of this schedule, such as Proposal Due Date, is delayed, the rest of the schedule will likely be shifted by the same number of days. The proposed schedule is as follows:

Issue RFP	
Request teleconference number for orientation	
Orientation	
Submission of Technical Proposal Questions- #1	
Notice of Intent to Propose	
Responses to Technical Proposal Questions- #1	
Submission of Technical Proposal Questions- #2	
Responses to Technical Proposal Questions- #2	
Proposal Due Date	
Proposal Evaluation Period	
Issue Proposed Capitation Rates with Supporting Documentation	
Issue Section 90	
Issue Appendix E	
Request teleconference number for capitation rate orientation	
Proposed Capitation Rates Orientation	
Submission of Proposed Capitation Rate Questions	
Written Responses to Proposed Capitation Rate Questions	
Issue Final Capitation Rates	
Request teleconference number for capitation rate meeting with applicants to discuss final capitation rates	
Capitation Rate Meeting with Applicants to discuss Final Capitation Rates	

Final Revised Proposal	
Contract Award	
Contract Effective Date	
Commencement of Services to Members	

20.200 Orientation

An orientation for applicants in reference to this RFP will be held on the date identified in Section 20.100 from 11:00 am to 12:00 pm Hawaii Standard Time (H.S.T.) Room 577A in the Kakuhihewa Building, 601 Kamokila Boulevard, Kapolei, Hawaii. In addition, applicants may access the orientation via teleconference. Applicants shall e-mail to QIRFP@medicaid.dhs.state.hi.us no later than 12:00 pm H.S.T on the date identified in Section 20.100 to receive the teleconference number. The e-mail requesting the teleconference information shall identify each of the persons calling into the teleconference to include their name, organization, and position.

A second orientation for applicants for the proposed capitation rates will be held on the date identified in Section 20.100 from 9:00 to 11:00 am H.S.T. in room 577A in the Kakuhihewa Building, 601 Kamokila Boulevard, Kapolei, Hawaii. In addition, applicants may access the orientation via teleconference. Applicants shall e-mail to QIRFP@medicaid.dhs.state.hi.us no later than 12:00 pm H.S.T on the date identified in Section 20.100 to receive the teleconference number. The e-mail requesting the teleconference information shall identify each of the persons calling into the teleconference to include their name, organization, and position.

The capitation rate meeting with applicants to discuss final capitation rates will be held on the date identified in Section 20.100 from 9:00 to 11:00 am H.S.T. in room 577A in the Kakuhihewa Building, 601 Kamokila Boulevard, Kapolei, Hawaii. In addition, applicants may access the orientation via teleconference. Applicants shall e-mail to QIRFP@medicaid.dhs.state.hi.us no later than 12:00 pm H.S.T on the date identified in Section 20.100 to receive the teleconference information for the meeting. Requests for teleconference information received after the date and time identified will not be granted. The e-mail requesting the teleconference information shall identify each of the persons calling into the meeting to include their name, organization, and position.

Impromptu questions will be permitted at the orientation and spontaneous answers provided at the State purchasing agency's discretion. However, answers provided at the orientation are only intended as general direction and may not represent the State purchasing agency's position. Formal official responses will be provided in writing. To ensure a written response, any oral questions must be submitted in writing on the date identified in Section 20.100 in accordance with the process identified in Section 20.300, Submission of Written Questions.

20.300 Submission of Written Questions

Applicants shall submit all questions in writing via e-mail or on diskette in Word 2010 format (.docx) or lower to the following mailing address or e-mail address:

Jon Fujii
c/o Eric Nouchi
Med-QUEST Division-Finance Office
1001 Kamokila Boulevard, Suite 317
Kapolei, Hawaii 96707-2005
Email Address: qirfp@medicaid.dhs.state.hi.us

Technical Proposal Questions shall be submitted on the appropriate format provided in Appendix A by 12:00 p.m. (H.S.T.) on the applicable dates identified in Section 20.100.

Proposed Capitation Rate Questions must be submitted on the appropriate format provided in Appendix B by 12:00 pm (H.S.T.) on the date identified in Section 20.100.

The DHS shall respond to the written questions no later than the dates identified in Section 20.100. No verbal responses shall be considered as official.

20.400 Notice of Intent to Propose

Potential applicants shall submit a Notice of Intent to Propose to the Issuing Officer no later than 2:00 p.m. (H.S.T.) on the date specified in Section 20.100 utilizing the format provided in Appendix C. Submission of a Notice of Intent to Propose is not a prerequisite for the submission of a proposal, but it is necessary that the Issuing Officer receive the letter by this deadline to assure proper distribution of amendments, questions and answers and other communication regarding this RFP.

The Notice of Intent can be mailed, e-mailed or faxed to:

Jon Fujii
c/o Eric Nouchi
Med-QUEST Division-Finance Office
1001 Kamokila Boulevard, Suite 317
Kapolei, Hawaii 96707-2005
Fax Number: (808) 692-7989
Email Address: qirfp@medicaid.dhs.state.hi.us

20.500 Requirements to Conduct Business in the State of Hawaii

Applicants are advised that if awarded a contract under this RFP, each Applicant shall, upon award of the contract, furnish proof of compliance with the following requirements of HRS, required to conduct business in the State:

HRS Chapter 237, tax clearance

HRS Chapter 383, unemployment insurance

HRS Chapter 386, workers' compensation

HRS Chapter 392, temporary disability insurance

HRS Chapter 393, prepaid health care

One of the following:

- Be registered and incorporated or organized under the laws of the State (hereinafter referred to as a "Hawaii business"); or
- Be registered to do business in the State (hereinafter referred to as a "compliant non-Hawaii business").

Applicants are advised that there are costs associated with compliance under this section. Any costs are the responsibility of the applicant. Proof of compliance is shown by providing the Certificate of Vendor Compliance issued by Hawaii Compliance Express.

20.600 Hawaii Compliance Express (HCE)

The DHS utilizes the HCE to verify compliance with the requirements to conduct business in the State, upon award of the contract. The HCE is an electronic system that allows vendors/contractors/service providers doing business with the State to quickly and easily demonstrate compliance with applicable laws. It is an online system that replaces the necessity of obtaining paper compliance certificates of Tax Clearance Certificates from the Department of Taxation and Internal Revenue Service, Certificate of Compliance from the Department of Labor and Industrial Relations, and a Certificate of Good Standing from the Department of Commerce and Consumer Affairs. There is a nominal annual fee for the service which is the responsibility of the applicant. The "Certificate of Vendor

Compliance" issued online through HCE provides the registered Applicant's current compliance status as of the issuance date, and is accepted for both contracting and final payment purposes. See website:

https://vendors.ehawaii.gov/hce/splash/welcome.html

20.700 Documentation

Applicants may review information describing Hawaii's QUEST, QUEST Expanded Access (QExA), and fee-for-service (FFS) programs in the Request for Proposals (RFP) documentation library located on the Med-QUEST Division (MQD) website at www.med-quest.us. The documentation library contains material designed to provide additional program and supplemental information and shall have no effect on the requirements stated in this RFP.

All possible efforts shall be made to ensure that the information contained in the documentation library is complete and current. However, the DHS does not warrant that the information in the library is complete or correct and reserves the right to amend, delete and modify the information at any time without notice to the applicants.

20.800 Rules of Procurement

To facilitate the procurement process, various rules have been established as described in the following subsections.

20.810 No Contingent Fees

No applicant shall employ any company or person, other than a bona fide employee working solely for the applicant or company regularly employed as its marketing agent, to solicit or secure this contract, nor shall it pay or agree to pay any company or person, other than a bona fide employee working solely for the applicant or a company regularly employed by the applicant as its marketing agent, any fee commission, percentage, brokerage fee, gift, or other consideration contingent upon or resulting from the award of a contract to perform the specifications of this RFP.

20.820 Discussions with Applicants

A. Prior To Submittal Deadline:
Discussions may be conducted with applicants to promote understanding of the purchasing agency's requirements.

B. After Proposal Submittal Deadline:
Discussions may be conducted with applicants whose proposals are determined to be reasonably susceptible of being selected for award, but proposals may be accepted without discussions, in accordance with Section 3-143-403, Hawaii Administrative Rules (HAR).

20.830 RFP Amendments

The DHS reserves the right to amend the RFP any time prior to the closing date for the submission of the proposals. In addition, addenda may also be made after proposal submission consistent with Section 3-143-301(e), HAR. Amendments shall be sent to all applicants who requested copies of the RFP or submitted a letter of intent to propose from the DHS pursuant to Section 20.400.

20.840 Costs of Preparing Proposal

Any costs incurred by the applicant for the development and submittal of a proposal in response to this RFP are solely the responsibility of the applicant, whether or not any award results from this solicitation. The State of Hawaii shall provide no reimbursement for such costs.

20.850 Provider Participation in Planning

Provider participation in a State purchasing agency's efforts to plan for or to purchase health and human services prior to the State purchasing agency's release of a RFP, including the sharing of information on community needs, best practices, and providers' resources, shall not disqualify providers from submitting proposals if conducted in accordance with Sections 3-142-202 and 3-142-203, HAR, pursuant to Chapter 103F, HRS.

20.860 Disposition of Proposals

All proposals become the property of the State of Hawaii. The successful proposal shall be incorporated into the contract. A copy of successful and unsuccessful proposal(s) shall be public record

as part of the procurement file as described in Section 3-143-616, HAR, pursuant to Chapter 103F, HRS. The State of Hawaii shall have the right to use all ideas, or adaptations to those ideas, contained in any proposal received in response to this RFP. Selection or rejection of the proposal shall not affect this right.

According to Section 3-143-612, HAR, applicants who submit technical proposals that fail to meet mandatory requirements or fail to meet all threshold requirements during the technical evaluation phase may retrieve their technical proposal within thirty (30) days after its rejection from the purchasing agency. After thirty (30) days, the purchasing agency may discard the rejected technical proposal.

20.870 Rules for Withdrawal or Revision of Proposals

A proposal may be withdrawn or revised at any time prior to, but not after, the Proposal Due Date specified in Section 20.100, provided that a request in writing executed by an applicant or its duly authorized representative for the withdrawal or revision of such proposal is filed with the DHS before the deadline for receipt of proposals. The withdrawal of a proposal shall not prejudice the right of an applicant to submit a new proposal.

After the Proposal Due Date as defined in Section 20.100, all proposals timely received shall be deemed firm offers that are binding on the applicants for ninety (90) days. During this period, an applicant may neither modify nor withdraw its proposals without written authorization or invitation from the DHS.

Applicants may withdraw their bid without incurring penalties as described in Section 100.700.

Notwithstanding the general rules for withdrawal or revision of proposals, the State purchasing agency may request that applicants submit a final revised proposal in accordance with Section 3-143-607, HAR.

20.900 Confidentiality of Information

The DHS shall maintain the confidentiality of proposals only to the extent allowed or required by law, including but not limited to Section 92F-13, HRS, and Sections 3-143-604 and 3-143-616, HAR. If the applicant seeks to maintain the confidentiality of sections of the proposal, each page of the section(s) shall be marked as "Proprietary" or "Confidential." An explanation to the DHS of how substantial competitive harm would occur if the information were released is required. If the explanation is sufficient, then to the extent permitted by the exemptions in Section 92F-13, HRS, the affected section may be deemed confidential. Such information shall accompany the proposal, be clearly marked, and shall be readily separable from the proposal to facilitate eventual public inspection of the non-confidential sections of the proposal. The DHS shall maintain the confidentiality of the information to the extent allowed by law. Blanket labeling of the entire document as "proprietary," however, shall result in none of the document being considered proprietary.

21.100 Acceptance of Proposals

The DHS reserves the right to reject any or all proposals received or to cancel this RFP according to the best interest of the State.

The DHS also reserves the right to waive minor irregularities in proposals providing such action is in the best interest of the State.

Where the DHS may waive minor irregularities, such waiver shall in no way modify the RFP requirements or excuse an applicant from full compliance with the RFP specifications and other contract requirements if the applicant is awarded the contract.

The DHS also reserves the right to consider as acceptable only those proposals submitted in accordance with all technical requirements set forth in this RFP and which demonstrate an understanding of the requirements. Any proposal offering any other set of terms and conditions contradictory to those included in this RFP may be disqualified without further notice.

Applicants shall submit their final revised proposals based upon changes to Section 80.310.F, 80.310.G, and 80.335.4 only. Final revised proposals shall be submitted electronically to qirfp@medicaid.dhs.state.hi.us in accordance with timelines identified in Section 20.100. If the applicant does not submit a final revised proposal, then the applicant's last proposal shall be deemed to be the applicant's final revised proposal.

21.200 Submission of Proposals

Each qualified applicant shall submit only one (1) proposal. More than one (1) proposal shall not be accepted from any applicant.

The Proposal Application Identification (Form SPO-H-200) shall be completed and submitted with the proposal (Appendix D).

The applicant shall submit three (3) bound copies of the technical proposal, and a complete electronic version (in MS Word 2010 or lower or in PDF) of the technical proposal on a CD. The Issuing Officer shall receive the technical proposals no later than 2:00 p.m. (H.S.T.) on the Proposal Due date specified in Section 20.100 or postmarked by the USPS no later than the date specified in Section 20.100 and received by the Department within ten (10) days of the Proposal Due date. All mail-ins postmarked by USPS after the date specified in Section 20.100, shall be rejected. Hand deliveries shall not be accepted after 2:00 p.m., H.S.T., the date specified in Section 20.100. Deliveries by private mail services such as FEDEX shall be considered hand deliveries and shall not be accepted if received after 2:00 p.m., H.S.T., the date specified in Section 20.100. Proposals shall be mailed or delivered to:

Jon Fujii
c/o Eric Nouchi
Department of Human Services
Med-QUEST Division/Finance Office
1001 Kamokila Boulevard, Suite 317
Kapolei, Hawaii 96707

The outside cover of the package containing the technical proposal shall be marked:

Hawaii DHS/RFP-MQD-2014-005

QUEST Integration (QI) Managed Care to Cover Medicaid and Other Eligible Individuals
Technical Proposal
(Name of Applicant)

Applicants are solely responsible for ensuring receipt of the proposals and amendments by the appropriate DHS office by the required deadlines.

Any amendments to proposals shall be submitted in a manner consistent with this section.

21.300 Disqualification of Applicants

An applicant shall be disqualified and the proposal automatically rejected for any of the following reasons:

- Proof of collusion among applicants, in which case all bids involved in the collusive action shall be rejected and any applicant participating in such collusion shall be barred from future bidding until reinstated as a qualified applicant;
- An applicant's lack of responsibility and cooperation as shown by past work or services;
- An applicant's being in arrears on existing contracts with the State or having defaulted on previous contracts;
- An applicant shows any noncompliance with applicable laws;
- An applicant's delivery of proposal after the proposal due date and time;

- An applicant's failure to pay, or satisfactorily settle, all bills overdue for labor and material on former contracts with the State at the time of issuance of this RFP;
- An applicant's lack of financial stability and viability;
- An applicant's consistently substandard performance related to meeting the MQD requirements from previous contracts;
- An applicant's lack of sufficient experience to perform the work contemplated;
- An applicant's lack of a proper provider network; or
- An applicant's lack of a proper license to cover the type of work contemplated if required to perform the required services.

21.400 Irregular Proposals

Proposals shall be considered irregular and rejected for the following reasons including, but not limited to the following:

- The transmittal letter is unsigned by an applicant or does not include evidence of authority of the officer submitting the proposal to submit such proposal;
- The proposal shows any non-compliance with applicable law or contains any unauthorized additions or deletions, conditional bids, incomplete bids, or irregularities of any kind, which may tend to make the proposal incomplete, indefinite, or ambiguous as to its meaning; or
- An applicant adds any provisions reserving the right to accept or reject an award, or to enter into a contract

pursuant to an award, or adds provisions contrary to those in the solicitation.

21.500 Rejection of Proposals

The State reserves the right to consider as acceptable only those proposals submitted in accordance with all requirements set forth in this RFP and which demonstrate an understanding of the issues involved and comply with the scope of service. Any proposal offering any other set of terms and conditions contradictory to those included in this RFP may be rejected without further notice.

A proposal may be automatically rejected for any or more of the following reasons: (Relevant sections of the HAR for Chapter 103F, HRS, are parenthesized)

1. Rejection for failure to cooperate or deal in good faith (Section 3-141-201, HAR);
2. Rejection for inadequate accounting system (Section 3-141-202, HAR);
3. Late Proposals (Section 3-143-603, HAR);
4. Unauthorized Multiple/Alternate Proposals (Section 3-143-605, HAR);
5. Inadequate response to RFPs (Section 3-143-609, HAR);
6. Proposal not responsive (Section 3-143-610(a)(1), HAR); or
7. Applicant not responsible (Section 3-143-610(a)(2), HAR).

21.600 Cancellation of RFP

The RFP may be canceled and any or all proposals may be rejected in whole or in part, when it is determined to be in the best interests of the State.

21.700 Opening of Proposals

Proposals, modifications to proposals, and withdrawals of proposals shall be date-stamped and, when possible, time-stamped upon receipt by the DHS. All documents so received shall be held in a secure place by the State purchasing agency and not opened until the Proposal Due Date as described in Sections 20.100 and 21.200.

Procurement files shall be open for public inspection after a contract has been awarded and executed by all parties.

21.800 Additional Materials and Documentation

Upon request from the State purchasing agency, each applicant shall submit any additional materials and documentation reasonably required by the State purchasing agency in its evaluation of the proposal.

21.900 Award Notice

A notice of intended contract award, if any, shall be sent to the selected applicant on or about the Contract Award date identified in Section 20.100.

Any contract arising out of this solicitation is subject to the approval of the Department of Attorney General as to form and to all further approvals, including the approval of the Governor as required by statute, regulation, rule, order, or other directive.

The State of Hawaii is not liable for any costs incurred prior to the Commencement of Services to Member date identified in Section 20.100.

22.100 Protests

Applicants may file a Notice of Protest against the awarding of the contract. The Notice of Protest form, SPO-H-801, is available on the State Procurement Office (SPO) website http://hawaii.gov/spo/ in the Toolbox/QuickLinks/ SPO Forms/Forms for Vendors, Contractors, and Service Providers/Forms for Health and Human Services Providers and Protest Forms Instructions section. Only the following may be protested:

1. A state purchasing agency's failure to follow procedures established by Chapter 103F, HRS;
2. A state purchasing agency's failure to follow any rule established by Chapter 103F, HRS; and
3. A state purchasing agency's failure to follow any procedure, requirement, or evaluation criterion in an RFP issued by the state-purchasing agency.

The Notice of Protest shall be postmarked by the USPS or hand delivered to: (1) the head of the state purchasing agency conducting the protested procurement; and (2) the procurement officer who is conducting the procurement (as indicated below) within five (5) working days of the postmark of the Notice of Findings and Decisions sent to the protestor. Delivery services other than USPS shall be considered hand deliveries and considered submitted on the date of the actual receipt by the DHS.

Procurement Officer	**Head of State Purchasing Agency**
Name: Meredith R. Nichols	Name: Pankaj Bhanot
Title: Med-QUEST Assistant Administrator	Title: Department of Human Services Director
Mailing Address: P.O. Box 700190 Kapolei, Hawaii 96709-0190	Mailing Address: P.O Box 339 Honolulu, Hawaii 96809-0339
Business Address: 1001 Kamokila Boulevard, Suite 317 Kapolei, Hawaii 96707	Business Address: 1001 Kamokila Boulevard, Suite 317 Kapolei, Hawaii 96707

SECTION 30 BACKGROUND AND DEPARTMENT OF HUMAN SERVICES RESPONSIBILITIES

30.100 Background and Scope of Service

30.110 Scope of Service

The State of Hawaii seeks to improve the health care and to enhance and expand coverage for persons eligible for Medicaid and Children's Health Insurance Program (CHIP) by the most cost effective and efficient means through the QUEST Integration (QI) program with an emphasis on prevention and quality health care. (Because CHIP in Hawaii is operated as Medicaid expansion, Medicaid is used to represent both Medicaid and CHIP.) Certain other individuals ineligible for these programs due to citizenship status may be eligible for other medical assistance and served through contracted health plans.

The health plan shall assist the State of Hawaii in this endeavor through the tasks, obligations and responsibilities detailed herein.

30.120 Background

Originally implemented as the QUEST program in 1994, QUEST stands for:

Quality care
Universal access
Efficient utilization
Stabilizing costs, and
Transforming the way health care is provided to QUEST members.

The QUEST program was designed in 1994 to increase access to health care and control the rate of growth in health care costs.

The QUEST program has gone through many changes since 1994 that included expanding the populations covered by QUEST. In 2009, the DHS implemented its QUEST Expanded Access (QExA) program that allowed its aged, blind, or disabled (ABD) population to also benefit from managed care.

The QUEST Integration program is a melding of several programs to include but not limited to QUEST, QUEST-ACE, QUEST-Net and QExA program into one-Statewide program providing managed care services to all of Hawaii's Medicaid population.

The goals of the QUEST Integration program are to:

- Improve health outcomes for Medicaid beneficiaries covered under the demonstration;
- Maintain a managed care delivery system that leads to more appropriate utilization of the health care system and a slower rate of expenditure growth; and
- Support strategies and interventions targeting the social determinants of health.

30.200 Definitions/Acronyms

Abuse - Any practices that are inconsistent with sound fiscal, business, or medical practice and result in unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized

standards or contractual obligations (including the terms of the RFP, contracts and requirements of state and federal regulations) for health care in the managed care setting. Incidents or practices of providers that are inconsistent with professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

Activities of Daily Living (ADLs) – Activities a person performs on a daily basis, for self care, such as feeding, grooming, bathing, ambulating, dressing and toileting.

Acute Care – Short-term medical treatment provided under the direction of a physician, usually in an acute care hospital, for members having an acute illness or injury.

Adult - All members age of twenty-one (21) years or older for coverage benefit purposes only.

Adult group- Individuals who obtain Medicaid eligibility in accordance with Hawaii Administrative Rules, 17-1718.

Adult Day Care Center – A licensed facility that is maintained and operated by an individual, organization, or agency for the purpose of providing regular care which includes supportive care to four (4) or more disabled adults.

Adult Day Health Center – A licensed facility that provides organized day programs of therapeutic, social, and health services provided to adults with physical or mental impairments, or both,

which require nursing oversight or care, for the purpose of restoring or maintaining, to the fullest extent possible, their capacity for remaining in the community.

Advance Directive - A written instruction, such as a living will or durable power of attorney for health care, recognized under State law relating to provision of health care when the individual is incapacitated.

Advanced Practice Registered Nurse with Prescriptive Authority (APRN-Rx)- A registered nurse with advanced education and clinical experience who is qualified within his/her scope of practice under State law to provide a wide range of primary and preventive health care services, prescribe medication, and diagnose and treat common minor illnesses and injuries consistent with §16-89, Subchapter 16, HAR.

Adverse Benefit Determination —Any one of the following:

- The denial or restriction of a requested service, including the type or level or service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or part, of payment for a service;
- The failure to provide services in a timely manner, as defined in Section 40.230 (availability of providers);

- The failure of the health plan to act within prescribed timeframes and regarding the standard resolution of grievances and appeals;
- For a rural area member or for islands with only one health plan or limited providers, the denial of a member's request to obtain services outside the network:
    - From any other provider (in terms of training, experience, and specialization) not available within the network;
    - From a provider not part of a network that is the main source of a service to the member, provided that the provider is given the same opportunity to become a participating provider as other similar providers;
    - If the provider does not choose to join the network or does not meet the qualifications, the member is given a choice of participating providers and is transitioned to a participating provider within 60 days;
    - Because the only health plan or provider does not provide the service because of moral or religious objections;
    - Because the member's provider determines that the member needs related services that would subject the member to unnecessary risk if received separately and not all related services are available within the network; and
    - The State determines that other circumstances warrant out-of-network treatment.
- The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums,

deductibles, coinsurance, and other member financial liabilities.

Ambulatory Care - Preventive, diagnostic and treatment services provided on an outpatient basis by physicians, nurse practitioners, physician assistants and other PCPs.

Annual Plan Change Period - A period established by the DHS which occurs annually and is the one scheduled time during which existing members may transfer between health care plans.

Appeal - A review by the health plan of an adverse benefit determination.

Applicant - A person, organization or entity proposing to provide the goods and services specified in the RFP.

Appointment – A face-to-face interaction between a provider and a member. This does include interactions made possible using telemedicine but does not include telephone or e-mail interaction.

Assisted Living Facility – A licensed facility that consists of a building complex offering dwelling units to individuals and services to allow residents to maintain an independent assisted living lifestyle. The facility shall be designed to maximize the independence and self-esteem of limited-mobility persons who feel that they are no longer able to live on their own.

Attending Physician - The physician primarily responsible for the care of a member with respect to any particular injury, illness, or routine care.

Authorized Representative – An individual or organization designated by the member, in writing, with the designee's signature or by legal documentation of authority to act on behalf of a member, in compliance with federal and state law regulations. Designation of an authorized representative may be requested at time of application or at other times as required.

Balanced Budget Act of 1997 (BBA) – Federal legislation that sets forth, among other things, requirements, prohibitions, and procedures for the provision of Medicaid services through managed care organizations and organizations receiving capitation payments.

Behavioral Health Services - Services provided to persons who are emotionally disturbed, mentally ill, or addicted to or abuse alcohol, prescription drugs or other substances.

Benchmark – A target, standard or measurable goal based on historical data or an objective/goal.

Beneficiary - Any person determined eligible by the DHS and is currently receiving Medicaid.

Benefit Year - A continuous twelve (12) month period generally following an open enrollment period. In the event the contract is

not in effect for the full benefit year, any benefit limits shall be pro-rated.

Benefits - Those health services that the member is entitled to under the QUEST Integration program and that the health plan arranges to provide to its members.

Breast and Cervical Cancer Program – A program implemented by the State of Hawaii, Department of Health (DOH) in the detection of breast and cervical cancer or pre-cancerous condition of the breast or cervix. These individuals receive treatment in the QUEST Integration program when referred by DOH.

Capitated Rate – The fixed monthly payment per member paid by the State to the health plan for which the health plan provides a full range of benefits and services contained in this RFP.

Capitation Payment – A fixed monthly payment paid per member by the DHS to the health plan for which the health plan provides the defined set of benefits and the payment may be prorated for the portion of the month for which the member was enrolled with the health plan.

The Centers for Medicare & Medicaid Services (CMS) – The organization within the Federal Department of Health and Human Services that administers the Medicare and Medicaid programs.

Child and Adolescent Mental Health Division (CAMHD) - A division of the State of Hawaii Department of Health that provides behavioral health services to children ages three (3) through twenty (20) who require support for emotional or behavioral development.

Child Health Insurance Program (CHIP))- A joint federal-state health care program for uninsured, targeted, low-income children, established pursuant to Title XXI of the Social Security Act that is implemented as a Medicaid expansion program in Hawaii.

Children - All members under the age of twenty-one (21) years of age for coverage benefit purposes only.

Chronic Condition – Any on-going physical, behavioral, or cognitive disorder, including chronic illnesses, impairments and disabilities. There is an expected duration of at least twelve (12) months with resulting functional limitations, reliance on compensatory mechanisms and service use or needs beyond what is normally considered routine.

Claim - A document which is submitted by the health plan for payment of health-related services rendered to a member.

Clean Claim - A claim that can be processed without obtaining additional information from the health plan of the service from a third party. It includes a claim with errors originating in a State's claims system. It does not include a claim from a provider who is

under investigation for fraud or abuse, or a claim under review for medical necessity.

Cold-Call Marketing – Any unsolicited personal contact, whether by phone, mail, or any other method, by the health plan with a potential member, member, or any other individual for marketing.

Community Care Foster Family Home (CCFFH) - A certified home that provides twenty-four (24) hour living accommodations, including personal care and homemaker services.

Community Care Management Agency (CCMA) - An agency that engages in locating, coordinating and monitoring comprehensive services to residents in community care foster family homes or members in E-ARCHs and assisted living facilities. A health plan may be the owner of a community care management agency.

Community Integration Services (CIS) – Pre-tenancy supports and tenancy sustaining services that support individuals to be prepared and successful tenants in housing that is owned, rented or leased to the individual. Pre-Tenancy supports help to identify the individual's needs and preferences, assists in the housing search process, and help to arrange details of the move. Tenancy sustaining services help with independent living sustainability that includes tenant/landlord education, tenant coaching and assistance with community integration and inclusion to help develop natural support networks.

Complete Periodic Screens - Screens that include, but are not limited to, age appropriate medical and behavioral health screening examinations, laboratory tests, and counseling.

Comprehensive Risk Contract – A risk contract that covers comprehensive services including, but not limited to inpatient hospital services, outpatient hospital services, rural health clinic services, Federally Qualified Health Center (FQHC) services, laboratory and X-ray services, early and periodic screening, diagnostic and treatment services, and family planning services.

Contract- A contract between the health plan and the DHS to provide medical services. A written agreement between the DHS and the contractor that includes the Competitive Purchase of Service (AG Form 103F1 (10/08)), General Conditions for Health & Human Services Contracts (AG Form 103F (10/08), any special conditions and/or appendices, this RFP, including all attachments and addenda, and the health plan's proposal.

Contract Services - The services to be delivered by the contractor that are designated by the DHS.

Contractor - Successful applicant that has executed a contract with the DHS.

Co-Payment - A specific dollar amount or percentage of the charge identified that a member pays at the time of service to a health care plan, physician, hospital or other provider of care for covered services provided to the member.

Cost-neutral – When the aggregate cost of serving people in the community is less than the aggregate cost of serving the same (or comparable) population in an institutional setting.

Covered Services - Those services and benefits to which the member is entitled under Hawaii's Medicaid programs.

Cultural Competency – A set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance, and respect for cultural differences and similarities within, among and between groups and the sensitivity to know how these differences influence relationships with members. This requires a willingness and ability to draw on community-based values, traditions and customs, to devise strategies to better meet culturally diverse member needs, and to work with knowledgeable persons of and from the community in developing focused interactions, communications and other supports.

Days - Unless otherwise specified, the term "days" refers to calendar days.

Deficit Reduction Act of 2005 (DRA) – Federal legislation that sets forth, among other things, requirements for improved enforcement of citizenship and nationality documentation as well as for long-term services and supports eligibility

Dental Emergency - An oral condition that does not include services aimed at restoring or replacing teeth and shall include

services for relief of dental pain, eliminate acute infection, treat acute injuries to teeth or supportive structures of the oral-facial complex.

Department of Human Services (DHS) – Department of Human Services, State of Hawaii.

Director - Director of the Department of Human Services, State of Hawaii.

D-SNP- A D-SNP is a dual-eligible special needs plan (D-SNP) that enrolls beneficiaries who are entitled to both Medicare (Title XVIII) and Medical Assistance from a State Plan under Title XIX (Medicaid). D-SNPs are defined in the federal regulations at 42 CFR 422.2 and authorized at section 1859 of the Social Security Act.

Dual Eligible – Eligible for both Medicare and Medicaid.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) – A mandated program under Title XIX of the Social Security Act that provides services for children up to age 21 years that emphasizes the importance of prevention through early screening for medical, dental and behavioral health conditions and timely diagnosis and treatment of conditions that are detected. The State covers all services under Title XIX of the Social Security Act that are included in Section 1905 (a) of the Social Security Act, when medically needed, to correct or

ameliorate defects and physical and mental illness and conditions discovered as a result of EPSDT screening.

Effective Date Of Enrollment - The date from which a participating health plan is required to provide benefits to a member.

Eligibility Determination - A process of determining, upon receipt of a written request on the Department's application form, whether an individual or family is eligible for medical assistance.

Emergency Medical Condition –The sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms, substance abuse) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to body functions;
3. Serious dysfunction of any bodily functions;
4. Serious harm to self or others due to an alcohol or drug abuse emergency;
5. Injury to self or bodily harm to others; or
6. With respect to a pregnant woman who is having contractions:

- That there is inadequate time to effect a safe transfer to another hospital before delivery; or
- That transfer may pose a threat to the health or safety of the woman or her unborn child.

Emergency Services – Covered inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition, furnished by a provider that is qualified to furnish emergency services, where and emergency is found to exist using a prudent layperson standard.

Encounter - A record of medical services rendered by a provider to a member enrolled in the health plan on the date of service.

Encounter Data - A compilation of encounters.

Enrollee – An individual who has selected or is assigned by the DHS to be a member of a participating QUEST Integration health plan. See also Beneficiary or Member.

Enrollee (Potential) – A Medicaid member who is subject to mandatory enrollment or may voluntarily elect to enroll in a health plan, who must make a choice on which plan to enroll into within a specified time designated by the DHS. See also Potential Member.

Enrollment - The process by which an individual, who has been determined eligible, becomes a member in a health plan, subject to the limitations specified in the DHS Rules.

Enrollment fee - The amount a member is responsible to pay that is equal to the spenddown amount for a medically needy individual or cost share amount for an individual receiving long term services and supports.

Expanded Adult Residential Care Home (E-ARCH) – A licensed facility that provides twenty-four (24) hour living accommodations, for a fee, to adults unrelated to the family, who require at least minimal assistance in the activities of daily living, personal care services, protection, and healthcare services, and who may need the professional health services provided in an intermediate care facility or skilled nursing facility. There are two types of expanded care ARCHs in accordance with Section 321-15.62, HRS:

- Type I – home allowing five (5) or fewer residents provided that up to six (6) residents may be allowed at the discretion of the department to live in a type I home, with no more than three (3) nursing facility level residents; and
- Type II – home allowing six (6) or more residents with no more than twenty percent (20%) of the home's licensed capacity as nursing facility level residents.

External Quality Review Organization (EQRO) – An organization that meets the competence and independence requirements pursuant to 42 CFR Section 438.350, 42 CFR Section 438.356, and performs external quality review.

Federal Financial Participation (FFP) - The contribution that the federal government makes to state Medicaid programs.

Federal Poverty Level (FPL) - The set minimum amount of gross income that a family needs for food, clothing, transportation, shelter and other necessities. This amount is updated annually by the Department of Health and Human Services (HHS).

Federally Qualified Health Center (FQHC) – An entity that provides outpatient health programs pursuant to Section 1905(l)(2)(B) of the Social Security Act and is accessible to all community members.

Federally Qualified Health Maintenance Organization (HMO) – A Health Maintenance Organization (HMO) that CMS has determined is a qualified HMO under Section 1310(d) of the Public Health Service Act.

Fee-for-service (FFS) – (1) a method of reimbursement based on payment for specific services rendered to a Medicaid member; and (2) a Med-QUEST Division program.

Financial Relationship – A direct or indirect ownership or investment interest (including an option or nonvested interest) in any entity. This direct or indirect interest may be in the form of equity, debt, or other means and includes an indirect ownership or investment interest no matter how many levels removed from a direct interest, or a compensation management with an entity.

Fraud - The intentional deception or misrepresentation made by an entity or a person with the knowledge that the deception could result in some unauthorized benefit to the entity, her/himself, or to some other person in a managed care setting.

Grievance - An expression of dissatisfaction from a member, member's representative, or provider on behalf of a member about any matter other than an adverse benefit determination.

Grievance Review - A State process for the review of a denied or unresolved (dissatisfaction from a member) grievance by a health plan.

Grievance System - The term used to refer to the overall system that includes grievances and appeals handled at the health plan level with access to the State administrative hearing process.

Hawaii Prepaid Medical Management Information System (HPMMIS) – Federally certified Medicaid Management Information System (MMIS) used for the processing, collecting, analysis and reporting of information needed to support Medicaid and CHIP functions.

Health Care Professional – A physician, podiatrist, optometrist, psychologist, dentist, physician assistant, physical or occupational therapist, speech-language pathologist, audiologist, registered or practical nurse, licensed clinical social worker, nurse practitioner,

or any other licensed or certified professional who meets the State requirements of a health care professional.

Health Care Provider – Any individual or entity that is engaged in the delivery of health care services and is legally authorized to do so by the State.

Health Maintenance Organization (HMO) – See Managed Care Organizations.

Health Plan - A plan offered by an insurance company or other organization, which provides different health care benefit packages.

Healthcare Effectiveness Data and Information Set(HEDIS) - A standardized reporting system for health plans to report on specified performance measures that are developed by the National Committee for Quality Assurance (NCQA).

Health Plan Manual, or State Health Plan Manual - MQD's manual describing policies and procedures used by MQD to oversee and monitor the health plan's performance, and provide guidance to the health plan.

HIPAA – The Health Insurance Portability and Accountability Act that was enacted in 1996. Title I of HIPAA protects health insurance coverage for workers and their families when they change or lose their jobs. Title II, the Administrative Simplification (AS) provisions, requires the establishment of

national standards for electronic healthcare transactions and national identifiers for providers, health insurance plans and employers. The HIPAA AS provisions also address the security and privacy of health information.

Home and Community Based Services (HCBS)- Long-term services and supports provided to individuals who meet nursing facility level of care to allow those individuals to remain in their home or community.

Hospital - Any licensed acute care facility in the service area to which a member is admitted to receive inpatient services pursuant to arrangements made by a physician.

Hospital Services - Except as expressly limited or excluded by this agreement, those medically necessary services for registered bed patients that are generally and customarily provided by licensed acute care general hospitals in the service area and prescribed, directed or authorized by the attending physician or other provider.

Incurred But Not Reported (IBNR) - Liability for services rendered for which claims have not been received. Includes Reported but Unpaid Claims (RBUC).

Incentive Arrangement – Any payment mechanism under which a health plan may receive funds for meeting targets specified in the contract; or any payment mechanism under which

a provider may receive additional funds from the health plan for meeting targets specified in the contract.

Incurred Costs - (1) Costs actually paid by a health plan to its providers for eligible services (for health plans with provider contracts); or (2) a percentage of standard charge to be negotiated with the DHS (for health plans that provide most services in-house or for capitated facilities), whichever is less. Incurred costs are based on the service date or admission date in the case of hospitalization. For example, all hospital costs for a patient admitted on December 22, 2014 and discharged on January 5, 2015 would be associated with the 2014 benefit year because the admission date occurred during that benefit year. All other costs apply to the benefit year in which the service was rendered.

Independent Activities of Daily Living (IADLs) – Activities related to independent living, including preparing meals, running errands to pay bills or pick up medication, shopping for groceries or personal items, and performing light or heavy housework.

Indian- The term ‘‘Indians’’ or ‘‘Indian’’, unless otherwise designated, means any person who is a member of an Indian tribe, as defined in this section 30.200, except that, for the purpose of sections 1612 and 1613 of title 25 of the U.S. Code, such terms shall mean any individual who:

- irrespective of whether he or she lives on or near a reservation, is a member of a tribe, band, or other organized group of Indians, including those tribes, bands,

or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member, or

- is an Eskimo or Aleut or other Alaska Native, or
- is considered by the Secretary of the Interior to be an Indian for any purpose, or
- is determined to be an Indian under regulations promulgated by the Secretary of Health and Human Services.

Indian tribe - The term "Indian tribe" means any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688) [43 U.S.C. 1601 et seq.], which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

Inquiry - A contact from a member that questions any aspect of a health plan, subcontractor's, or provider's operations, activities, or behavior, or requests disenrollment, but does not express dissatisfaction.

Institutional or nursing facility level of care (NF LOC)-The determination that a member requires the services of licensed nurses in an institutional setting to carry out the physician's planned regimen for total care. These services can be provided in

the home or in community-based programs as a cost-neutral, least restrictive alternative to institutional care in a hospital or nursing home.

Interperiodic Screens - EPSDT screens that occur between the comprehensive EPSDT periodic screens for determining the existence of physical or mental illnesses or conditions. An example of an interperiodic screen is a physical examination required by the school before a child can participate in school sports and a comprehensive periodic screen was performed more than three (3) months earlier.

Kauhale (community) On-Line Eligibility Assistance (KOLEA) System - The State of Hawaii certified system that maintains eligibility information for Medicaid and other medical assistance beneficiaries.

Long-Term Services and Supports (LTSS) – A continuum of care and assistance ranging from in-home and community-based services for individuals 65 years or older and individuals with a disability(ies) who need help in maintaining their independence, to institutional care for those who require that level of support.

Managed Care – A comprehensive approach to the provision of health care that combines clinical services and administrative procedures within an integrated, coordinated system to provide timely access to primary care and other necessary services in a cost effective manner.

Managed Care Organization (MCO) – An entity that has, or is seeking to qualify for, a comprehensive risk contract under the final rule of the BBA and that is: (1) a federally qualified HMO that meets the requirements under Section 1310(d) of the Public Health Service Act; (2) any public or private entity that meets the advance directives requirements and meets the following conditions: (a) makes the service it provides to its Medicaid members as accessible (in terms of timeliness, amount, duration, and scope) as those services that are available to other non-Medicaid members within the area served by the entity and (b) meets the solvency standards of 42 CFR Section 438.116 and Section 432-D-8, HRS.

Marketing – Any communication from a health plan to a member, potential member, or any other individual that can reasonably be interpreted as intending to influence the individual to enroll in the particular health plan, or dissuade them from enrolling into, or disenrolling from, another health plan.

Marketing Materials – Materials that are produced in any medium by or on behalf of a health plan and can reasonably be interpreted as intending to market to potential enrollees.

Medicaid -

The following federal/state programs, established and administered by the State, that provide medical care and long-term care services to eligible individuals in the State:

1. Medicaid under Title XIX of the Social Security Act;

2. The State children's health insurance program (CHIP) under Title XXI of the Social Security Act; and
3. The section 1115 demonstration project under Title XI of the Social Security Act (42 U.S.C. subchapters XIX, XXI and XI).

Medical Expenses - The costs (excluding administrative costs) associated with the provision of covered medical services under a health plan.

Medical Facility – An inpatient hospital or outpatient surgical facility.

Medical Necessity – Procedures and services, as determined by the department, which are considered to be necessary and for which payment will be made. Medically necessary health interventions (services, procedures, drugs, supplies, and equipment) must be used for a medical condition. There shall be sufficient evidence to draw conclusions about the intervention's effects on health outcomes. The evidence shall demonstrate that the intervention can be expected to produce its intended effects on health outcomes. The intervention shall be the most cost-effective method available to address the medical condition. Sufficient evidence is provided when evidence is sufficient to draw conclusions, if it is peer-reviewed, is well-controlled, directly or indirectly relates the intervention to health outcomes, and is reproducible both within and outside of research settings.

Medical Office - Any outpatient treatment facility staffed by a physician or other healthcare professional licensed to provide medical services.

Medical Services - Except as expressly limited or excluded by the contract, those medical and behavioral health professional services of physicians, other health professionals and paramedical personnel that are generally and customarily provided in the service area and performed, prescribed, or directed by the attending physician or other provider.

Medical Specialist - A physician, surgeon, or osteopath who is board certified or board eligible in a specialty listed by the American Medical Association (AMA), or who is recognized as a specialist by the participating health care plan or managed care health system.

Medicare - The health care insurance program for the aged and disabled administered by the Social Security Administration under Title XVIII of the Social Security Act. Part A of Medicare covers hospitalization; Part B of the program covers outpatient services and requires a premium; Part C which is an alternative to Parts A and B and offers managed care options, and Part D of the program which covers prescription drugs and may require a premium.

Medicare Special Savings Program Members – Qualified Severely Impaired Individuals, Medical Payments to Pensioners, Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMB's), Qualifying Individuals (QIs) and

Qualified Disabled Working Individuals (QDWIs) who may be eligible to receive assistance with some Medicare cost-sharing.

Member – An individual who has been designated by the Med-QUEST Division to receive medical services through the QUEST Integration program as defined in Section 30.300 and is currently enrolled in a QUEST Integration health plan. See also Enrollee.

Member (Potential) – A Medicaid member who is subject to mandatory enrollment and must choose a health plan in which to enroll within a specified timeframe determined by DHS. See also Enrollee (Potential).

Med-QUEST Division (MQD) – ~~Under the State of Hawaii, Department of Human Services, the single state Medicaid agency responsible for administering Medicaid and other medical assistance programs, in Hawaii.~~
The offices of the State of Hawaii, Department of Human Services, which oversees, administers, determines eligibility, and provides medical assistance and services for State residents.

National Committee for Quality Assurance (NCQA) – An organization that sets standards, develops HEDIS measures, and evaluates and accredits health plans and other managed care organizations.

New Member - A member (as defined in this section) who has not been enrolled in a health plan during the prior six (6) month period.

Non-Managed Care Med-QUEST Division programs- programs run by the Med-QUEST Division outside of the managed care program such as FFS or SHOTT (Section 30.700).

Nurse Delegation – In accordance with HAR 16-89-106, the ability of a registered nurse to delegate the special task for nursing care to an unlicensed assistive person.

Nursing Facility (NF) – A licensed facility that provides appropriate care to persons referred by a physician. Such persons are those who:

- Need twenty-four (24) hour a day assistance with the normal activities of daily living;
- Need care provided by licensed nursing personnel and paramedical personnel on a regular, long-term basis; and
- May have a primary need for twenty-four (24) hours of skilled nursing care on an extended basis and regular rehabilitation services.

Partial Screens - Those EPSDT screens that occur when a screen for one (1) or more specific conditions is needed. An example of a partial screen is a vision or hearing screen needed to confirm the school's report of abnormal vision or hearing for a child. A partial screen includes making the appropriate referrals for treatment.

Participating - When referring to a health plan it means a health plan that has entered into a contract with the DHS to provide

covered services to enrollees. When referring to a health care provider it means a provider who is employed by or who has entered into a contract with a health plan to provide covered services to enrollees. When referring to a facility it means a facility that has entered into a contract with a health plan for the provision of covered services to members.

Patient Protection and Affordable Care Act of 2010 (ACA) – Federal legislation that, among other things, puts in place comprehensive health insurance reforms.

Pay for Performance Actual Rate - The actual score on a specific performance measure, for either the current period or prior period.

Pay for Performance Target Rate - The target score on a specific performance measure, for the current period.

Pay for Performance Rate Gap – The difference between the current target rate and the prior actual rate on a specific performance measure. It is an indicator of the room for improvement a health plan has for a specific performance measure.

Personal Assistance – Care provided when a member, member's parent, guardian or legal representative employs and supervises a personal assistant who is certified by the health plan as able to provide the designated services whose decision is based on direct observation of the member and the personal assistant

during the actual provision of care. Documentation of this certification will be maintained in the member's individual plan of care.

Physician – A licensed doctor of medicine or doctor of osteopathy.

Post-Stabilization Services – Covered services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition or to improve or resolve the member's condition.

Prepaid Plan - A health plan for which premiums are paid on a prospective basis, irrespective of the use of services.

Presumptive Eligibility - Initial Medicaid eligibility given to a potential member or enrollee for a specified period of time prior to the final determination of their eligibility.

Primary Care – Outpatient care to include prevention, treatment of acute conditions, and management of chronic conditions. Primary care is often first contact care of an undifferentiated complaint which may result in diagnostic testing and treatment, appropriate consultation or referral, and incorporates coordination and continuity of care.

Primary Care Provider (PCP) - A provider who is licensed in the State of Hawaii and is (1) a physician, either an M.D. (Doctor of Medicine) or a D.O. (Doctor of Osteopathy), and must generally

be a family practitioner, general practitioner, general internist, pediatrician or obstetrician/gynecologist (for women, especially pregnant women); or (2) an advanced practice registered nurse with prescriptive authority; or (3) a licensed physician assistant.

Prior Period Coverage – The period from the eligibility effective date as determined by the DHS up to the date of enrollment in a health plan.

Private Health Insurance Policy - Any health insurance program, other than a disease-specific or accident-only policy, for which a person pays for insurance benefits directly to the carrier rather than through participation in an employer or union sponsored program.

Proposal - The applicant's response to this RFP submitted in the prescribed manner to perform the required services.

Protected Health Information (PHI) – As defined in the HIPAA Privacy Rule, 45 CFR Section 160.103.

Provider - An individual, clinic, or institution, including but not limited to allopathic and osteopathic physicians, nurses, referral specialists and hospitals, responsible for the provision of health services under a health plan. Providers are not a subset of subcontractors.

Provider Grievance – An expression of dissatisfaction made by a provider as described in Section 40.620.

QUEST Integration (QI)- QUEST Integration is the capitated managed care program that provides health care benefits, including long-term services and supports, to individuals, families, and children, both non-aged, blind, or disabled (non-ABD) individuals and ABD individuals, with household income up to a specified federal poverty level (FPL).

Resident of Hawaii - A person who resides in the State of Hawaii or establishes his or her intent to reside in the State of Hawaii.

Request For Proposal (RFP) – This Request for Proposal number RFP-MQD-2014-005, issued on August 5, 2013.

Risk Share –The losses or gains associated with health plan costs or savings related to expected health care expenditures that are shared between the health plan and the DHS (see Appendix E). A health plan may separately enter into risk share arrangements with providers.

Rural Health Center (RHC) - An entity that provides outpatient services in a rural area designated as a shortage area and certified in accordance with 42 CFR Part 491, Subpart A.

Service Area - The geographical area defined by zip codes, census tracts, or other geographic subdivisions, i.e. island that is served by a participating health plan as defined in its contract with the DHS.

Service Coordination – The process which assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet a member's healthcare needs using communication and all available resources to promote quality outcomes. Proper care coordination occurs across a continuum of care, addressing the ongoing individual needs of a member rather than being restricted to a single practice setting.

Service Coordinator – An individual who coordinates, monitors and ensures that appropriate and timely care is provided to the member. A service coordinator may be a specific person selected by the member or assigned by the health plan.

Service Plan– A written plan based on an assessment that includes, but is not limited to, the following:

- Goals, objectives or desired outcomes; and
- A list of all services required (Medicaid and non-Medicaid) the amount, the frequency and duration of each service, and the type of provider to furnish each service.

The service plan is regularly reviewed and updated and agreed upon by the member/or authorized representative with their service coordinator.

Significant Change- A change that may affect access, timeliness or quality of care for a member (i.e., loss of a large provider group, change in benefits, change in health plan operations, etc.) or that would affect the member's understanding and procedures for receiving care.

Special Treatment Facility – A licensed facility that provides a therapeutic residential program for care, diagnoses, treatment or rehabilitation services for individuals who are socially or emotionally distressed, have a diagnosis of mental illness or substance abuse, or who have a developmental or intellectual disability (DD/ID).

State - The State of Hawaii.

State Fiscal Year (SFY) - The twelve (12) month period for Hawaii's fiscal year that runs from July 1 through June 30.

Sub-Acute Care – A level of care that is needed by a patient not requiring acute care, but who needs more intensive skilled nursing care than is provided to the majority of patients in a skilled nursing facility.

Subcontract - Any written agreement between the health plan and another party to fulfill the requirements of the contract.

Subcontractor – A party with whom the health plan contracts to provide services and/or conduct activities related to fulfilling the requirements of this RFP and contract.

Support for Emotional and Behavioral Development (SEBD) – A program for behavioral health services for children and adolescents administered by CAMHD.

Temporary Assistance to Needy Families (TANF) - Time limited public financial assistance program that replaced Aid to Families with Dependent Children (AFDC) that provides a cash grant to qualified adults and children.

Third Party Liability (TPL) – Any person, institution, corporation, insurance company, public, private or governmental entity who is or may be liable in contract, tort or otherwise by law or equity to pay all or part of the medical cost of injury, disease or disability of a member or to Medicaid.

Urgent Care - The diagnosis and treatment of medical conditions which are serious or acute but pose no immediate threat to life or health but which require medical attention within 24 hours.

Utilization Management Program (UMP) - The requirements and processes established by a health plan to ensure members have equitable access to care, and to manage the use of limited resources for maximum effectiveness of care provided to members.

Waste – Overutilization of services or other practices that do not improve health outcomes and result in unnecessary costs. Generally not considered caused by criminally negligent actions but rather the misuse of resources.

30.300 Program Population Descriptions

QI programs are mandatory managed care programs that provide a package of medical, behavioral health, and LTSS benefits to

individuals meeting the Medicaid financial and non-financial eligibility requirements for individuals and families. Description of the individuals eligible and benefits for QI are found in Hawaii Administrative Rules, Title 17, Med-QUEST Division (1700 series).

30.310 Medicaid Covered Populations

- Children under 19 years of age
- Former foster care children under age 26
- Pregnant women
- Parent or caretaker relatives
- Individuals receiving transitional medical assistance
- Adults 19 to 64 years of age
- Individuals who are aged, blind, or with a disability
- Non-citizens or refugees
- Repatriates
- Individuals with breast and cervical cancer

30.320 Non-Medicaid Covered Population

- Individuals who are aged, blind, or with a disability, ineligible for Medicaid due to citizenship status, and legally reside in Hawaii
- Individuals with breast and cervical cancer who are ineligible for Medicaid due to citizenship status

30.330 ACA Basic Health Option

The DHS may add a program that shall meet the requirements of the Basic Health Option under the ACA for individuals with household income <200% of the federal poverty level (FPL) who are <65 years old, ineligible for Medicaid, and eligible for advance-premium tax credits through a health insurance exchange.

30.340 Excluded Populations

Individuals excluded from participation in managed care under this contract include those who are:

- Medicare Special Savings Program Members;
- Enrolled in the State of Hawaii Organ and Transplant Program (SHOTT);
- Retroactively eligible only; and
- Eligible under non-ABD medically needy spenddown.

Individuals who are residents of the State applying to enter the QI program from an inpatient facility located in the continental U.S. or U.S. Territories shall not be enrolled in a health plan until they return to the State of Hawaii and determined eligible for medical assistance by the Department.

30.400 Overview of the Department of Human Services (DHS) Responsibilities

The DHS shall administer this contract and monitor the health plan's performance in all aspects of the health plan's operations. Specifically, the DHS shall:

- Establish and define the medical, behavioral health, and LTSS benefits to be provided by the health plan;
- Develop the rules, policies, regulations and procedures governing the programs;
- Establish the health plan capitation rates;
- Negotiate and contract with the health plans;
- Determine initial and continued eligibility of members;

- Enroll and disenroll members;
- Provide benefits and services as described in Section 30.700;
- Conduct the readiness review as described in Section 51.700 and determine if health plan is ready to commence services on the date described in Section 20.100.
- Review and monitor the adequacy of the health plan's provider networks;
- Monitor the quality assessment and performance improvement programs of the health plan and providers;
- Review and analyze utilization of services and reports provided by the health plan;
- Participate in the State Administrative Hearing processes;
- Monitor the health plan's grievance processes;
- Monitor the financial status of the programs;
- Analyze the programs to ensure they are meeting the stated objectives;
- Manage the Hawaii Prepaid Medicaid Management Information System (HPMMIS);
- Provide member information to the health plan;
- Review and approve the health plan's marketing materials;
- Review and approve all health plan materials that are distributed to their members;
- Establish health plan incentives when deemed appropriate;
- Oversee the activities of other MQD contracts, including but not limited to the SHOTT program contractor;
- Oversee the activities of the ombudsman program which will be available to all members to assure access to care, to

promote quality of care and to strive to achieve member satisfaction with QI;

- Impose civil or administrative monetary penalties and/or financial sanctions for violations or health plan non-compliance with contract provisions;
- Report criminal conviction information disclosed by providers and report provider application denials pursuant to 42 CFR Section 455.106(b);
- Verify out-of-state provider licenses during provider enrollment and review and monitor provider licenses on an on-going basis;
- Refer member and provider fraud cases to appropriate law enforcement agencies; and
- Coordinate with and monitor fraud and abuse activities of the health plan.

The DHS shall comply with, and monitor the health plan's compliance with, all applicable state and federal laws and regulations including but not limited to 42 CFR 438.602.

The DHS shall screen and enroll, and periodically revalidate, all network providers in accordance with the requirements of 42 CFR part 455, subparts B and E. Through its contracts with the health plan, DHS shall ensure that all network providers are enrolled with DHS as Medicaid providers consistent with provider disclosure, screening and enrollment requirements.

30.500 Eligibility and Enrollment Responsibilities

30.510 Eligibility Determinations

The DHS is solely responsible for determining eligibility. Provided the applicant meets all eligibility requirements, the individual shall become eligible for Medical Assistance, and be effectively enrolled in and covered by a health plan on:

- The date a completed application is received by the Department; or
- If specified by the applicant, any date on which Medicaid eligible medical expenses were incurred and is no earlier than the immediate ten (10) days immediately prior to the date of application; or
- Any date specified by the individual for which Medicaid eligible LTSS were incurred and is no earlier than three (3) months immediately prior to the date of application; or
- The first day of the subsequent month in which all eligibility requirements are met.

30.520 Enrollment Responsibilities

Upon notification of application approval, eligible individuals who submitted their applications electronically shall be provided the opportunity to select a participating health plan on the date of notification. DHS must provide informational notices to potential enrollees upon their eligibility within a timeframe that allows them to use the information to choose a participating health plan. Notices are to include (i) the available health plans from which they can choose, (ii) clear instructions on how to tell DHS their choice, (iii) implications of actively choosing or not making an active choice of a health plan, (iv) an explanation of the length of the enrollment period, 90 day without cause disenrollment period,

and all other disenrollment options. Individuals who make a health plan selection upon eligibility notification will be enrolled in that health plan retroactively to date of eligibility as applicable and prospectively. Individuals who do not make a choice of health plans when notified of eligibility, and those who do not submit an application electronically, will be auto-assigned to a health plan retroactively to date of eligibility as applicable and prospectively. The following exceptions shall apply:

- Initial enrollment for existing QI program members shall be as described in Section 30.540.1;
- Newborn enrollment shall be as described in Section 30.540.2;
- Enrollment of a new member to an existing case shall be as described in Section 30.540.3;
- Enrollment of foster care children shall be as described in Section 30.540.4;
- Changes made during annual plan change period shall be described in Section 30.550;
- Individuals who have lost eligibility for a period of less than six (6) months; and
- Exceptions identified in Section 30.560 related to enrollment cap or limit.

Individuals who are auto-assigned to a health plan will have fifteen (15) days to change their health plan. Their change shall be effective prospectively beginning the first day of the following month. The DHS or its agent shall provide information and assistance to individuals who are auto-assigned to a health plan. This information and assistance includes information about the

basics of managed care; benefits covered by the QI programs; and how to access information on the health plans' provider networks. The DHS shall provide new beneficiaries an informational booklet that includes this information. The DHS shall prorate the total cost of printing the informational booklet equally among the number of health plans.

Individuals who have lost eligibility for a period of less than six (6) months shall be automatically reenrolled into their former health plan.

In addition, the DHS shall allow all members to change health plans without cause for the first ninety (90) following their enrollment in a health plan regardless of whether enrollment is a result of selection or auto-assignment, and whether enrollment is from initial eligibility or from annual plan change. Members have only one (1) change of health plan during the ninety (90) day grace period. The DHS shall educate providers about the option for members to make health plan changes during the ninety (90) day grace period. This applies to all members, including aged, blind, and disabled members.

Health plan change requests received during the ninety (90) day period shall be effective prospectively beginning the first day of the following month in which the health plan change request was received by DHS. After the ninety (90) day grace period, members shall only be allowed to change plans during the Annual Plan Change Period, except for cause, as described in Section 30.600, or as outlined in Section 30.540.

The DHS or its agent shall provide the member with written notification of the health plan in which the member is enrolled and the effective date of enrollment each time health plan enrollment changes. This notice shall serve as verification of enrollment until a membership card is received by the member from the health plan.

The health plan shall receive a daily file of enrollment/disenrollment information in a HIPAA-compliant 834 file format via the MQD Secure File Transfer (SFT) file server. The enrollment information shall include at a minimum the case name, case number, member's name, mailing address, date of enrollment, TPL coverage, date of birth, sex, and other data that the DHS deems pertinent and appropriate.

DHS shall exclude health plans that are not awarded a future contract, from the member selection choice notice or auto assignment ninety (90) days prior to the end of this current contract. This exclusion shall be applied on a per island basis, based on the islands awarded each health plan in the future contract.

30.530 Auto-Assignment to a Health Plan

The DHS shall make the auto-assignment according to the following algorithm:

- Sixty (60%) of the auto-assign algorithm shall be split equally amongst each of health plans;

- Forty (40%) of the auto-assign algorithm shall be based upon quality factors that may include but not be limited to the following quality measures:
    - CAHPS scores;
    - HEDIS measures (relative and/or actual improvement);
    - EPSDT measures;
    - CMS designated Medicaid and CHIP measures; and
    - Technical proposal scores.
- The DHS may include (as part of the quality-based component of the auto-assign algorithm) other validated measures associated with health plans performance and improved health outcomes of their members;
- The quality portion of the auto-assign algorithm shall be updated on an annual basis;
- The quality-based component of the auto-assign shall not be implemented until the date indicated in Section 51.800;
- For each contract year following the first year in which the quality-based component is implemented, the quality-based component shall increase by 10% and the non quality-based component shall decrease by 10%;
- Prior to implementing the quality portion of the auto-assign, the auto-assign algorithm shall be split equally amongst each health plan; and
- Health plans shall be allowed to waive their right to participate in the auto-assignment algorithm.

DHS shall inform the health plan of the specifications of each measure for the auto-assign algorithm no less than fourteen (14)

days prior to the beginning of the time period from which the data is being measured.

The DHS shall keep members enrolled in the same QI health plan if they remain eligible for QI benefits but their eligibility category changes. The DHS shall not provide a choice to the member until the next annual plan change period unless there is cause, as defined in Section 30.600. Nothing in this section negates the members' rights.

30.540 Enrollment Exceptions

30.540.1 Initial Enrollment Period for Existing QI Program Members

Prior to the Commencement of Services to Members date identified in Section 20.100, all individuals in the populations identified in Section 30.300 shall be required to select a health plan. A thirty (30) day period in the one-hundred and eighty days (180) prior to Commencement of Services to Members is hereby referred to as the initial enrollment period for existing members. All enrollments that occur during this period shall be effective on the Commencement of Services to Members date identified in Section 20.100.

For individuals that do not select a health plan, but are enrolled in a health plan from the previous QUEST or QExA procurement that has been awarded a contract in this procurement, the individual shall remain in their current health plan in order to promote continuity of care.

To assure a smooth transition into a new health plan during the enrollment period for existing members, health plan requirements are described in Section 41.700.

30.540.2 Newborn Enrollment

Throughout the term of the contract and to the extent possible, newborns shall be assigned to have the same health insurer as their mother, whether the mother was enrolled in a QI or commercial plan, retroactive to the newborn's date of birth. The newborn auto-assignment shall be effective for at least the first thirty (30) calendar days following the birth. The DHS shall notify the mother that she may select a different health plan for her newborn at the end of the thirty (30) day period. Choice of health plan shall be effective the first day of the following month.

If the newborn mother's health insurance is unknown or she is not enrolled in a health plan offered by a health insurer that also offers QI plan, the newborn may be auto-assigned into a QI health plan in accordance with Section 30.530 until member makes a choice of health plan. If auto-assignment is required, the newborn will be enrolled based on health plan enrollment of family members in the case. If the newborn does not have any family members in QI, then the newborn is auto-assigned based on the algorithm.

The DHS reserves the right to disenroll the newborn if the newborn is later determined to be ineligible for QI. The DHS shall notify the health plan of the disenrollment by electronic media. The DHS shall make capitation payments to the health plan for the months in which the newborn was enrolled in the health plan.

30.540.3 Additions to Existing Cases

For any new case or new member enrolled to an existing case, DHS shall promote family continuity. All members of a newly eligible case shall be auto-assigned to the same plan. If the new member is less than 19 years, he or she will be enrolled in the same health plan as the youngest family member. If the new member is 19 years or older, he or she will be enrolled in the same health plan as the primary client.

30.540.4 Foster Children

Foster children may be enrolled or disenrolled from a health plan at any time upon written request from the DHS Child Welfare Services (CWS) staff. Disenrollment shall be at the end of the month in which the request was made and enrollment into the new health plan shall be on the first day of the next month.

30.550 Annual Plan Change (APC) Period

The DHS shall hold an APC period at least annually to allow members the opportunity to change health plans without cause.

The DHS may establish additional APC periods as deemed necessary on a limited basis (e.g., termination of a health plan during the contract period).

At least sixty (60) days before the start of the enrollment period, the DHS shall mail, to all households with individuals who are eligible to participate in the APC period, an information packet that describes the process. The DHS shall include in the packet a

newsletter that includes information about the health plans. The DHS may provide this information via electronic means (i.e., e-mail) if this is the preferred form of communication of the member.

If during any APC period during this contract period, no health plan selection is made and the member is enrolled in a returning plan (the health plan has a current and new contract with the DHS), the person shall remain in the current health plan. This policy also applies to a person enrolled in a returning plan that is capped (see Section 30.560).

If during any APC period during this contract period, no health plan selection is made and the member is enrolled in a non-returning health plan (the health plan has a current, but not a new contract with the DHS), the DHS shall auto-assign the member to a health plan using the DHS established auto-assignment algorithm in Section 30.530.

For members changing from one health plan to another during the APC period, the effective date of enrollment shall be the first day of the second month after the annual plan change period end.

30.560 Member Enrollment Limits/Caps

An *enrollment cap* is a limit on enrollment placed on health plan by the DHS to ensure that no one health plan has a majority of members in their health plan or as a sanction. When in response to member distribution among health plans, the DHS may implement enrollment caps as follows:

Island	**Enrollment Cap**
Oahu	60% of island enrollment (for member choice)
Oahu	40% of island enrollment (for auto-assignment)
All other islands	No cap

Prior to all annual plan change periods, the DHS may review the enrollments of the health plans. The DHS may implement an enrollment cap on any health plan that has an enrollment equal to or exceeding the enrollment cap for the island. If an enrollment cap is enacted, it will start at the beginning of the benefit year. The DHS reserves the right to lift an enrollment cap at any time.

The DHS may implement an enrollment cap for auto-assignment for health plans that have an enrollment equal to or exceeding the enrollment cap for the island. The DHS may review health plans enrollments at the times identified in Section 51.800 to enact health plan enrollment cap(s). The DHS reserves the right to lift an enrollment cap related to auto-assignment at any time.

An *enrollment limit* is a maximum number of members that a health plan chooses to accept into its health plan Statewide. A health plan's request for an enrollment limit must be approved by DHS. At minimum, DHS approval requires that at least two health plans are operating without an enrollment cap or limit in all of the service areas in which the requesting health plan operates.

Health plan(s) shall notify DHS of their enrollment limit no less than ninety (90) days prior to Initial Enrollment (Section 30.540.1) or ninety (90) days prior to annual plan change (Section 30.550) as applicable. Enrollment limits shall apply for one year and may be renewed. Enrollment limits shall be enacted Statewide; DHS shall not allow health plan(s) to enact island-specific enrollment levels.

If a health plan has an enrollment cap or limit, it shall not be available during the annual plan change period or to new enrollees but will be available for existing members to continue with the health plan. Below are exceptions to this policy:

1. Enrollment of newborns in a QI plan that have the same health insurer as their mother, whether the mother was enrolled in a QI or commercial plan, shall be exempt from any cap or limit; or
2. Newly determined eligibles that have PCPs or behavioral health providers who are exclusive to the capped or limited health plan within the previous twelve (12) months shall be allowed to enroll in the capped or limited health plan. The capped or limited health plan shall provide the DHS with a listing of exclusive PCP and behavioral health providers, which shall be verified with the other health plans; or
3. Members who have lost eligibility for a period of less than six (6) months may return to the capped or limited health plan; and
4. A child(ren) under foster care, kinship guardianship or subsidized adoption;

5. In a health plan with a waiting list for HCBS or "at risk" services when another health plan in the same service area open to new members does not have a waitlist for these services shall be able to enroll in a capped or limited health plan;
6. A newly-eligible Medicare individual who enrolls in a D-SNP will be able to continue enrollment in the health plan he/she was already enrolled in for Medicaid, regardless of whether the D-SNP is offered by the same organization offering the Medicaid plan, or will be able to switch to another D-SNP (for both Medicare and Medicaid);
7. A newly eligible Medicaid individual who is already enrolled in a Medicare Advantage (MA) D-SNP will be able to continue enrollment in the MA plan D-SNP he/she was already enrolled in for Medicare; or
8. The enrollment cap imposed under Hawaii's Medicaid program would not allow a current enrolled dual eligible to move his/her Medicaid portion of benefits from one plan to another, but will not limit a currently enrolled Medicare beneficiary from switching his/her Medicare portion of benefits to another D-SNP.

30.570 Member Education Regarding Status Changes

The DHS shall educate members concerning the necessity of providing, to the health plan and the DHS, any information affecting their member status. Events that could affect the member's status and may affect the eligibility of the member include but are not limited to:

- Change in household (movements in and out of a household);
- Death of the member or family member (spouse or dependent);
- Birth;
- Marriage;
- Divorce;
- Adoption;
- Transfer to LTSS;
- Change in health status (e.g., pregnancy or permanent disability);
- Change of residence or mailing address;
- Institutionalization (e.g., state mental health hospital, Hawaii Youth Correctional Facility, or prison);
- TPL coverage that includes accident related medical condition;
- Inability of the member to meet citizenship, alien status, photo and identification documentation requirements as required in the Deficit Reduction Act (DRA) Section 6037 and in other federal law;
- Telephone number;
- Change or addition of Social Security Number (SSN); or
- Other household changes.

30.600 Disenrollment Responsibilities

The DHS shall be the sole authority to disenroll a member from a health plan and from the programs. The DHS shall process all

disenrollment requests submitted orally or in writing by the member or his or her authorized representative.

Appropriate reasons for disenrollment include, but are not limited to the following related to program participation:

- Member no longer qualifies based on the medical assistance eligibility criteria or voluntarily leaves the program;
- Death of a member;
- Incarceration of the member;
- Member enters the State Hospital;
- Member enters the Hawaii Youth Correctional Facility;
- Member enters the State of Hawaii Organ and Tissue Transplant (SHOTT) program;
- Member is in foster care and has been moved out-of-state by the DHS;
- Member becomes a Medicare Special Savings Program member beneficiary; or
- Member provides false information with the intent of enrolling in the programs under false pretenses.

Additional appropriate reasons for disenrollment include, but are not limited to the following related to the health plan:

- Member chooses another health plan during the annual plan change period;
- The member missed Annual Plan Change due to temporary loss of Medicaid eligibility and was reenrolled in their former health plan as described in Section 30.520;

- Member's PCP, behavioral health provider, or LTSS residential facility is not in the health plan's provider network and is in the provider network of a different health plan;
- Member is eligible to receive HCBS or "at risk" services and is enrolled in a health plan with a waiting list for HCBS or "at risk" services and another health plan does not have a waiting list for the necessary service(s);
- The health plan's contract with DHS is terminated or is suspended as described in Section 71.600;
- Mutual agreement by participating health plans, the member, and DHS;
- Member requests disenrollment for cause, at any time, due to:
    - An administrative appeal decision;
    - Provisions in administrative rules, Federal or State statutes;
    - A legal decision;
    - Relocation of the member to a service area where the health plan does not provide service;
    - Change in foster placement if necessary for the best interest of the child;
    - The health plan's refusal, because of moral or religious objections, to cover the service the member seeks as allowed for in Section 40.300;
    - The member's need for related services (for example a cesarean section and a tubal ligation) to be performed at the same time and not all related services are available within the network and the

member's PCP or another provider determines that receiving the services separately would subject the member to unnecessary risk;

- The member does not have access to women's healthcare specialists for breast cancer screening, pap smears, or pelvic exams;
- The member is a medically needy individual who is two full months in arrears in the payment of the designated enrollment fee, unless the failure to pay occurs because:
  - The enrollee is not in control of their personal finances, and the arrearage is caused by the party responsible for the enrollee's finances, and action is being taken to remediate the situation, including but not limited to:
    - Appointment of a new responsible party for the enrollee's finances; or
    - Recovery of the enrollee's funds from the responsible party which will be applied to the enrollee's enrollment fee obligation.
  - The member is in control of their finances, and the arrearage is due to the unavailability of the enrollee's funds due to documented theft or financial exploitation, and action is being taken to:
    - Ensure that theft or exploitation does not continue; or
    - Recover the enrollee's funds to pay the enrollee's enrollment fee obligation; or

- Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's health care needs, lack of direct access but not limited to certified nurse midwives, pediatric nurse practitioners, family nurse practitioners, women's health care specialists for breast cancer screenings, pap smears and pelvic exams, if available in the geographic area in which the member resides.

- Any member who uses MLTSS that would experience a disruption in their residence or employment due to having to change their residential, institutional, or employment supports provider based on that provider's change in status from in-network to out-of-network.

The DHS shall provide daily disenrollment data to the health plan via disenrollment roster on the MQD FTP file server seven (7) days a week.

The effective date of all approved disenrollments shall be no later than the first day of the second month following the month that the member or the health plan files the request. If the DHS fails to make a determination in that time frame, the disenrollment shall be considered approved.

Any member dissatisfied with DHS' determination denying their request to transfer or disenroll from their health plans shall be given access to the State administrative hearing process.

30.700 Covered Benefits and Services Provided by the DHS

30.710 State of Hawaii Organ and Tissue Transplant (SHOTT) Program

The health plan shall be responsible for cornea transplants and bone grafts.

The DHS shall provide medically necessary transplants through the SHOTT program. Covered transplants must be non-experimental, non-investigational for the specific organ/tissue and specific medical condition being treated. The SHOTT Program covers adults and children (from birth through the month of their 21st birthday). These transplants may include liver, heart, heart-lung, lung, kidney, kidney-pancreas, and allogenic and autologus bone marrow transplants regardless of the member's Medicare eligibility. In addition, children may be covered for transplants of the small bowel with or without liver. Children and adults must meet specific medical criteria as determined by the State and the SHOTT Program contractor.

The health plan shall work with the transplant facility to submit a request for an evaluation by the SHOTT Program, to include the referral request (DHS 1144) as well as complete supporting documentation. In addition, the health plan shall also submit an ADRC packet to MQD for disability determination. Based on the information provided, the ADRC shall 1) make a disability determination, and 2) The MQD and the SHOTT contractor shall evaluate the member as a potential transplant candidate.

For members in the Adult group, the health plan shall only submit a referral request (DHS 1144) with complete supporting documentation. The health plan shall not submit an ADRC packet for disability determination.

The State and the SHOTT Program contractor shall determine eligibility of individuals for transplants except those transplants provided by the health plan. If the DHS and the SHOTT Program contractor determine that the individual meets the transplant criteria, the individual shall be disenrolled from the health plan and transferred to the SHOTT program. If the individual does not meet the criteria for transplantation, the individual shall remain in the health plan.

The following shall occur if the individual is determined to meet the criteria for a transplant by SHOTT, but the transplantation facility does not accept the individual as a patient:

- The individual shall be re-enrolled into the same health plan in which he/she was enrolled prior to the transplant evaluation, effective the 1st day of the following month.
- If the individual's condition changes to make him/her a better candidate for a transplant, the health plan in which he/she belongs may resubmit him/her for re-consideration for the transplant program.

30.720 Dental Services

The DHS shall provide dental services to health plan members through the month of their twenty-first (21st) birthday.

The DHS shall provide emergency dental services for adult members age twenty-one (21) years and older. Covered adult dental emergencies are services to: relieve dental pain, eliminate infections, and treat acute injuries to teeth and supporting structures.

The health plan shall provide dental services that are medically necessary to treat medical conditions. The health plan shall be responsible for providing referrals, follow-ups, coordination, and provision of appropriate medical services related to medically necessary dental needs.

The health plan shall provide any dental or medical services resulting from a dental condition that are provided in a medical facility (e.g., inpatient hospital and ambulatory surgical center). This includes medical services provided to QI adults and children that are required as part of a dental treatment and certain dental procedures performed by both dentists (oral surgeons) and physicians (primarily plastic surgeons, otolaryngologists and general surgeons), as defined in Appendix F.

Specifically, the health plan shall be responsible for:

- Referring EPSDT eligible members to the DHS Dental Program contractor for EPSDT dental services and other dental needs not provided by the health plan;
- Providing referral, follow-up, coordination, and provision of appropriate medical services related to medically necessary dental needs, including but not limited to emergency room

treatment, hospital stays, ancillary inpatient services, operating room services, excision of tumors, removal of cysts and neoplasms, excision of bone tissue, surgical incisions, treatment of fractures (simple & compound), oral surgery to repair traumatic wounds, surgical supplies, blood transfusion services, ambulatory surgical center services, x-rays, laboratory services, drugs, physician examinations, consultations, and second opinions;

- Providing sedation services associated with dental treatment, when performed in an acute care setting, by a physician anesthesiologist, shall be the responsibility of the health plan. Sedation services administered by an oral and maxillofacial surgeon, or other qualified dental anesthetist, in a private office or hospital-based outpatient clinic for services that are not medically related shall be the responsibility of the Dental Program contractor;
- Providing dental services performed by a dentist or physician that are needed due to a medical emergency (e.g., car accident) where the services provided are primarily medical; and
- Providing dental services in relation to oral or facial trauma, oral pathology (including but not limited to infections of oral origin, cyst and tumor management) and craniofacial reconstructive surgery, performed on an inpatient basis in an acute care hospital setting.

The health plan shall work closely and coordinate with the DHS or its agent to assist members in finding a dentist, making

appointments, and coordinating transportation and translation services.

The health plan is not responsible for services that are provided in private dental offices, government sponsored or subsidized dental clinics, and hospital based outpatient dental clinics.

In cases of medical disputes regarding coverage, the health plan's Medical Director shall consult with the Med-QUEST Division's Medical Director to assist in defining and clarifying the respective responsibilities.

30.730 Intentional Termination of Pregnancies (ITOPs)

The health plan shall not cover any ITOPs. The health plan shall instruct its providers to submit claims for ITOPs directly to the DHS' fiscal agent. DHS shall cover all procedures, medications, transportation, meals, and lodging associated with ITOPs. All costs associated with ITOPs shall be covered with State-funds only.

The health plan shall cover treatment of medical complications occurring because of an elective termination and treatments for spontaneous, incomplete, or threatened terminations as well as for ectopic pregnancies.

All financial penalties assessed by the federal government and imposed on the DHS because of the health plan's action or inaction in complying with the federal requirements of this section shall be passed on to the health plan.

30.740 Comprehensive Behavioral Health Services for Adults

Adult members age twenty-one (21) years or older with a diagnosis of serious mental illness (SMI) or serious and persistent mental illness (SPMI) may be eligible for additional behavioral health services within the Community Care Services (CCS) behavioral health program. Those members determined eligible by the DHS shall receive their behavioral health services from the CCS program. The DHS shall oversee all activities related to the CCS program.

CCS shall provide to its adult members a full range of specialized behavioral health services including inpatient, outpatient therapy and tests to monitor the member's response to therapy, and intensive case management. Adult members who are receiving services through CCS that require alcohol and/or drug abuse treatment may also receive these services through CCS.

Health plans shall have a process in place to identify adults with SMI or SPMI who are in need of additional behavioral health services based on the criteria listed below. Health plans shall send a referral to DHS that they identify as meeting criteria for the CCS program.

Members may be eligible for additional behavioral health services if they meet the following criteria:

- The member is eligible for the QUEST Integration program;
- The member falls under one of the qualifying diagnoses (see Appendix G);

- The member demonstrates the presence of a qualifying diagnosis for at least twelve (12) months or is expected to demonstrate the qualifying diagnosis for the next twelve (12) months; and
- The member meets at least one of the criteria below demonstrating instability and/or functional impairment:
    - Clinical records demonstrate that the member is currently unstable under current treatment or plan of care (e.g., multiple hospitalizations in the last year and currently unstable, substantial history of crises and currently unstable to include but not limited to consistently noncompliant with medications and follow-up, unengaged with providers, significant and consistent isolation, resource deficit causing instability, significant co-occurring medical illness causing instability, poor coping/independent living/problem solving skills causing instability, at risk for hospitalization); or
    - The member is under Protective Services or requires intervention by housing or law enforcement officials.
- Members that do not meet the requirements listed above, but are assessed by the health plan's medical director that additional services are medically necessary for the member's health and safety shall be evaluated on a case-by-case basis for provisional eligibility.

The health plan shall submit the designated DHS referral form, completed by a qualified mental health professional (QHMP), along with supporting documentation of SMI/SPMI and functional

impairment consistent with eligibility criteria (i.e. admission and discharge summaries, day hospital admission and discharge summaries, outpatient admission and discharge summaries, psychiatric assessment, psychological test results, and other pertinent documents).

CCS has a process in place to regularly assess and re-evaluate members to provide appropriate and individualized services and to ensure the continued need for services.

DHS has the sole authority to disenroll members from CCS. Reasons for disenrollment include, but are not limited to, the following:

- Member loses Medicaid eligibility;
- No contact with the member for a total of three (3) months;
- Member refuses services and requests disenrollment from the program;
- Member no longer meets CCS eligibility criteria;
- Member moves to another State;
- Death of a member;
- Incarceration of the member;
- Transfer of the member to a long term care nursing facility or an ICF-MR facility and the behavioral health care needs of the member will be assumed by the facility;
- Member is waitlisted at an acute hospital for a long term care bed and the behavioral health care needs of the member will be assumed by the facility;
- Member is sent out –of-state for medical treatment by DHS or a health plan and DHS or the health plan will assume

responsibility for the behavioral health care needs of the member;

- Member is admitted to the State Hospital; or
- Member provides false information with the intent of enrolling in a DHS program under false pretenses.

Members that are assessed as no longer needing services through CCS shall continue to have access to all standard behavioral services offered by the health plan. Should a member again meet criteria again for the provision of additional comprehensive behavioral health interventions, the health plan shall refer the member to DHS to assess for transition to the CCS program.

The health plan and CCS shall coordinate on the medical and behavioral health needs of its members. Health plans shall have business associates agreements with the CCS program contractor in order to share protected health information including but not limited to claims files and service plans. Collaboration among the health plan's and CCS's case managers is expected. The DHS shall enact joint health plan/CCS performance incentives for their members with SMI or SPMI.

30.800 Covered Benefits and Services Provided by Other State Agencies

30.810 School Based Services

The DOE shall provide all school health services including transportation. The cost for school health services is not included in the capitation rate paid to the health plans.

30.820 Department of Health (DOH) Programs

DOH, through its various programs, may provide direct services to program members. This section describes the DOH services and responsibilities as well as the requirements of the health plan.

30.820.1 Behavioral Health Services for Children/Support for Emotional and Behavioral Development (SEBD) Program

The DOH, through its Child and Adolescent Mental Health Division (CAMHD), shall provide behavioral health services, including transportation, to children and adolescents age three (3) through age twenty (20) determined to be eligible for the SEBD program through CAMHD and in need of intensive behavioral health services. The services covered for the SEBD program are described in Appendix H.

Health plans shall have a process in place to identify and refer to CAMHD, children/youth that are unstable, of moderate-high risk, and in need of the SEBD program. The eligibility criteria for the CAMHD program include:

- The member is age three through twenty (3-20) years;
- The member has a DSM IV, Axis 1 (or updated version) primary diagnosis for at least 6 months except for the following, substance abuse, learning disorders, communication disorders, pervasive developmental disorders inclusive of autism disorder, Rett's disorder, childhood disintegrative disorder or Asperger's disorder;

- The DSM IV, Axis I(or updated version)primary diagnosis listed above may be covered if the diagnosis is secondary to a qualifying primary Axis I mental health disorder;
- The member's Child and Adolescent Functional Assessment Scale (CAFAS) score is 80 or greater; and
- The CAMHD Medical Director or designated qualified mental health professional reviews and makes the determination of SEBD eligibility.
- Members that do not meet the eligibility criteria, however based upon assessment by the health plan's medical director it is determined that additional services are medically necessary for the member's health and safety, shall be referred to the CAMHD for provisional eligibility on a case-by-case basis.

The CAMHD program is a program carved out of the health plans' responsibilities. The health plan shall work with CAMHD in transitioning members in and out of the CAMHD program and for coordinating medical services.

The CAMHD criteria to end or suspend additional behavioral health services are based on the member's stabilization and clinical indication to be able to be maintained by standard behavioral health services available to all health plan members. The clinical criteria include:

- The member is unable to engage or demonstrate benefit or maintenance of benefit from additional services despite maximum intervention for at least twelve (12) months; OR
- All of the following:

- CAFAS < 80; and
- Stable for at least six (6) months with no anticipated change; and
- Able to remain stable without intensive additional services.

- Members that meet the discharge criteria, but are assessed by CAMHD's medical director to need additional medically necessary services for the member's health and safety, may continue to stay in the CAMHD program for a specified additional length of time with approval by the health plan's medical director.

Members that are assessed as no longer needing additional intensive behavioral health services shall continue to have access to all other standard behavioral health services offered by the health plan found in Section 40.740.2.a. Should a member again meet criteria for the provision of additional intensive behavioral health interventions, the member shall again be provided these services by CAMHD.

30.820.2 Services for Individuals with Developmental Disabilities/Intellectual Disabilities (DD/ID)

The DOH Developmental Disability Division (DOH/DDD) shall provide ICF/ID services to individuals in the 1915(c) waiver and ICF/ID facilities. Health plans shall coordinate activities with DOH/DDD in accordance with QExA ADMX-1015 as provided in Appendix I. Any updates to QExA ADMX-1015 shall be enacted as part of this section of the RFP.

30.820.3 Kapi'olani Cleft and Craniofacial Clinic and DOH/Family Health Services Division/Children with Special Health Needs (CSHN) Branch

The Kapi'olani Cleft and Craniofacial Clinic is a multidisciplinary program that services children with cleft and craniofacial disorders across the state. The clinic provides the services of pediatric dentists, orthodontists, oral surgeons, otorhinolaryngologists, pediatric psychiatrists, audiologists, speech and feeding specialists, neonatologists, geneticists, and genetic counselors. The QI health plans are responsible for reimbursing these covered services as well as coordinating with the clinic care for members receiving care at the clinic.

The CSHN Branch is the community component to the Kapi'olani Cleft and Craniofacial Clinic. It provides staff to assist the clinic in coordinating care for these children, which includes QI members. The CSHN Branch may link QI children receiving care at the clinic to the Early Intervention program and provide additional outreach or support to the children and their families, facilitate health plan authorizations for specialized feeding bottles, etc.

The health plans shall collaborate with both the Kapi'olani Cleft and Craniofacial Clinic and the CSHN Branch in coordinating care for their members with cleft and craniofacial disorders receiving care at the clinic.

The health plan shall also aid in coordination of care in cases involving coverage by more than one health plan and shall

facilitate the processing of prior authorization requests and claims. If a member changes health plans, the originating health plan shall assist the accepting health plan by providing information on the clinic's multidisciplinary recommendations, treatment provided, and progress to date. The originating health plan shall coordinate with the accepting health plan to ensure a smooth transition.

30.820.4 Vaccines for Children (VFC) Program

The health plan shall be responsible for ensuring that their members receive all necessary childhood immunizations. The State of Hawaii participates in the VFC program, a federally funded program that replaces public and private vaccines for children under the age of eighteen (18). These vaccines are distributed to qualified providers who administer them to children. Providers shall enroll and complete appropriate forms for VFC participation.

As a result, the health plan shall not be reimbursed for any privately acquired vaccines that can be obtained through Hawaii VFC program. Although the cost of the vaccines is not included in the capitated rate paid to the health plans, the health plan is not prohibited from allowing privately acquired vaccines and may decide who, if any, and how it shall reimburse for these vaccines. The health plan shall receive the fee for the administration of the vaccine as part of the capitated rate.

30.820.5 Zero-To-Three (Early Intervention) Program

The DOH administers and manages the Zero-to-Three or Early Intervention Program (EIP) services. The cost of those services is not included in the health plan's capitation rate.

The Zero-to-Three program provides services, including transportation, for the developmentally delayed and biologically at risk children aged zero (0) to three (3) years old. The services are for screening, assessment, and home visitation services. The health plan is responsible, during the EPSDT screening process, for identifying and referring children who may qualify for these services. The DOH programs shall evaluate and determine eligibility for these programs. The health plan is responsible for providing any medically necessary services if the child is not found eligible for the Early Intervention Program. The health plan remains responsible for providing all other medically necessary services in the QI program as well as EPSDT screens and services, including evaluations to confirm the medical necessity of the services.

30.900 Aid to Disabled Review Committee (ADRC)

The ADRC determines the disability status of persons who are *not* in receipt of Retirement, Survivors and Disability Insurance (RSDI) and Supplemental Security Income (SSI) disability benefits. If the health plan has supporting documentation that a member is SSI eligible (copy of SSA letter, payment stub, or any other evidence of payment), this documentation shall be sent to DHS in accordance with established procedures so that appropriate action can be taken to change the member's status to disabled without the ADRC process.

The health plan needs to comply with the ADRC process for the following individuals who are not in the Adult group:

- Members who have had a decline in physical or mental functioning and require LTSS; and
- Members who qualify for SHOTT.

When the health plans identifies one of these members, they shall refer the member to DHS/MQD for an ADRC evaluation utilizing the ADRC packet (DHS Forms 1180, 1128, 1127). Specifically, the health plan shall submit to the ADRC Coordinator in MQD, the following forms and documentation:

- A DHS 1180, "ADRC Referral and Determination";
- A completed DHS 1127, "Medical History and Disability Statement";
- A completed DHS 1128 "Disability Report"; and
- Any current and additional documentation from the medical provider or the health plan, which provides supporting evidence for physical or mental disability, including diagnosis and prognosis (e.g. clinical progress notes, history and physical reports, discharge summaries).
- A CMS 2728 may be substituted for DHS 1128 for ADRC referrals on clients with end stage renal disease. A DHS 1270 may be substituted for DHS 1128 for ADRC referrals on clients coming through the Benefit, Employment and Support Services Division (BESSD).

The health plan shall only submit an ADRC packet on members in the Adult group if the member:

1) Meets nursing facility level of care on the DHS 1147 and has chosen to receive home and community based services; and
2) Has signed their agreement to have their assets reviewed on the DHS 1127.

All other ADRC packets for members in the Adult group will be returned by DHS to the health plan. These returns shall count towards a non-disability determination.

If the member is going through ADRC to obtain LTSS, then the DHS shall send the approved ADRC packet to eligibility branch for post-eligibility review.

If approved for SHOTT, the member shall be disenrolled from the health plan, converted to FFS, and transitioned to SHOTT. Prior to exiting from SHOTT, the member shall be re-evaluated for disability and placed back into the QI program based on the disability determination. If the ADRC does not determine that a member meets the SHOTT program criteria, the health plan shall continue to provide all services to the member as described in Section 30.710.

To qualify for ADRC disability determination, the disability must be for a minimum of one year. The ADRC follows criteria outlined in the latest edition of the Disability Evaluation Under Social Security (Blue Book), which is also available online at: http://www.ssa.gov/disability/professionals/bluebook/.

31.100 Monitoring and Evaluation

The DHS has developed a Quality Strategy to guide the implementation of MQD's quality activities. It outlines the strategies to monitor and evaluate health plan compliance to standards for access to care, structure and operations, and quality measurement and improvement, according to 42 CFR Section 438.66(b) and 438.66(c).

As part of these monitoring responsibilities, the DHS shall:

- Assess the quality and appropriateness of care and services furnished to all members, with particular emphasis on care/services provided to members with special health care needs;
- Regularly monitor and evaluate the health plan's compliance with the standards established by the State in accordance with federal law and regulations; and
- Arrange for annual, external independent reviews of the quality outcomes and timeliness of and access to the services covered under each health plan contract as described in Section 31.120.

31.110 Quality Assessment and Performance Improvement (QAPI) Program

See Section 50.700 for DHS' responsibilities for monitoring of the health plan's QAPI program.

31.120 External Quality Review/Monitoring

The DHS contracts with an External Quality Review Organization (EQRO) to perform, on an annual basis, an external, independent review of the quality outcomes of, timeliness of, and access to the services provided for QI members by the health plans. The EQRO shall monitor the health plan's compliance with all applicable provisions of 42 CFR 438, Subpart E. Specifically, the EQRO shall provide the following mandatory activities as described in 42 CFR 438.358:

- Validation of Performance Improvement Projects (PIP) required by the DHS;
- Validation of health plan performance measures (e.g., HEDIS measures) required by the State; ~~and~~
- A review, conducted within the previous three-year period, to determine compliance with standards established by the State concerning access to care, structure and operations, and quality measurement and improvement.

The health plan shall collaborate with the DHS contracted EQRO in the external quality review (EQR) activities performed by the EQRO to assess the quality of care and services provided to members and to identify opportunities for health plan improvement. To facilitate this review process, the health plan shall provide all requested QAPI Program related documents and data to the EQRO.

The health plan shall submit to the DHS and the EQRO its corrective action plans, which address identified issues requiring improvement, correction or resolution.

The EQRO may also perform the following optional EQR activities, which include but are not limited to:

- Administration, analysis, and reporting the results of the CAHPS® Consumer Survey. The survey shall be conducted annually, administered to an NCQA-certified sample of members enrolled in each health plan and analyzed using NCQA guidelines. Adult and child surveys are conducted in alternate years using the most current CAHPS® survey for managed care plans. A CHIP specific CAHPS® Consumer Survey is conducted annually to meet Federal requirements. DHS may modify this schedule based upon the needs of the Department. The EQRO shall provide an overall report of survey results to the DHS. The DHS and the health plan shall receive a copy of their health plan-specific raw data by island;
- Administration, analysis, and reporting of the results of the Provider Satisfaction Survey. This survey shall be conducted every other year within the broad parameters of CMS protocols for conducting Medicaid EQR surveys (the DHS, CMS 2002, Final Protocol, Version 1.0 -- *Administering of Validating Surveys: Two Protocols for Use in Conducting Medicaid External Quality Review Activities*). DHS may modify this schedule based upon the needs of the Department. The EQRO shall assist the DHS in developing a survey tool to gauge PCPs' and specialists' satisfaction in areas such as: how providers feel about managed care, how satisfied providers are with reimbursement, and how

providers perceive the impact of health plan utilization management on their ability to provide quality care. The EQRO shall provide the DHS with a report of findings, including the raw data broken down by island. Each health plan shall receive an electronic version of the report with its plan-specific raw data per island from the EQRO;

- Providing technical assistance to the health plan to assist them in conducting activities related to the mandatory and optional EQR activities according to 42 CFR 438.310(c)(2); ~~and~~
- Assisting with the quality rating of the health plans consistent with 42 CFR Section 438.334;and
- Administration, analysis, and reporting of the results of the Encounter Data Validation (EDV) per 42 CFR §438.358(c)(1), optional activities related to external quality review. The EQRO is responsible for validating encounter data by using information derived during the preceding twelve (12) months reported by the health plans [described in §438.310(c)(2)]. The EQRO will be responsible for developing the methodology, generating and issuing the questionnaires, collecting data, and conducting a comparative analysis. Finally, the EQRO shall furnish a special report that summarizes the results to the State and the health plans.

In compliance with 42 CFR 438.364, the EQRO must submit to DHS, an annual detailed technical report of all the EQR activities conducted. DHS submits a copy of the final report to CMS.

31.130 Case Study Interviews

The DHS or its designee may conduct case study interviews. These could require that key individuals involved with the programs (including representatives of the health plans, association groups and consumer groups) identify what was expected of the program, changes needed to be made, effectiveness of outreach and enrollment, and adequacy of the health plans in meeting the needs of the populations served.

31.200 QUEST Integration Policy Memorandums

The DHS issues policy memorandums to offer clarity on policy or operational issues or legal changes impacting the health plan. The health plan shall comply with the requirements of all the policy memorandums during the course of the contract and execute each QI memorandum when distributed by MQD during the period of the contract. The health plan shall acknowledge receipt of the memoranda through electronic mail.

All QI policy memorandum issued prior to the Commencement of Services to Members date identified in Section 20.100 are ineffective except for those that DHS has determined shall remain in effect. Health plans shall be advised of these memoranda by the date identified in Section 51.800.

31.300 Readiness Review

Prior to the date of Commencement of Services to Members as described in Section 20.100, the DHS or its agent shall conduct a readiness review of the health plan in accordance with 42 CFR Section 438.66 in order to provide assurances that the health plan

is able and prepared to perform all administrative functions required by this contract and to provide high quality service to members. The health plan's responsibilities in this readiness review are described in Section 51.700.

The DHS' review may include, but is not limited to, a walk-through of the health plan's operations, information system demonstrations and interviews with health plan staff. The review may also include desk and on-site review of:

- Provider network composition and access;
- Provision of services to include LTSS;
- Case management system;
- Quality Assessment and Performance Improvement (QAPI) program standards;
- Utilization Management Program (UMP) strategies; and
- All required policies and procedures.

Based on the results of the review activities, the DHS shall provide the health plan with a summary of findings including the identification of areas requiring corrective action before the DHS shall enroll members in the health plan.

If the health plan is unable to demonstrate its ability to meet the requirements of the contract, as determined by the DHS, within the time frames specified by the DHS, the DHS may postpone availability for enrollment or terminate the contract in accordance with Section 71.600.

31.400 Information Systems

31.410 Hawaii Prepaid Medical Management Information Systems (HPMMIS)

To effectively and efficiently administer the programs, the DHS has implemented the Hawaii Prepaid Medical Management Information Systems (HPMMIS). HPMMIS is an integrated Medicaid Management Information System that supports the administration of the program. The major functional areas of HPMMIS include:

- Receiving daily eligibility files from KOLEA and processing enrollment/disenrollment of members into/from the health plans based on established enrollment/disenrollment rules;
- Processing member health plan choices submitted to the MQD enrollment call center;
- Producing daily enrollment/disenrollment rosters, monthly enrollment rosters, and TPL rosters;
- Processing monthly encounter submissions from health plans and generating encounter error reports for health plan correction. Accepting and processing monthly health plan provider network submissions to assign Medicaid provider IDs for health plan use. Errors associated with these submissions are generated and returned to the health plans on a monthly basis for correction;
- Monitoring the utilization of services provided to the members by the health plans and the activities or movement of the members within and between the health plans;

- Monitoring the activities of the health plans through information and data received from the health plans and generating management reports;
- Determining the amount due to the health plans for the monthly capitated rate for enrolled members;
- Producing a monthly provider master registry file for the health plans to use for assigning Medicaid provider IDs to health plan providers for the purpose of submitting encounters to DHS;
- Generating the required CMS reports; and
- Generating management information reports.

Receiving/transmitting of data files between the health plans and HPMMIS is done via the MQD Secure File Transfer (SFT) file server. The SFT file server allows the MQD and health plans to securely transfer member, provider, and encounter data via the internet.

In addition, the MQD, through its fiscal agent, processes Medicaid fee-for-service payments in the Medicaid fee-for-service program utilizing HPMMIS.

The HPMMIS processes and reports on Medicaid fee-for-service payments. This includes Medicaid fee-for-service payments that are authorized under the program. The HPMMIS and reporting subsystems provide the following:

- Member processing (ID cards, eligibility, buy-in, etc.);

- Claims processing (input preparation, electronic media claim capture, claim disposition, claim adjudication, claim distribution, and payments);
- Provider support (certification, edit and update, rate change, and reporting);
- Management and Administrative Reporting Subsystem (MARS) and Surveillance and Utilization Reporting Subsystem (SURS) reports;
- Reference files for the validation of procedures, diagnosis, and drug formularies; and
- Other miscellaneous support modules (TPL, EPSDT, DUR, MQC, etc.).

31.420 Electronic Visit Verification

The 21st Century Cures Act (Section 12006(a)(1)(A)), passed by Congress in December 2016, requires states to implement Electronic Visit Verification (EVV). This new law requires states to have an EVV system to electronically capture point of service information for personal care services (PCS) and home health care services (HHCS).

At a minimum, the EVV system must be able to electronically capture these six data points:

- Type of service performed
- Individual receiving the services
- Date of service
- Location of service delivery
- Individual providing the service
- Time the service begins and ends

MQD plans to deploy an Open Vendor Model in the state of Hawaii. This model as interpreted by MQD has the following characteristics:

- Med-Quest will contract statewide with a single EVV vendor for both the EVV data capture services (for PCS and HHCS) and a mandated data aggregator;
- This statewide EVV vendor will be an option available for use by providers and Managed Care Organizations (MCOs) in Hawaii. This EVV vendor will offer a data capture system for providers without a legacy/alternate EVV system;
- Providers and Managed Care Organizations (MCOs) may continue to use an existing EVV system or choose to use an alternate EVV vendor. Providers and MCOs choosing to use an existing or alternate system will incur any all and all related costs, including costs related to system requirements necessary to transmit data to the statewide EVV vendor data aggregator;
- Med-QUEST will fund the development of the statewide EVV vendor;
- Health Plans will be required to submit PCS and HHCS prior authorization information to the statewide EVV vendor. Health Plans will be required to validate, with the statewide EVV vendor data aggregate, that the six (6) EVV data points have been captured as a pre-payment edit prior to PCS and HHCS claim payment; and
- There will be minimal functional requirements for alternate EVV vendors.

SECTION 40 PROVISION OF SERVICES – HEALTH PLAN RESPONSIBILITIES

40.100 Health Plan's Role in Managed Care & Qualified Health Plans

The QUEST Integration (QI) program is a managed care program that includes all medical, behavioral health, and long-term services and supports (LTSS) benefits for members. The health plan shall provide for the direction, coordination, monitoring and tracking of the medical, behavioral health, and LTSS services needed by the members.

The health plan shall provide each member with a PCP who assesses the member's healthcare needs and provides/directs the services to meet the member's needs. The health plan shall develop and maintain a provider network capable of providing the required individualized health services needed by the members.

The health plan shall be properly licensed as a health plan in the State of Hawaii (See Chapters 431, 432, and 432D, HRS). The health plan is not required to be licensed as a federally qualified HMO, but shall meet the requirements of Section 1903(m) of the Social Security Act and the requirements specified by the DHS.

40.200 Provider Network

40.210 <u>General Provisions</u>

The health plan shall develop and maintain a provider network that is sufficient to ensure that all medically necessary covered services are accessible and available. At a minimum, this means that the health plan shall have sufficient providers to ensure all access and appointment wait times defined in Sections 40.230 and 40.240 are met. This network of providers shall provide the benefits defined in Sections 40.700.

The health plan needs to contract with enough providers for their members to have timely access to medically necessary covered services. The health plan is responsible for assuring that members have access to providers listed in Section 40.220. If the health plan's network is unable to provide medically necessary covered services to a particular member within its network or on the island of residence, the health plan shall adequately, and in a timely manner, provide these services out-of-network or transport the member to another island or out-of-state to access the covered services for as long as the health plan's network is unable to provide the member with medically necessary covered services on their island of residence as described in Section 41.500.

The health plan shall notify the out-of-network providers providing covered services to its members that payment by the plan is considered as "payment-in-full" and that those providers cannot "balance bill" the members for the covered services. The health plan is prohibited from charging the member more than it would have if the covered services were furnished within the network.

The health plan shall not discriminate with respect to participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely based on that license or certification. The health plan shall not discriminate against providers serving high-risk populations or those that specialize in conditions requiring costly treatments. This is not to be construed as: (1) requiring that the health plan contract with providers beyond the number necessary to meet the needs of its members; (2) precluding the health plan from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or (3) precluding the health plan from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members. The health plan is not required to contract with every willing provider. If the health plan does not or will not include individuals or groups of providers of a specialty grouping in its network, it shall provide that information in its proposal.

If the health plan decides during the contract period that it no longer will include individuals or groups of providers in its network, the health plan shall give the affected providers written notice of the reason for its decision at least thirty (30) days prior to the effective date and shall notify the DHS at least forty-five (45) days prior to the effective date if the individuals or providers represent five percent (5%) or more of the total providers in that specialty, or if it is a hospital.

The health plan shall require that all providers that submit claims to the health plans have a national provider identifier (NPI) number. This requirement should be consistent with 45 CFR Section 162.410.

The health plan shall not include in its network any providers when a person with an ownership or controlling interest in the provider (an owner including the provider himself or herself), or an agent or managing employee of the provider, has been excluded from participation by the Department of Health and Human Services (DHHS), Office of Inspector General (OIG) under section 1128 of the Social Security Act, or has been excluded by the DHS from participating in the Hawaii Medicaid program. The health plan shall monthly check with the MQD for those providers excluded from the Hawaii Medicaid program. On a monthly basis, the health plan shall check the Federal exclusion lists, including but not limited to the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), List of Excluded Individuals and Entities (LEIE) maintained by the OIG, and System for Award Management (SAM).

The health plan shall immediately terminate any provider(s) or affiliated provider(s) whose owners, agents, or managing employees are found to be excluded on the State or Federal exclusion list(s). The health plan shall report provider application denials or terminations to the DHS where individuals were on the exclusions list, including denial of credentialing for fraud-related concerns, as they occur.

The health plan is prohibit from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished:

- At the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, or XX or under this title pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) of the Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).
- By an individual or entity to whom the state has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the state determines there is good cause not to suspend such payments.
- With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act (ASFRA) of 1997.

The health plan shall immediately comply if the DHS requires that it remove a provider from its network if: (1) the provider fails to meet or violates any State or Federal laws, rules, or regulations; or (2) the provider's performance is deemed inadequate by the State based upon accepted community or professional standards.

The health plan shall have written policies and procedures for the selection and retention of providers. These policies and procedures shall include a process for identifying and assuring that excluded providers are not part of their network. The health plan shall submit these selection and retention of providers' policies and procedures as required in Section 51.700, Readiness Review.

The health plan shall have an established provider network that meets the requirements of this RFP at the time of proposal submission for all primary care, acute care, behavioral health and long-term care services including nursing facilities and home and community-based services providers. If the health plan does not have an established network of home and community-based services providers at the time of proposal submission, the health plan shall include with its proposal letters of intent to contract from these providers.

40.220 Specific Minimum Requirements

The health plan is solely responsible for ensuring it: (1) has the network capacity to serve the expected enrollment in the service area; (2) offers an appropriate range of services and access to preventive, primary, acute, behavioral health, and long-term services and supports (LTSS); and (3) maintains a sufficient number, mix, and geographic distribution of providers of covered services. The following is a listing of the minimum required components of the provider network. This is not meant to be an all-inclusive listing of the components of the network, rather the health plan may add provider types, or the DHS may require that the health plan add providers as required based on the needs of

the members or due to changes in Federal or State law. At a minimum, the network shall include the following medical care providers:

- Hospitals (a minimum of 5 on Oahu; 1 on Maui; 1 on Kauai; 2 on Hawaii (1 in East Hawaii and 1 in West Hawaii); 1 on Lanai and 1 on Molokai if bidding Statewide);
- Emergency transportation providers (both ground and air);
- Non-emergency transportation providers (both ground and air);
- Primary Care Providers (PCPs) (at least 1 per 300 members) as described in Section 40.250;
- Physician specialists, including but not limited to: cardiologists, endocrinologists, general surgeons, geriatricians, hematologists, infectious disease specialists, nephrologists, neurologists, obstetricians/ gynecologists, oncologists, ophthalmologists, orthopedists, otolaryngology, pediatric specialists, plastic and reconstructive surgeons, pulmonologists, radiologists and urologists;
- Laboratories which have either a CLIA certificate or a waiver of a certificate of registration;
- Optometrists;
- Pharmacies;
- Physical and occupational therapists, audiologists, and speech-language pathologists;
- Licensed dietitians;
- Physician Assistants;
- Behavioral health providers:

    - Psychiatrists (1 per 150 members with a SMI or SPMI diagnosis);
    - Other behavioral health providers to include psychologists, licensed mental health counselors, licensed clinical social workers, Advanced Practice Registered Nurse (APRN) – behavioral health (1 to 100 members with a SMI or SPMI diagnosis); and
    - Certified substance abuse counselors;
- State licensed Special Treatment Facilities for the provision of substance abuse therapy/treatment;
- Home health agencies and hospices;
- Durable medical equipment;
- Case management agencies;
- Long-term services and supports (listed below);
- Providers of lodging and meals associated with obtaining necessary medical care; and
- Sign language interpreters and interpreters for languages other than English.

At a minimum, the network shall include the following behavioral health providers: licensed therapists, counselors and certified substance abuse counselors, and State licensed Special Treatment Facilities for the provision of substance abuse therapy/treatment.

In geographic areas with a demonstrated shortage of qualified physicians, a behavioral health APRN with prescriptive authority (APRN Rx) may assume the role of a psychiatrist in order to meet network adequacy requirements.

Physician specialists must be available at the hospital to which the health plan's PCPs admit. The health plan may submit to the DHS a formal written request for a waiver of this requirement for areas where there are no physician specialists.

The health plan may have contracts with physician specialists or pay for emergency services, urgent outpatient services, and inpatient acute services provided without prior authorization by non-participating physician specialists. If the contracted specialist cannot provide twenty-four (24) hours/seven (7) days a week coverage for the specialty, the health plan must pay the non-participating physician specialists who provide emergency, urgent outpatient, sub-acute services, and inpatient acute services.

At a minimum, the network shall include the following long-term service and support (LTSS) providers:

- Adult day care facilities;
- Adult day health facilities;
- Assisted living facilities;
- Community care foster family homes (CCFFH);
- Community care management agencies (CCMA);
- Expanded adult residential care homes (E-ARCHs);
- Home delivered meal providers;
- Non-medical transportation providers;
- Nursing facilities;
- Personal care assistance providers;
- Personal emergency response systems providers;
- Private duty nursing providers;

- Respite care providers; and
- Specialized medical equipment and supply providers.

Due to the limited frequency of utilizing LTSS providers, health plans may contract with the following providers on an as needed basis:

- Environmental accessibility adaptation providers;
- Home maintenance providers; and
- Moving assistance providers.

40.230 Availability of Providers

The health plan shall monitor the number of members cared for by its providers and shall adjust PCP assignments as necessary to ensure timely access to medical care and to maintain quality of care. The health plan shall have a sufficient network to ensure members can obtain needed health services within the acceptable wait times. The acceptable wait times are:

- Emergency medical situations - Immediate care (twenty-four (24) hours a day, seven (7) days a week) and without prior authorization;
- Urgent care and PCP pediatric sick visits - Appointments within twenty-four (24) hours;
- PCP adult sick visits - Appointments within seventy-two (72) hours;
- Behavioral Health (routine visits for adults and children) - Appointments within twenty-one (21) days;
- PCP visits (routine visits for adults and children) - Appointments within twenty-one (21) days; and

- Visits with a specialist or Non-emergency hospital stays - Appointments within four (4) weeks or of sufficient timeliness to meet medical necessity.

The health plan shall ensure that:

- Network providers accept new members for treatment unless the provider has requested a waiver from the health plan from this provision;
- Network providers do not segregate members in any way from other persons receiving services, except for health and safety reasons;
- Members are provided services without regard to race, color, creed, ancestry, sex, including gender identity or expression, sexual orientation, religion, health status, income status, or physical or mental disability; and
- Network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to hours offered to members under Medicaid fee-for-service, if the provider has no commercial members.

The health plan shall establish policies and procedures to ensure that network providers comply with these acceptable wait times; monitor providers regularly to determine compliance; and take corrective action if there is a failure to comply. The health plan shall submit these availability of providers policies and procedures as required in Section 51.700, Readiness Review.

40.240 Geographic Access of Providers

In addition to maintaining in its network a sufficient number of providers to provide all services to its members, the health plan shall meet the following geographic access standards for all members:

	Urban*	**Rural**
PCPs	30 minute driving time	60 minute driving time
Specialists	30 minute driving time	60 minute driving time
OB/GYN	30 minute driving time	60 minute driving time
Adult Day Care and Adult Day Health	30 minute driving time	60 minute driving time
Hospitals	30 minute driving time	60 minute driving time
Emergency Services Facilities	30 minute driving time	60 minute driving time
Mental Health Providers	30 minute driving time	60 minute driving time
Pharmacies	15 minute driving time	60 minute driving time
24-Hour Pharmacy	60 minute driving time	N/A

*Urban is defined as the Honolulu metropolitan statistical area (MSA).

All travel times are maximums for time it takes a member, in normal traffic conditions, using usual travel means in a direct route to travel from his or her home to the provider.

The health plan may submit to the DHS a formal written request for a waiver of these requirements for areas where there are no providers within the required driving time after contract award. In such situations, the DHS may waive the requirement entirely or expand the driving time. The health plan may also submit to the DHS a formal written request for a waiver of these requirements if it is unable to enter into an agreement with a specialty or ancillary service provider within

the required driving time. In such situations, the DHS may waive the requirement entirely or expand the driving time.

40.250 Primary Care Providers (PCPs)

The health plan shall implement procedures to ensure that each member is assigned a PCP who shall be an ongoing source of primary care appropriate to his or her needs and that this PCP is formally designated as primarily responsible for coordinating the health care services furnished to the member. Individuals who are enrolled in a Medicare Advantage plan are not required to have a PCP. However, members with fee-for-service Medicare shall choose a PCP. This PCP for a Medicare beneficiary does not have to be in the health plan's provider network. The health plan shall pay their co-payments or co-insurance as described in Section 60.310.

Each PCP shall be licensed in the State of Hawaii as:

- A physician, either an M.D. (Doctor of Medicine) or a D.O. (Doctor of Osteopathy), and shall be one of the following: a family practitioner, general practitioner, general internist, pediatrician, obstetrician/gynecologist, or geriatrician;
- An advanced practice registered nurse with prescriptive authority (APRN-Rx) who is a registered professional nurse authorized by the State to practice as a nurse practitioner in accordance with State law and Section 16-89, Subchapter 16, HAR; or

- A physician's assistant recognized by the State Board of Medical Examiners as a licensed physician assistant.

The health plan may allow specialists or other health care practitioners to serve as PCPs for members with chronic conditions provided:

- The member has selected a specialist with whom he or she has a historical relationship as his or her PCP;
- 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
- The health plan submits to the DHS prior to implementation a plan for monitoring their performance as PCPs.

The health plan shall allow a clinic to serve as a PCP as long as the clinic is appropriately staffed to carry out the PCP functions.

The PCP is responsible for 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 plan shall monitor the number of members that are assigned to each PCP, maintaining the ratio of less than or equal to 1 to 300, and report this information to the DHS as described in Section 51.520.3. The health plan may not restrict their members from choosing a PCP who reaches the 1 to 300 ratio. However, the health plan may not auto-assign any additional members to the PCP until the ratio has decreased below the 1 to 300 ratio. The health plan shall not apply this standard to clinics.

The health plan shall require that PCPs fulfill these responsibilities for all members. If the PCP is unable to fulfill his or her responsibilities to the member, the health plan shall transition the member to another PCP. The original PCP shall be responsible for continuing to provide services to the member until the other PCP has accepted the member except in situations where the PCP is terminated from either the health plan or Medicaid program. The health plan may support the transition and coordination of care by providing the PCP with the member's service plans and medication lists in the appropriate electronic format/s.

The health plan shall notify all members in writing within ten (10) days of selection, assignment, or processed PCP changes. Health plan shall assure its auto-assign algorithm includes the following:

- Women over sixty-five (65) years of age shall not be auto-assigned to a obstetrician/gynecologist;

- Geriatricians shall not be auto-assigned to anyone under the age of sixty-five (65); and
- PCPs with a ratio of 1 to 275 members are removed from the algorithm.

The health plan shall establish PCP policies and procedures that shall, at a minimum:

- Not establish any limits on how frequently and for what reasons a member may choose a new PCP;
- Allow each member, to the extent possible and appropriate, to have freedom of choice in choosing his or her PCP;
- Describe the steps taken to assist and encourage members to select a PCP;
- Describe the process for informing members about available PCPs;
- Describe the process for selecting a PCP;
- Describe the process for auto-assigning a member to a PCP if one is not selected;
- Describe the process for changing PCPs; and
- Describe the process for monitoring PCPs, including specialists acting as PCPs, to ensure PCPs are fulfilling all required responsibilities described above.

The health plan shall describe the policies and procedures for selecting and changing PCPs in its Member Handbook as described in Section 50.440. The health plan shall also describe in its Member Handbook, how PCPs are auto-assigned, if necessary.

The health plan shall submit the PCP policies and procedures to the DHS for review and approval by the date identified in Section 51.700, Readiness Review. If the health plan revises its PCP policies and procedures during the term of the contract, the DHS must be advised and copies of the revised policies and procedures must be submitted to the DHS for review and approval prior to implementation of the revised policies and procedures.

If a PCP ceases participation in the health plan's provider network the health plan shall send written notice to the members who have chosen the provider as their PCP or were seen on a regular basis by the provider. This notice shall be issued within fifteen (15) days after receipt or issuance of the termination notice, to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. The health plan shall be responsible for ensuring a seamless transition for the member so that continuity of care is preserved until a new PCP has been selected. However, if a federally qualified health center (FQHC) is not participating in a health plan's provider network, but the FQHC is necessary for the health plan to have an adequate network, the health plan shall allow members to continue to use that FQHC as their PCP.

40.260 Direct Access to Women's Health Specialists

The health plan shall provide female members with direct in-network access to a women's health specialist for covered care

necessary to provide her routine and preventive healthcare services as well as management of obstetric and gynecologic conditions. Women's routine and preventive healthcare services include, but are not limited to breast and cervical cancer screening. This direct in-network access is in addition to the member's designated source of primary care if the PCP is not a women's health specialist.

40.270 Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs)

The health plan shall make FQHC and RHC services available and accessible in its network, unless the health plan can demonstrate to the DHS that it has both adequate capacity and an appropriate range of services for vulnerable populations. The health plan shall allow all members to receive covered services that are urgent in nature at any FQHC or RHC without prior authorization. The health plan shall require the FQHC to refer the patient back to and inform the assigned PCP or help the individual select a new PCP.

40.280 Certified Nurse Midwives, Pediatric Nurse Practitioners, Family Nurse Practitioners and Behavioral Health Nurse Practitioners

The health plan shall ensure that members have appropriate access to certified nurse midwives, pediatric nurse practitioners, family nurse practitioners, and behavioral health nurse practitioners through either provider contracts or referrals. This includes certified nurse midwives, pediatric nurse practitioners, family nurse practitioners, and behavioral health nurse practitioners who participate in the program as

part of a clinic or group practice. Services provided by certified nurse midwives, pediatric nurse practitioners, family nurse practitioners, and behavioral health practitioners, if requested and available in the geographic area in which the member resides, must be provided. If there are no providers of the specific services in the area, the health plan shall not be required to fly the member to another island to access these services.

If the health plan does not have these providers in its network, it may choose to arrange and provide the service(s) through an out-of-network provider in a timely manner. Alternatively, if the health plan chooses not to use out-of-network providers, the health plan must allow the member to change to a health plan that does have these providers in its network if the member expresses a desire for services rendered by one of these provider types.

This provision shall in no way be interpreted as requiring the health plan to provide any services that are not covered services.

40.290 Rural Exceptions

In areas in which there is only one health plan, any limitation the health plan imposes on the member's freedom to choose between PCPs may be no more restrictive than the limitation on disenrollment under 42 CFR Section 438.56(c) and Sections 30.520, 30.550 and 30.600 of this RFP. In this case, the member must have the freedom to:

- Choose from at least two (2) PCPs;
- Obtain services from any other provider under any of the following circumstances:
    - The service or type of provider (in terms of training, experience, and specialization) is not available within the health plan;
    - The provider is not part of the network but is the main source of a service to the member, is given the opportunity to become a participating provider under the same requirements for participation in the health plan, and chooses to join the network. If this provider chooses not to join the network, or does not meet the necessary qualifications to join, the health plan shall transition the member to an in-network provider within sixty (60) days. If the provider is not appropriately licensed or is sanctioned, the health plan shall transition the member to another provider immediately;
    - Select an out-of-network provider because the only provider in-network and available to the member does not, because of moral or religious objections provide the services the member seeks, or all related services are not available;
    - The member's PCP determines that the member needs related services that would subject the member to unnecessary risk if received separately and not all of the related services are available within the network; and

- The State determines that other circumstances warrant out-of-network treatment.

40.300 Provider "Gag Rule" Prohibition

The health plan may not prohibit or otherwise restrict physicians or other healthcare professionals acting within the lawful scope of practice from advocating or advising on behalf of a member who is his or her patient for:

- The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;
- Any information the member needs in order to decide among all relevant treatment options;
- The risks, benefits and consequences of treatment or non-treatment; and
- The member's right to participate in decisions regarding his or her healthcare, including the right to refuse treatment, and to express preferences about future treatment decisions.

Further, the health plan is prohibited from restricting providers acting within the lawful scope of practice from advising their patients about their medical conditions or diseases and the care or treatment required, regardless of whether the care or treatment is covered under the contract and whether or not the services or benefits are provided by the health plan. All members are legally entitled to receive from their provider the

full range of medical advice and counseling appropriate for their condition.

While the health plan is precluded from interfering with member-provider communications, the health plan is not required to provide, reimburse for, or provide coverage for counseling or referral services for specific services if the plan objects to the service on moral or religious grounds. In these cases, the health plan must notify, in writing:

- The DHS within one-hundred twenty (120) days prior to adopting the policy with respect to any service;
- The DHS with the submission of its proposal to provide services under this RFP;
- Members at least thirty (30) days prior to the effective date of the policy for any particular service; and
- Members and potential members before and during enrollment.

40.400 Provider Credentialing, Recredentialing and Other Certification

DHS will follow the most current NCQA credentialing and recredentialing standards including delegation and provider monitoring/oversight. DHS reserves the right to require approval of standards and thresholds set by the organization (e.g., with regards to performance standards, office site criteria, medical record keeping, complaints triggering on-site visits). The health plan must also meet requirements of the RFP related to appointment availability (Section 40.230) and medical record keeping (Section 50.740).

The health plan shall ensure each behavioral health provider's service delivery site meets all applicable requirements of law and has the necessary and current licenses/certification/accreditation/designation approval per State requirements. When individuals providing behavioral health treatment services are not required to be licensed or certified, it is the responsibility of the health plan to ensure, based on applicable State licensure rules and/or program standards, that they are appropriately educated, trained, qualified, and competent to perform their job responsibilities.

The health plan shall ensure each LTSS provider's service delivery site or services meet all applicable requirements of law and have the necessary and current licenses/certification/accreditation/designation approval per State requirements. When individuals providing LTSS are not required to be licensed or certified, it is the responsibility of the health plan to ensure, based on applicable State licensure rules and/or program standards, that they are appropriately educated, trained, qualified, and competent to perform their job responsibilities. In addition, health plans are responsible for assuring that all criminal history record check requirements are conducted for all LTSS providers.

The health plan shall ensure that all facilities including, but not limited to, hospitals, are licensed as required by the State.

The health plan shall ensure that all providers including, but not limited to, therapists, meet State licensure requirements.

The health plan shall require that all laboratory testing sites providing services under this RFP have either a current Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver shall provide only the types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests. The health plan shall comply with the provisions of CLIA 1988.

The health plan shall ensure that its providers submit full disclosures as identified in 42 CFR Part 455, Subpart B. Disclosures shall include:

1.(i) The name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address;

(ii) Date of birth and Social Security Number of each person with an ownership or control interest in the disclosing entity; and

(iii) Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has a five (5) percent or more interest.

2. Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person with an ownership or control interest in any subcontractor in which the disclosing entity has a five (5) percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.
3. The name of any other disclosing entity in which an owner of the disclosing entity has an ownership or control interest.
4. The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity.
5. The identity of any individual who has an ownership or control interest in the provider, or is an agent or managing employee of the provider, and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs.

The health plan shall obtain disclosures from its providers at the following times:

- When the provider submits a provider application;
- Upon execution of the provider agreement;
- During recredentialing;
- Upon request from the health plan or DHS;
- Within thirty-five (35) days after any change in ownership of the disclosing entity information to the health plan.

The provider shall submit, within thirty-five (35) days of the date on a request by the health plan, the DHS, or the Secretary full and complete information about:

- The ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and
- Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

The health plan may refuse to enter into or renew an agreement with a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the Title XX Services Program. In addition, the health plan may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure required above.

The health plan may execute network provider agreements, pending the outcome of State screening, enrollment, and revalidation, for up to 120 days but must terminate a network provider immediately upon notification from the State that the network provider cannot be enrolled, or the expiration of one

120 day period without enrollment of the provider, and notify affected enrollees.

The health plan shall notify DHS through its Provider Suspension and Termination report identified in Section 51.520.6 of any providers that the health plan refuses to enter into or renew an agreement.

The health plan shall submit its credentialing, recredentialing and other certification policies and procedures to MQD for review and approval by the due date identified in Section 51.700, Readiness Review.

40.500 Provider Contracts

All contracts between providers and the health plan shall be in writing. The health plan's written provider contracts shall:

1. Specify covered populations and specifically cite the QUEST Integration program;
2. Specify covered services;
3. Specify rates of payment;
4. Prohibit the provider from seeking payment from the member for any covered services provided to the member within the terms of the contract and require the provider to look solely to the health plan for compensation for services rendered, with the exception of cost sharing pursuant to the Hawaii Medicaid State Plan;

5. Prohibit the provider from imposing a no-show fee for QI program members who were scheduled to receive a Medicaid covered service;
6. Specify that in the case of newborns, the provider shall not look to any individual or entity other than the QI or the mother's commercial health plan for any payment owed to providers related to the newborn;
7. Require the provider to cooperate with the health plan's quality improvement activities;
8. Require that providers meet all applicable State and Federal regulations, including but not limited to all applicable HAR sections, and Medicaid requirements for licensing, certification and recertification;
9. Require the provider to cooperate with the health plan's utilization review and management activities;
10. Not prohibit a provider from discussing treatment or non-treatment options with members that may not reflect the health plan's position or may not be covered by the health plan;
11. Not prohibit, or otherwise restrict, a provider from acting within the lawful scope of practice, from advising or advocating on behalf of a member for the member's health status, medical care, or treatment or non-treatment options, including any alternative treatments that might be self-administered;
12. Not prohibit, or otherwise restrict, a provider from advocating on behalf of the member to obtain necessary healthcare services in any grievance system or utilization review process, or individual authorization process;

13. Require providers to meet appointment waiting time standards pursuant to the terms of this contract and as described in Section 40.230;
14. Provide for continuity of treatment in the event a provider's participation terminates during the course of a member's treatment by that provider except in the case of adverse reasons on the part of the provider;
15. Require that providers comply and maintain the confidentiality of member's information and records as required by law, including but not limited to privacy and security regulations adopted under HIPAA;
16. Keep any records necessary to disclose the extent of services the provider furnishes the members;
17. Specify that CMS, the State Medicaid Fraud Control Unit, and the DHS or their respective designee shall have the right to inspect, evaluate, and audit any pertinent books, financial records, medical records, documents, papers, and records of any provider involving financial transactions related to this contract and for the monitoring of quality of care being rendered without the specific consent of the member;
18. Require that provider comply with disclosure requirements identified in accordance with 42 CFR Part 455, Subpart B found in Section 40.400;
19. Require providers that are compensated by capitation payments to submit complete and accurate encounter data on a monthly basis and any and all medical records to support encounter data upon request from the health

plan without the specific consent of the member, DHS or its designee for the purpose of validating encounters;

20. Require provider to certify claim/encounter submissions to the plan as accurate and complete;
21. Require the provider to provide medical records or access to medical records to the health plan and the DHS or its designee, within sixty (60) days of a request. Refusal to provide medical records, access to medical records or inability to produce the medical records to support the claim/encounter shall result in recovery of payment;
22. Include the definition and standards for medical necessity, pursuant to the definition in Section 30.200 of this RFP;
23. Specify acceptable billing and coding requirements;
24. Require that providers comply with the health plan's cultural competency plan;
25. Require that the provider submit to the health plan any marketing materials developed and distributed by providers related to the QI program to include the use of either QUEST Integration or Medicaid;
26. Require that the provider maintain the confidentiality of members' information and records as required by the RFP and in Federal and State law, including but not limited to:
    a. The Administration Simplification (AS) provisions of HIPAA, Public Law 104-191 and the regulations promulgated thereunder, including but not limited to 45 CFR Parts 160, 162, and 164, if the provider is a covered entity under HIPAA;

b. 42 CFR Part 431 Subpart F;
c. Chapter 17-1702, HAR;
d. Section 346-10, HRS;
e. 42 CFR Part 2;
f. Section 334-5, HRS; and
g. Chapter 577A, HRS.

27. Require that providers comply with 42 CFR Part 434 and 42 CFR Section 438.6, if applicable;
28. Require that providers not employ or subcontract with individuals or entities whose owner, those with controlling interest, or managing employees are on any state or federal exclusion lists;
29. Prohibit providers from making referrals for designated health services to healthcare entities with which the provider or a member of the provider's family has a financial relationship as defined in Section 30.200;
30. Require providers of transitioning members to cooperate in all respects with providers of other health plans to assure maximum health outcomes for members;
31. Require the provider to comply with corrective action plans initiated by the health plan;
32. Specify the provider's responsibilities regarding third party liability;
33. Require the provider to comply with the health plan's compliance plan including all fraud and abuse requirements and activities;

34. Require that providers accept members for treatment, unless the provider applies to the health plan for a waiver of this requirement;
35. Require that the provider provide services without regard to race, color, creed, ancestry, sex, including gender identity or expression, sexual orientation, religion, health status, income status, or physical or mental disability;
36. Require that providers offer hours of operation that are no less than the hours of operation offered to commercial members or, if the provider has no commercial members, that the hours of operation are comparable to hours offered to recipients under Medicaid fee-for-service;
37. Require that providers offer access to interpretation services for members that have a Limited English Proficiency (LEP) at no cost to the member, and to document the offer and provision of interpreter services to the same extent as the health plan under the Contract;
38. Require that providers offer access to auxiliary aids and services at no cost for members living with disabilities, and to document the offer and provision of auxiliary aids to the same extent as the health plan under the Contract;
39. Include a statement that the State and the health plan members shall bear no liability for the health plan's failure or refusal to pay valid claims of subcontractors or providers for covered services;

40. Include a statement that the provider shall accept health plan payment in full and cannot charge the patient for any cost of a health plan covered service whether or not the service was reimbursed by the health plan;
41. Include a statement that the State and the health plan members shall bear no liability for services provided to a member for which the State does not pay the health plan;
42. Include a statement that the State and the health plan members shall bear no liability for services provided to a member for which the plan or State does not pay the individual or healthcare provider that furnishes the services under a contractual, referral, or other arrangement to the extent that the payments are in excess of the amount that the member would owe if the health plan provided the services directly;
43. Require the provider to secure and maintain all necessary liability insurance and malpractice coverage as is necessary to protect the health plan's members and the health plan;
44. Require the provider to secure and maintain automobile insurance when transporting members, if applicable;
45. Require that the provider use the definition for emergency medical condition included in Section 30.200;
46. Require that if the provider will be offering EPSDT services, the provider complies with all EPSDT requirements;

47. Require that the provider provides copies of medical records to requesting members and allows them to be amended as specified in 45 CFR Part 164;
48. Require that the provider provide record access to any authorized DHS personnel or personnel contracted by the DHS without member authorization so long as the access to the records is required to perform the duties of the contract with the State and to administer the QUEST Integration programs;
49. Require that the provider complies with health plan standards that provide the DHS or its designee(s) prompt access to members' medical records whether electronic or paper;
50. Require that the provider coordinate with the health plan in transferring medical records (or copies) when a member changes PCPs;
51. Require that the provider comply with the advance directives requirements for hospitals, nursing facilities, providers of home and health care, hospices, and HMOs specified in 42 CFR Part 489, subpart I, and 42 CFR Section 417.436(d);
52. Require all Medicaid related records, be retained in accordance with 42 CFR Section 438.3(u) for a minimum of ten (10) years after the last date of entry in the records. For minors, records must be preserved and maintained during the period of minority plus a minimum of ten (10) years after the minor reaches the age of majority;

53. Require that the provider complies with all credentialing and re-credentialing activities;
54. Require that the provider refund any payment received from a resident or family member (in excess of share of cost) on behalf of the member for the prior coverage period;
55. Require that the provider submit annual cost reports to the MQD, if applicable;
56. Require that the provider comply with all requirements regarding when they may bill a member or assess charges as described in Section 60.320;
57. Require that the provider is licensed in good standing, in the State of Hawaii; and
58. Require that providers (if they will be providing vaccines to children) enroll and complete appropriate forms for the Vaccines For Children (VFC) program.
59. Require provider to report capitation payments or other overpayments in excess of amounts specified in the contract within sixty (60) calendar days when identified.

In addition, the provider contracts for providers who are serving as PCPs (including specialists acting as PCP) shall include the following:

1. A requirement that the provider be responsible for supervising, coordinating, and providing all primary care to each assigned member;
2. A requirement that the provider coordinates and initiates referrals for specialty care;

3. A requirement that the provider maintains continuity of each member's healthcare and maintains the member's health record;
4. A requirement that the provider has admitting privileges to a minimum of one general acute care hospital that is in the health plan's network and on the island of service. For the island of Hawaii this means that the provider shall have admitting privileges to one general acute care hospital in either East Hawaii or West Hawaii, depending on which is closer; and
5. A requirement that if the provider (both PCP and specialist acting as a PCP) has a written agreement with at least one other provider with admitting privileges to an acute care hospital within the health plan's network, in the event he/she does not have one.

The health plan may utilize an addendum to an already executed provider contract if the addendum and the provider agreement together include all requirements to the QUEST Integration provider contract. In addition, it must be clearly stated that if language in the addendum and the provider agreement conflict, the language in the QUEST Integration addendum shall apply.

The health plan shall submit to the DHS for review and approval a model for each type of provider contract by the due date identified in Section 51.700, Readiness Review, and at the DHS' request at any point during the contract period.

In addition, the health plan shall submit to the DHS the signature page of all finalized and executed contracts that have not been previously submitted on the dates identified in Section 51.700.

The health plan shall continue to solicit provider participation throughout the contract term when provider network deficiencies are found.

Requirements for contracts with subcontractors (non-providers) are addressed in Section 70.400.

40.600 Provider Services

40.610 Provider Education

The health plan shall be responsible for educating the providers about managed care and all program requirements. The health plan shall conduct provider education sessions, either one-on-one or in a group setting, for all contracted providers during the two (2) month period prior to the Date of Commencement of Services to Members identified in Section 20.100. The health plan shall conduct education sessions at least every six (6) months for their contracted providers after Date of Commencement of Services to Members identified in Section 20.100. In addition, the health plan shall provide one-on-one education to providers who are not fulfilling program requirements as outlined in the provider agreements and the provider manual. One-on-one provider education includes

educating providers on how to process their specific claims for payment.

Specifically, the health plan shall educate providers on:

- The health plan's referral process and prior authorization process;
- The role of the PCP, if applicable;
- Claims processing;
- Availability of interpreter, auxiliary aids, and services for their patients;
- Availability of service coordination services and how to access these services;
- Role of service coordinators;
- Members' rights and responsibilities, including the right to file a grievance or appeal and how a provider can assist members;
- Reporting requirements;
- Circumstances and situations under which the provider may bill a member for services or assess charges or fees;
- The health plan's medical records documentation requirements including the requirement that this documentation must be tied to claims submission or encounter data;
- Methods the health plan will use to update providers on program and health plan changes (e.g., monthly newsletters, etc.); and
- The provider grievance, complaints, and appeals process.

Additionally, the health plan shall provide the following information on the Member Grievance System to all providers and subcontractors at the time they enter into a contractual relationship with the health plan:

- The member's right to file grievances and appeals and their requirements, and timeframes for filing;
- The member's right to a State administrative hearing, how to obtain a hearing and rules on representation at a hearing;
- The availability of assistance in filing a grievance or an appeal;
- The member's right to have a provider or authorized representative file a grievance and/or an appeal on his or her behalf, provided he or she has provided written consent to do so;
- The toll-free numbers to file a grievance or an appeal; and
- When an appeal or hearing has been requested by the member, the right of a member to receive benefits while the appeal or hearing is pending and that the member may be held liable for the costs of those benefits if the health plan's adverse action is upheld.

The health plan shall ensure that the providers are aware of their responsibilities for compliance with the Americans with Disabilities Act (ADA), including how to access interpreter and sign language services as described in Section 50.435.

The health plan shall develop provider education curricula and schedules that shall be submitted to the DHS for review and approval by the due date identified in Section 51.700, Readiness Review.

The health plan must educate network providers about how to access the formulary in the health plan website. In addition, the health plan may allow network providers' access to the formulary through a free, point-of-care web-based application accessible on smart phones, tablets, or similar technology. The formulary must also identify preferred/non-preferred drugs, Clinical PAs, and any preferred drugs that can be substituted for non-preferred drugs. The health plan must ensure that the providers have access to its current formulary that is updated at least monthly.

40.620 Provider Grievance and Appeals Process

The health plan shall have policies and procedures for a provider grievance system that includes provider grievances and provider appeals. Provider grievances and provider appeals shall be resolved within sixty (60) days of the day following the date of submission to the health plan. The health plan shall give providers thirty (30) days from the decision of the grievance to file an appeal. Providers may utilize the provider grievance system to resolve issues and problems with the health plan (this includes a problem regarding a member). A provider may file a grievance or appeal on behalf of a

member by following the procedures outlined in Section 51.100, Member Grievance System.

A provider, either contracted or non-contracted, may file a provider grievance. Below are some examples of items that may be filed as a grievance:

- Benefits and limits, for example, limits on behavioral health services or formulary;
- Eligibility and enrollment, for example long wait times or inability to confirm enrollment or identify the PCP;
- Member issues, including members who fail to meet appointments or do not call for cancellations, instances in which the interaction with the member is not satisfactory; instances in which the member is rude or unfriendly; or other member-related concerns; and
- Health plan issues, including difficulty contacting the health plan or its subcontractors due to long wait times, busy lines, etc; problems with the health plan's staff behavior; delays in claims payments; denial of claims; claims not paid correctly; or other health plan issues.
- Issues related to availability of health services from the health plan to a member, for example delays in obtaining or inability to obtain emergent/urgent services, medications, specialty care, ancillary services such as transportation, medical supplies, etc.;
- Issues related to the delivery of health services, for example, the PCP did not make referral to a specialist, medication was not provided by a pharmacy, the member did not receive services the provider believed

were needed, provider is unable to treat member appropriately because the member is verbally abusive or threatens physical behavior; and

- Issues related to the quality of service, for example, the provider reports that another provider did not appropriately evaluate, diagnose, prescribe or treat the member, the provider reports that another provider has issues with cleanliness of office, instruments, or other aseptic technique was used, the provider reports that another provider did not render services or items which the member needed, or the provider reports that the plan's specialty network cannot provide adequate care for a member.

The health plan shall log all provider grievances and report to DHS in accordance with Section 51.520.7, Provider Grievance and Claims Report.

The grievance and appeals process shall provide for the timely and effective resolution of any disputes between the health plan and provider(s).

The health plan shall submit provider grievance system policies and procedures to the DHS for review and approval by the due date identified in Section 51.700, Readiness Review.

40.630 Provider Manual

The health plan shall develop a provider manual 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. If a provider requests a hard copy, the health plan shall provide it at no charge to the provider.

The health plan shall update the electronic version of the provider manual immediately, not more than five (5) days following a change to it. In addition, the health plan shall notify all providers, in writing, of any changes. These notifications may be electronic or hard copy, unless the provider specifically requests a hard copy, in which case it shall be provided without charge to the provider.

The health plan shall include, at a minimum, the following information in the provider manual:

- A table of contents;
- An introduction that explains the health plan's organization and administrative structure, including an overview of the health plan's provider services department, function, and how they may be reached;
- Provider responsibilities and the health plan's expectations of the provider;
- A listing and description of covered and non-covered services, requirements and limitations;
- Information about appropriate and inappropriate utilization of emergency department services as well as the definitions of emergency medical condition and

emergency medical services as provided in Section 30.200;

- Health plan fraud and abuse activities, including how to report suspected fraud and/or abuse;
- Appointment and waiting time standards as described in Section 40.230;
- Formulary information which shall be updated in advance of the change and sent to the providers;
- The description of the referral process which explains the services requiring referrals and how to obtain referrals;
- A description of the prior authorization (PA) process, including the services requiring PA and how to obtain PAs;
- A description of who may serve as a PCP as described in Section 40.250;
- Applicable criteria for specialists or other healthcare practitioners to serve as PCPs for members with chronic conditions as described in Section 40.250;
- The description of the roles and responsibilities of the PCP, including:
    - Serving as an ongoing source of primary care for the member, including supervising, coordinating, and providing all primary care to the member;
    - Being primarily responsible for coordinating other healthcare services furnished to the member, including;
        - Coordinating and initiating referrals to specialty care (both in-network and out-of-network);

        - Maintaining continuity of care; and
        - Maintaining the member's medical record (this includes documentation of services provided by the PCP as well as any specialty services);
- Information on the health plan's policies and procedures (P&P) for changing PCPs, including:
    - The process for changing PCPs, (e.g., whether the member may make the request by phone, etc.); and
    - When PCP changes are effective;
- Information on the availability of service coordination and how to access these services;
- The description of the role of service coordinators;
- The description of members' rights and responsibilities as identified in Section 50.450;
- A description of cost sharing responsibilities;
- A description of reporting requirements, including encounter data requirements, if applicable;
- Reimbursement information, including reimbursement for members eligible for both Medicare and Medicaid (dual eligible), or members with other insurance;
- Explanation of remittance advices;
- A statement that if a provider fails to follow health plan procedures which results in nonpayment, the provider may not bill the member;
- The description of when a provider may bill a member or assess charges or fees which shall include a provision

that the provider may not bill a member or assesses charges or fees except:

- If a member self-refers to a specialist or other provider within the network without following health plan procedures (e.g. without obtaining prior authorization) and the health plan denies payment to the provider, the provider may bill the member; and
- If a provider bills the member for non-covered services or for self-referrals, the provider shall inform the member and obtain prior agreement from the member regarding the cost of the procedure and the payment terms at time of service;

- A description of the health plan's grievance system process and procedures for members which shall include, at a minimum:
  - The member's right to file grievances and appeals with requirements, and time frames for filing;
  - The member's right to a State administrative hearing, how to obtain a hearing and rules on representation at a hearing;
  - The availability of assistance in filing a grievance or an appeal;
  - The member's right to have a provider or authorized representative file a grievance and/or an appeal on his or her behalf, provided he or she has provided consent to do so;

    - The toll-free numbers to file a grievance or an appeal; and
    - When an appeal or hearing has been requested by the member, the right of a member to receive benefits while the appeal or hearing is pending and that the member may be held liable for the costs of those benefits if the health plan's adverse action is upheld;
- A description of the provider grievance system including how to file a grievance or appeal;
- A description of how the provider can access language interpretation, auxiliary aids, sign language services, and specialized communication for its members (e.g., Braille, translation in a language other than English, etc.);
- A description of the provider's responsibility for continuity of treatment in the event a provider's participation with the health plan terminates during the course of a member's treatment by that provider;
- A description of credentialing and recredentialing requirements and activities;
- A description of the health plan's QAPI and the provider's responsibilities as it relates to the QAPI;
- Medical records standards and the provider's responsibilities regarding medical records;
- A description of confidentiality and HIPAA requirements with which the provider must comply;

- A statement that the health plan shall immediately transfer a member to another PCP, health plan, or provider if the member's health or safety is in jeopardy;
- Claims submission and adjudication procedures;
- Utilization review and management activities;
- A description of the provider's role in the development of treatment or service plans for members; and
- Processes surrounding provider termination to include transition of care.

The health plan shall submit the provider manual to the DHS for review and approval by the due date identified in Section 51.700, Readiness Review.

40.640 Provider Call-Center/Prior Authorization (PA) Line

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 assure that access to prior authorization staff is readily accessible. The toll-free provider call center shall be available and accessible to providers from all islands on which the health plan serves.

The health plan's provider call center systems shall have the capability to track call center metrics identified by the DHS. The call center metrics for the provider call center shall be able to be reported to DHS separate from the member call center metrics.

The provider call center shall 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 provider call center staff shall be trained to respond to provider questions in all areas.

The health plan shall meet the following call center standards:

- The call abandonment rate is five percent (5%) or less;
- The average speed of answer is thirty (30) seconds or less;
- The average hold time is two (2) minutes or less;
- The blocked call rate does not exceed one percent (1%); and
- The longest wait in queue does not exceed four (4) minutes.

The health plan shall have an automated system or answering service available between the hours of 4:30 p.m. (H.S.T.) and 7:45 a.m. (H.S.T.) Monday through Friday and during all hours on weekends and holidays. This automated system or answering service shall include a voice mailbox or other method for providers to leave messages. The health plan shall ensure that the voice mailbox has adequate capacity to receive all messages. The health plan shall ensure that representatives return all calls by close of business the following business day. In emergency situations, the health plan shall ensure that calls are returned to providers within thirty (30) minutes whether the message is left on the automated system or by the answering service.

The health plan shall develop provider call center/PA line policies and procedures. These policies and procedures shall permit a participating provider who treats a member after hours for an urgent or emergent condition and determines that the individual requires prompt outpatient specialist follow up and that requiring a visit to the member's primary care provider will delay the receipt of necessary care to refer the member for follow up specialty care. The health plan shall submit these policies and procedures to the DHS for review and approval by the due date identified in Section 51.700, Readiness Review.

40.650 Web-site for Providers

The health plan shall have a provider portal on its web-site that is accessible to providers. The portal shall include all pertinent information including, but not limited to, the provider manual, sample provider contracts, update newsletters and notifications, and information about how to contact the health plan's provider services department. In addition, the web-site shall have the functionality to allow providers to make inquiries and receive responses from the health plan regarding care for the member, including real-time health plan membership verification, electronic prior authorization request and approval, filled medication list look-up, and electronic referrals requiring health plan authorization.

Health plans are encouraged to develop a smart PA system, such that if a provider has a certain percentage of PA requests

approved for certain services or overall, that subsequent PA requests from the provider could be waived in order to reduce administrative burden on high performing providers.

The health plan shall have policies and procedures in place to ensure the web-site is updated regularly and contains accurate information. The health plan shall submit these policies and procedures to the DHS for review and approval by the due date identified in Section 51.700, Readiness Review.

The health plan shall submit screenshots of its provider web-site to the DHS for review and approval by the due date identified in Section 51.700, Readiness Review. In addition, the health plan shall submit access to the provider web-site (even if in a test environment) to the DHS for review and approval by the due date identified in Section 51.700, Readiness Review.

40.700 Covered Benefits and Services

General Overview

The health plan shall be responsible for providing all medically necessary covered services to all eligible members as defined in this section. These medically necessary covered services shall be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to recipients under Medicaid fee-for-service. The health plan may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. The health plan may

incorporate utilization controls as described in Section 50.800 as long as the services furnished to the member can be reasonably expected to achieve its purpose.

The health plan shall ensure that services are provided in a manner that facilitates maximum community placement for members that require LTSS.

A member's access to behavioral health services shall be no more restrictive than for accessing medical services. The health plan must not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to enrollees (whether or not the benefits are furnished by the same health plan).

The health plan shall provide all preventive services as defined in Appendix J and all required EPSDT services defined in Section 41.100.

Included in the services to be provided to adults and children are the medical services required as part of a dental treatment. The health plan shall provide and be financially responsible for medical services related to the dental services and for certain dental procedures performed by both dentists (oral surgeons) and physicians (primarily plastic surgeons, otolaryngologists,

and general surgeons), as defined in Section 30.720 and Appendix F.

With the exception of covering services specifically excluded by the Federal Medicaid requirements, the health plan may, at its own option and as an administrative expense, choose to provide additional services, either non-covered services or services in excess of the required covered services or benefit limits. The health plan shall provide a description of any additional services it will provide to the DHS by the due date identified in Section 51.700, Readiness Review.

The health plan may choose to offer additional services later, but first shall submit the services to the DHS for approval at least thirty (30) days prior to service implementation. The health plan shall also include in its notification to the DHS any benefit limits, the process it will use to notify members about new services and the process it will use to update program materials to reflect new services.

40.710 Primary and Acute Care Services- Physical Health

The health plans shall provide the following services to all its members including those enrolled in the health plan during prior period coverage. Services shall be provided if medically necessary in the amount and duration listed below. The scope of services is defined in Section 40.740.

- Diagnostic tests to include but not limited to:
  - laboratory tests,

- imaging services, or
- other diagnostic tests;

- Dialysis;
- Durable medical equipment, including visual appliances and medical supplies to include orthotics and prosthetics;
- Emergency medical services as defined in Section 40.740.1.e to include medically necessary ground and air (fixed wing and air) ambulance;
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for individuals under age twenty-one years who require benefits for which either coverage has been exhausted or not described under the State Plan;
- Habilitation services;
- Hospice services;
- Immunizations;
- Inpatient hospital days for medical and surgical care to include:
  - post-stabilization services,
  - maternity and newborn care, or
  - sterilization and hysterectomies;
- Non-emergency transportation;
- Outpatient hospital procedures or ambulatory surgical center procedures to include but not limited to:
  - sleep laboratory services and
  - surgeries performed in a free-standing ambulatory surgery center (ASC) and hospital ASC;
- Outpatient medical or behavioral health visits to include:
  - family planning,
  - fluoride varnish,

- home health,
- medical services related to dental needs,
- nutrition counseling,
- other practitioner services,
- physician services,
- podiatry,
- post-stabilization services, if applicable,
- preventive services,
- smoking cessation,
- urgent care, and
- vision and hearing services;

- Pregnancy-related services
- Prescription drugs; and
- Rehabilitation Services both inpatient and outpatient to include cognitive rehabilitation services.

Members may be billed directly by the rendering provider for any non-covered services and for covered services exceeding any established limits, as applicable. The health plans shall inform members that they may be billed directly by the rendering provider for any non-covered services and for covered services exceeding any established limits, as applicable. With the exception of covering services specifically excluded, the health plan, at its own option, may choose to provide additional services in excess of the required covered services on an individual consideration basis.

40.720 Behavioral Health Services

The health plan shall provide the following standard behavioral health services to members as part of their benefit package including those enrolled in the health plan during prior period coverage. Details of coverage for each of these services are discussed in Section 40.740.2.

- Inpatient Psychiatric Hospitalizations to include:
  - o psychiatric services, and
  - o substance abuse treatment services.
- Ambulatory Mental Health Services that includes crisis management;
- Medications and Medication Management;
- Psychiatric or psychological evaluation and treatment;
- Medically necessary alcohol and chemical dependency services; and
- Methadone management services.

40.720.1 Additional Behavioral Health Services for Children

Children/youth less than twenty-one (21) years old with a diagnosis of serious emotional behavioral disorders are eligible for additional behavioral health services within the Department of Health, Child and Adolescent Mental Health Division (CAMHD) Support for Emotional and Behavioral Development (SEBD) program. Refer to Section 30.820.1 for additional information on CAMHD.

40.720.2 Additional Behavioral Health Services for Adults

Adult members age twenty-one (21) years of age or older with a diagnosis of serious and persistent mental illness (SPMI) who are eligible for additional behavioral health services shall receive those services through the Community Care Services (CCS) program as described in Section 30.750.

40.730 Long-Term Services and Supports (LTSS)

The health plan shall provide these services to members who meet appropriate level of care. Long-term services and supports (LTSS) are divided into two categories: (1) HCBS (services provided in a member's home or other community residential setting) and (2) services provided in an institutional setting. Details of coverage for each of the services are discussed in Section 40.740.3.

- HCBS:
  - Adult day care;
  - Adult day health;
  - Assisted living services;
  - Community Care Management Agency (CCMA) services;
  - Counseling and training;
  - Environmental accessibility adaptations;
  - Home delivered meals;
  - Home maintenance;
  - Moving assistance;
  - Non-medical transportation;
  - Personal assistance services –Level I and Level II;
  - Personal Emergency Response Systems (PERS);
  - Residential care including E-ARCH and CCFFH;

- Respite care;
- Skilled (or private duty) nursing; and
- Specialized medical equipment and supplies.

- Institutional Services:
  - Acute Waitlisted ICF/SNF;
  - Nursing Facility (NF), Skilled Nursing Facility (SNF), or Intermediate Care Facility (ICF); and
  - Subacute facility services.

Each health plan must establish and maintain a member advisory committee to members receiving LTSS services. The committee must include at least a reasonably representative sample of the LTSS populations, or other individuals representing those members, covered under the contract with the health plan.

The health plan shall meet the time and distance standards as described in section 40.240 and the network adequacy standards described in section 40.220 in accordance to 42 CFR Section 438.68(b)(2).

40.735 Community Integration Services (CIS)

The health plan shall provide CIS to members eighteen (18) years of age or older if the member meets the following criteria.

1. Member meets at least one of the following health needs-based criteria and is expected to benefit from community integration services:

a. Member assessed to have a behavioral health need which is defined as one or both of the following criteria:
   i. Mental health need, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support) resulting from the presence of a serious mental illness; and/or
   ii. Substance use need, where an assessment using American Society of Addiction Medicine (ASAM) criteria indicates that the member meets at least ASAM level 2.1 indicating the need for outpatient day treatment for Substance Use Disorder (SUD) treatment.
b. Member assessed to have a complex physical health need, which is defined as a long continuing or indefinite physical condition requiring improvement, stabilization, or prevention of deterioration of functioning (including the ability to live independently without support).

AND

2. Member has at least one of the following risk factors:
   a. Homelessness, defined as lacking a fixed, regular, and adequate nighttime residence, meaning:
      i. Has a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human

beings, including a car, park, abandoned building, bus or train station, airport, or camping ground; or

ii. Living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low income individuals).

b. At risk of homelessness, defined as a member who will lose their primary nighttime residence:

i. There is notification in writing that their residence will be lost within 21 days of the date of application for assistance;

1. No subsequent residence has been identified; and
2. Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to or living in a place not meant for human habitation, a safe haven, or an emergency shelter; or

ii. History of frequent and/or lengthy stays in a nursing facility

1. Frequent is defined as more than one contact in the past 12 months.
2. Lengthy is defined as 60 or more consecutive days within an institutional care facility.

Identification of the members who meet the above criteria will be done by health plans using their encounter data, consultation with social service agencies/case management agencies' assessments and partnerships established for Hawaii's Homeless Management Information System (HMIS) and Homeless Coordinated Entry Systems (CES).

Community Integration Services (CIS) are divided into two categories: (1) pre-tenancy supports, and (2) tenancy sustaining services. Details of coverage for the services are discussed in Section 40.740.4.

- Pre-tenancy supports:
  - Conducting a functional needs assessment identifying the member's preferences related to housing (e.g., type, location, living alone or with someone else, identifying a roommate, accommodations needed, or other important preferences) and needs for support to maintain community integration (including what type of setting works best for the individual); and providing assistance in budgeting for housing and living expenses.
  - Developing an individualized plan based upon the functional needs assessment as part of the overall person-centered plan. Identifying and establishing short and long-term measurable goal(s), and establishing how goals will be achieved and how

concerns will be addressed.

- Assisting the member with connecting to social services to help with finding and applying for housing necessary to support the individual in meeting their medical care needs.
- Participating in person-centered plan meetings at redetermination and/or revision plan meetings, as needed.
- Providing supports and interventions per the person-centered plan.

- Tenancy sustaining services:
  - Service planning support and participating in person-centered plan meetings at redetermination and/or revision plan meetings, as needed.
  - Coordinating and linking the member to services and service providers including primary care and health homes; substance use treatment providers; mental health providers; medical, vision, nutritional and dental providers; vocational, education, employment and volunteer supports; hospitals and emergency rooms; probation and parole; crisis services; end of life planning; and other support groups and natural supports.
  - Entitlement assistance including assisting members in obtaining documentation, navigating and monitoring application process, and coordinating with

the entitlement agency.

- Assistance in accessing supports to preserve the most independent living such as individual and family counseling, support groups, and natural supports.
- Providing supports to assist the member in the development of independent living skills, such as skills coaching, financial counseling, and anger management.
- Providing supports to assist the member in communicating with the landlord and/or property manager regarding the participant's disability (if authorized and appropriate), detailing accommodations needed, and addressing components of emergency procedures involving the landlord and/or property manager.
- Coordinating with the member to review, update and modify housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.
- Connecting the member to training and resources that will assist the member in being a good tenant and lease compliance, including ongoing support with activities related to household management.

40.740 Coverage Provisions

The health plan shall provide the following services in accordance with the prescribed parameters and limitations. The health plan shall comply with all State and Federal laws pertaining to the provision of such services.

40.740.1 Coverage Provisions for Primary and Acute Care Services

The health plan shall provide the following primary and acute care services in accordance with the prescribed parameters and limitations as part of their benefit package as described in Section 40.710. The health plan shall comply with all State and Federal laws pertaining to the provision of such services.

The health plan shall make available triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions, when applicable.

a. Cognitive Rehabilitation Services

Cognitive Rehabilitation Services are services provided to cognitively impaired persons, most commonly those with traumatic brain injury, that assess and treat communication skills, cognitive and behavioral ability, and cognitive skills related to performing ADLS. Reassessments are completed at regular intervals, determined by the provider and according to the member's assessed needs, treatment goals and objectives.

Five cognitive skills area should be comprehensively assessed and, as appropriate, treated:

- Attention Skills- sustained, selective, alternating, and divided;
- Visual Processing Skills- acuity, oculomotor control, fields, visual attention, scanning, pattern recognition, visual memory, or perception;
- Information Processing Skills- auditory or other sensory processing skills, organizational skills, speed, and capacity of processing;
- Memory Skills- orientation, episodic, prospective, encoding, storage, consolidation, and recall; and
- Executive Function Skills- self-awareness, goal setting, self-initiation, self-inhibition, planning and organization, self-monitoring, self-evaluation, flexible problem solving, and metacognition.

Assessment and treatment should begin at attention skills and move up accordingly. Executive function skills should be worked on at all levels of cognitive skill areas.

There are several approaches and techniques/strategies that can be used to provide cognitive rehabilitation services. The approaches include:

- Education;
- Process training;
- Strategy development and implementation; and
- Functional application.

Selected approaches should match the appropriate level of awareness of cognitive skills.

Some of the approved cognitive rehabilitation techniques/strategies include:

- Speech/language/communication – Process to address the member's articulation, distortions, and phonological disorders, including: 1) inappropriate pitch, loudness, quality or total loss of speech, and fluency disorder or stuttering and 2) training on the tools needed to effectively communicate wants and needs.
- Neuropsychological assessment - Process to provide an objective and quantitative assessment of a member's functioning following a neurological illness or injury. The evaluation consists of the administration of a series of objective tests, designed to provide specific information about the member's current cognitive and emotional functioning.
- Compensatory memory techniques - Strategies to improve functions of attention and concentration that can impact on the member's ability to regain independence in daily living activities as well as in auditory processing, planning, problem solving, decision making, and memory functions.
- Executive functions strategies – Strategies to teach the member to engage in self-appraisal of strengths and weakness, setting goals, self-monitoring, self-evaluating and problem solving.

- Reading/writing skills retraining – Process to relearn levels of writing and reading structure and content to member's maximum potential.

b. Diagnostic Testing

The health plan shall provide diagnostic testing to include but not limited to screening and diagnostic radiology and imaging; screening and diagnostic laboratory tests; and other medically necessary screening or diagnostic radiology or laboratory services.

Health plans may not prior authorize any laboratory, imaging or diagnostic services other than the following:

- Magnetic Resonance Imaging (MRI);
- Magnetic Resonance Angiogram (MRA);
- Positron Emission Tomography (PET);
- Reference lab tests that cannot be done in Hawaii and not specifically billable by clinical laboratories in Hawaii;
- Disease specific new technology lab tests;
- Chromosomal analysis;
- Psychological testing;
- Neuropsychological testing; or
- Cognitive testing.

c. Dialysis

The health plan shall provide dialysis services when provided by participating Medicare certified hospitals and Medicare certified End Stage Renal Disease (ESRD) providers. The health plan shall assure that only services, equipment,

supplies, diagnostic testing (including medically necessary laboratory tests) and drugs medically necessary for the dialysis treatment that are approved by Medicare are provided. The health plan shall allow for dialysis treatments in various settings: hospital inpatient, hospital outpatient, non-hospital renal dialysis facility or members' home. The health plan shall structure provision of home dialysis to include those items in Medicare's global reimbursement for home dialysis. All facilities providing maintenance renal dialysis treatments to members must be certified as meeting the conditions for compliance with Medicare health, safety and other Medicare requirements.

The health plan shall include the following as part of dialysis services:

- Laboratory Tests including Hepatitis B surface antigen (HBsAg) and Anti-HB testing for patients on Hemodialysis, Intermittent Peritoneal Dialysis (IPD), and Continuous Cycling Peritoneal Dialysis (CCPD);
- Hepatitis B vaccines;
- Alfa Epoetin (EPO) when provided during dialysis and the health plan is encouraged to follow evidence-based best practices about target hemoglobin/hematocrit levels;
- Other drugs related to ESRD;
- Home dialysis equipment prescribed by a physician;
- Continuous ambulatory peritoneal dialysis (CAPD), a variation of peritoneal dialysis, that is an alternative mode for dialysis for home dialysis patients;

- Physician's Services; and
- Inpatient hospitalization when the hospitalization is for an acute medical condition requiring dialysis treatments; a patient receiving chronic outpatient dialysis is hospitalized for an unrelated medical condition, or for placement, replacement or repair of the chronic dialysis route.

d. Durable Medical Equipment and Medical Supplies

Durable medical equipment and medical supplies include, but are not limited to, the following: oxygen tanks and concentrators; ventilators; wheelchairs; crutches and canes; eyeglasses; orthotic devices; prosthetic devices; hearing aids; pacemakers; medical supplies such as surgical dressings, continence supplies and ostomy supplies; foot appliances (orthoses, prostheses); orthopedic shoes and casts; orthodigital prostheses and casts; and other medically necessary durable medical equipment covered by the Hawaii Medicaid program.

e. Emergency and Post Stabilization Services

The health plan is responsible for providing emergency services twenty-four (24) hours a day, seven (7) days a week to treat an emergency medical condition. The health plan shall provide education to its members on the appropriate use of emergency

services, the availability of a 24/7 nurse triage line, and alternatives for members to receive non-emergent care outside of the emergency department.

The health plan shall establish a twenty-four (24) hour nurse triage phone line in accordance with Section 50.480. The health plan shall submit monthly reports to DHS in a format determined by DHS on the number of calls received, their times, reason for the call, and disposition in accordance with reporting requirements described in Section 51.540.2.

Through the requirements of Section 50.500, member access to providers through extended office hours or after-hours access will increase and is expected to decrease inappropriate emergency department usage. The health plan is encouraged to expand access beyond the minimum requirements of Section 50.500 to promote utilization of urgent care centers or after-hours care in order to prevent inappropriate emergency department usage.

An emergency medical condition is a medical condition manifesting itself by acute onset of symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the physical or mental health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part;
- Serious harm to self or others due to an alcohol or drug abuse emergency;
- Injury to self or bodily harm to others; or
- With respect to a pregnant woman having contractions: (1) that there is not adequate time to effect a safe transfer to another hospital before delivery; or (2) that transfer may pose a threat to the health or safety of the woman or her unborn child.

An emergency medical condition shall not be defined or limited based on a list of diagnoses or symptoms.

Emergency services include inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition that is found to exist using a prudent layperson's standard. The services must also be furnished by a provider that is qualified to furnish such services.

The health plan shall provide payment for emergency services when furnished by a qualified provider, regardless of whether that provider is in the health plan's network. These services shall not be subject to prior authorization requirements. The health plan shall pay for all emergency services that are medically necessary to be provided on an emergent basis until

the member is stabilized. The health plan shall also pay any screening examination services to determine whether an emergency medical condition exists.

The health plan shall base coverage decisions for initial screening examinations to determine whether an emergency medical condition exists on the severity of the symptoms at the time of presentation and shall cover these examinations when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson. The health plan shall not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency medical condition under the prudent layperson standard, turned out to be non-emergency in nature.

The emergency department physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the health plan, which shall be responsible for coverage and payment. The health plan is responsible for coverage and payment of medically necessary emergency services. The health plan shall not refuse to cover emergency services based on the emergency department provider failing to notify the member's PCP or the health plan within ten (10) days of presentation for emergency services. However, the health plan may deny reimbursement for any services provided on an emergent basis to an individual after

the provider could reasonably determine that the individual did not have an actual emergency medical condition.

The health plan, however, may establish arrangements with a hospital whereby the health plan may send one of its own physicians with appropriate emergency department privileges to assume the attending physician's responsibilities to stabilize, treat, and transfer the member, if such arrangement does not delay the provision of emergency services.

If an emergency screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition does not exist, then the determining factor for payment liability for the screening examination shall be whether the member had acute symptoms of sufficient severity at the time of presentation. However, in this situation, the health plan shall deny reimbursement for any non-emergent diagnostic and treatments provided, with the exception below.

When a member's PCP or other health plan representative instructs the member to seek emergency services, the health plan shall be responsible for payment for the medical screening examination and other medically necessary emergency services, without regard to whether the condition meets the prudent layperson standard.

The member who has an emergency medical condition shall not be held liable for payment of subsequent screening and

treatment needed to diagnose the specific condition or stabilize the patient.

Once the member's condition is stabilized, the health plan may require pre-certification for hospital admission or prior authorization for follow-up care.

The health plan shall be responsible for providing post-stabilization care services twenty-four (24) hours a day, seven (7) days a week, both inpatient and outpatient, related to an emergency medical condition, that are provided after a member is stabilized in order to maintain the stabilized condition, or, as prescribed in 42 CFR Section 438.114, to improve or resolve the member's condition. Post-stabilization services include follow up outpatient specialist care.

The health plan is financially responsible for post-stabilization services obtained from any provider that are not prior authorized or pre-certified by a health plan provider or organization representative, regardless of whether provider is within or outside the health plan's provider network, if these services are rendered to maintain, improve, or resolve the members' stabilized condition in the following situations:

- The health plan does not respond to the provider's request for pre-certification or prior authorization within one (1) hour;
- The health plan cannot be contacted; or

- The health plan's representative and the attending physician cannot reach an agreement concerning the member's care, and a health plan physician is not available for consultation. In this situation, the health plan shall give the treating physician the opportunity to consult with an in-network physician, and the treating physician may continue with the care of the member until a health plan physician is reached or one of the criteria outlined below are met.

The health plan's responsibility for post-stabilization services that it has not approved shall end when:

- An in-network provider with privileges at the treating hospital assumes responsibility for the member's care;
- An in-network provider assumes responsibility for the member's care through transfer;
- The health plan's representative and the treating physician reach an agreement concerning the member's care; or
- The member is discharged.

In the event the member receives post-stabilization services from a provider outside of the health plan's network, the health plan is prohibited from charging the member more than he or she would be charged if he or she had obtained the services through an in-network provider.

f. Family Planning Services

The health plan shall provide access to family planning services within the network. However, member freedom of choice may not be restricted to in-network providers. Family planning services include family planning drugs, supplies and devices to include but not limited to generic birth control pills, medroxyprogesterone acetate (Depo-Provera), intrauterine device (IUD), and diaphragms. The health plan shall inform members of the availability of family planning services and shall provide services to members wishing to prevent pregnancies, plan the number of pregnancies, plan the spacing between pregnancies, or obtain confirmation of pregnancy. These services shall include, at a minimum, the following:

- Education and counseling necessary to make informed choices and understand contraceptive methods;
- Emergency contraception and counseling, as indicated;
- Follow-up, brief, and comprehensive visits;
- Pregnancy testing;
- Contraceptive supplies and follow-up care; and
- Diagnosis and treatment of sexually transmitted diseases.

The health plan shall furnish all services on a voluntary and confidential basis to all members.

g. Fluoride Varnish

Topical fluoride varnish application by qualified primary care providers will be covered for children age >1 and <6 years who have not received a topical fluoride treatment, by a dentist or qualified primary care provider, within the previous six months. Qualified PCPs include physicians and nurse practitioners. These PCPs may delegate under direct supervision to a physician assistant (PA), registered nurse (RN), licensed practical nurse (LPN), or Certified Medical Assistant (CMA). Prior to performing topical fluoride varnish applications, PCPs must receive either Continuing Medical Education (CME) or CME-equivalent training in fluoride varnish application approved by either the American Academy of Pediatrics (AAP) or the American Academy of Family Physicians (AAFP). Documentation of approved training must be provided upon request. Topical fluoride varnish application shall be billed using HCPCS code D1206. This code shall be covered for children beginning at age one year until reaching age six years if they have not received a topical fluoride treatment in the previous six months.

h. Habilitation Services

Habilitative services and devices develop, improve, or maintain skills and functioning for daily living that were never learned or acquired to a developmentally appropriate level. Skills and functioning for daily living, such as basic activities of daily living, are typically learned or acquired during childhood development.

Habilitative Services and Devices include:

- Audiology Services
- Occupational Therapy
- Physical Therapy
- Speech-Language Therapy
- Vision Services
- Devices associated with these services including augmentative communication devices, reading devices, and visual aids but exclude those devices used specifically for activities at school

When being provided as habilitative services and devices, these should be covered only when medically necessary, and only if not otherwise covered in the benefits package.

Habilitative services do not include routine vision services that are found in Section 40.740.1.ab.

i. Home Health Services

Home health services are part-time or intermittent care for members who do not require hospital care. This service is provided under the direction of a physician in order to prevent re-hospitalization or institutionalization. A participating home health service provider must meet Medicare requirements.

Home health visits shall be covered as follows when part of a written plan of care:

- Daily visits permitted for home health aid and nursing services in the first two weeks of patient care if part of the written plan of care;
- No more than three visits per week for each service in the third to seventh week of care;
- No more than one visit per week for each service in the eighth to fifteenth week of care; and
- No more than one visit every other month for each service from the sixteenth week of care.

Services exceeding these parameters shall be prior authorized.

The following is a list, but not an inclusive list, of the services that are included in home health services:

- Skilled nursing;
- Home health aides;
- Medical supplies and durable medical equipment;
- Therapeutic services such as physical and occupational, therapy; and
- Audiology and Speech-language pathology.

j. Hospice Care

Hospice is a program that provides care to terminally ill patients who are not expected to live more than six (6) months. A participating hospice provider must meet Medicare requirements. Children under the age of twenty-one (21) years can receive treatment to manage or cure their disease while concurrently receiving hospice services.

k. Immunizations

The health plans shall provide any Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP) approved vaccine to include but not limited to influenza, pneumococcal, diphtheria and tetanus. Refer to Section 30.820.4 for health plan responsibilities regarding the VFC Program.

l. Inpatient Hospital Services for Medical, Surgical, Maternity/Newborn Care, and Rehabilitation

These services include the cost of room and board for inpatient stays. The services include: nursing care; medical supplies, equipment and drugs; diagnostic services; physical therapy, occupational therapy, audiology, and speech-language pathology services; and other medically necessary services.

m. Medical Services Related to Dental Needs

Please refer to Section 30.720 for health plan responsibilities pertaining to Medical Services related to Dental Needs.

n. Nutrition Counseling

This service is provided by a licensed dietitian. This preventive health service includes diabetes self-management training (DSMT) programs as part of an American Diabetes Association (ADA)/American Association of Diabetes Educators (AADE) recognized DSMT programs, nutrition counseling for

obesity, and when medically necessary for other metabolic conditions. Nutrition counseling requires a physician's order and must be part of a treatment program to mitigate the effects of an illness or condition.

o. Other Practitioner Services

Other practitioner services include, but are not limited to: certified nurse midwife services, licensed advanced practice registered nurse services (including family, pediatric, and psychiatric health specialists), and other medically necessary practitioner services provided by a licensed or certified healthcare provider to include behavioral health providers such as psychologists, marriage and family therapists, mental health counselors and certified substance abuse counselors.

p. Outpatient Hospital Services

This service includes: twenty-four (24) hours a day, seven (7) days per week, emergency services; outpatient surgical or other interventional procedures; urgent care services; medical supplies, equipment and drugs; diagnostic services; therapeutic services including chemotherapy and radiation therapy; and other medically necessary services.

q. *Physician Services*

Physician services are provided within the scope of practice of allopathic or osteopathic medicine as defined by State law. Services must be medically necessary and provided at locations

including, but not limited to: physician's office; a clinic; a private home; a licensed hospital; a licensed skilled nursing or intermediate care facility; or a licensed or certified residential setting.

r. Podiatry Services

Podiatry services shall include, but are not limited to, the treatment of conditions of the foot and ankle such as:

- Professional services, not involving surgery, provided in the office and clinic;
- Professional services, not involving surgery, related to diabetic foot care in the outpatient and inpatient hospital;
- Surgical procedures are limited to those involving the ankle and below;
- Diagnostic radiology procedures limited to the ankle and below;
- Foot and ankle care related to the treatment of infection or injury is covered in the office or an outpatient clinic setting; and
- Bunionectomies are covered only when the bunion is present with overlying skin ulceration or neuroma secondary to the bunion.

s. *Pregnancy-related Services - Services for Pregnant Women and Expectant Parents*

The health plan shall provide pregnant women any medically necessary pregnancy-related services for the health of the

woman and her fetus without limitation during the woman's pregnancy and up to sixty (60) days post-partum. The following services are covered under pregnancy-related services: prenatal care; radiology, laboratory, and other diagnostic tests; treatment of missed, threatened, and incomplete abortions; delivery of the infant; postpartum care; prenatal vitamins; lactation counseling (for six months); breast pump (purchased or rental for six months); inpatient hospital services, physician services, other practitioner services, and outpatient hospital services that impact pregnancy outcomes.

The health plan is prohibited from limiting benefits for postpartum hospital stays to less than forty-eight (48) hours following a normal delivery or ninety-six (96) hours following a caesarean section, unless the attending provider, in consultation with the mother, makes the decision to discharge the mother or the newborn child before that time. The health plan is not permitted to require that a provider obtain authorization from the health plan before prescribing a length of stay up to forty-eight (48) or ninety-six (96) hours.

The health plan is prohibited from:

- Providing monetary payments or rebates to mothers to encourage them to accept less than the minimum stays available under Newborns' and Mothers' Health Protection Act (NMHPA);
- Penalizing, reducing, or limiting the reimbursement of an attending provider because the provider provided care in a manner consistent with NMHPA; or

- Providing incentives (monetary or otherwise) to an attending provider to induce the provider to provide care inconsistent with NMHPA.

The health plan shall ensure that appropriate perinatal care is provided to women. The health plan shall have in place a system that provides, at a minimum, the following services:

- Access to appropriate levels of care based on medical need, including emergency care;
- Transfer and care of pregnant women, newborns, and infants to tertiary care facilities when necessary;
- Availability and accessibility of OB/GYNs, anesthesiologists, and neonatologists capable of dealing with complicated perinatal problems; and
- Availability and accessibility of appropriate outpatient and inpatient facilities capable of dealing with complicated perinatal problems.

t. Prescription Drugs

This service includes medications that are determined medically necessary to optimize the member's medical condition, including behavioral health prescription drugs for children receiving services from CAMHD. Medication management and patient counseling are also included in this service.

The health plan shall develop a common formulary drug list for its QI program available in electronic and paper form. The

health plans formulary drug list shall include medications covered (both generic and name brand), over-the-counter medications included in the Medicaid State plan, and a medication tier list. The health plan shall make available the formulary drug list on their website in a machine readable file and format as specified by the Secretary. In accordance with Section 346-59.9, HRS, a member shall not be denied access to, or have any limitations on, any medication that is required to be covered by statute, including antipsychotic medications and continuation of antidepressant and anti-anxiety medications prescribed by a licensed psychiatrist or physician duly licensed in the State for a U. S. Food and Drug Administration (FDA) approved indication as treatment of a mental or emotional disorder. Similarly, in accordance with Section 346-352, HRS, any physician licensed in the State who treats a member suffering from the human immunodeficiency virus, acquired immune deficiency syndrome, or hepatitis C, or a member in need of transplant immunosuppressives, shall be able to prescribe any medications approved by the FDA, that are eligible pursuant to the Omnibus Budget Reconciliation Rebates Act, and necessary to treat the condition, without having to comply with the requirements of any preauthorization procedures.

The health plan shall inform its providers in writing, at least thirty (30) days in advance, of any drugs deleted from its formulary. The health plan shall establish and inform providers of the process for obtaining coverage of a drug not on the health plan's formulary. At a minimum, the health plan shall

have a process to provide an emergency supply of medication for at least seven (7) days to the member until the health plan can make a medically necessary determination regarding new drugs.

The health plan shall have an employed or contracted pharmacist geographically located within the State of Hawaii. This person, or designee, shall serve as the contact for the health plan's providers, pharmacists, and members.

The health plan shall cover treatment, such as medications, of non-pulmonary and latent tuberculosis that is not covered by DOH.

The health plan may require a prescriber's office to request a Prior Authorization (PA) as a condition of coverage or pharmacy payment if the PA request is approved or denied within twenty-four (24) hours of receipt. If a prescription cannot be filled when presented to the pharmacist due to a PA requirement and the prescriber's office cannot be reached, then the health plan must instruct the pharmacy to dispense a seventy-two (72) hour emergency supply of the prescription. The pharmacy is not required to dispense a seventy-two (72) hour supply if the dispensing pharmacist determines that taking the prescribed medication would jeopardize the member's health or safety, and he or she has made good faith efforts to contact the prescriber. The health plan must reimburse the pharmacy for dispensing the emergency supply of medication.

The DHS may, at a future date, require that members pay co-payments for prescription drugs and/or may carve-out prescription drug coverage. The DHS would provide at least three months' notice for either change.

For all covered outpatient drugs, as described in 42 CFR 438.3 (s) (1), the health plan shall:

- Report drug utilization data that is necessary for the state to bill manufacturers for rebates no later than 45 calendar days after the end of each quarterly rebate period.
- Report drug utilization information that includes, at a minimum, information on the total number of units of each dosage form, strength, and package size by National Drug Code (NDC) of each covered outpatient drug dispensed or covered by MCP.
- Establish procedures to exclude utilization data for covered outpatient drugs that are subject to discounts under the 340B drug pricing program from drug utilization data reports when states do not require submission of managed care drug claims data from covered entities directly.
- Operate a drug utilization review program that includes prospective drug review, retrospective drug use review, and an educational program as required at 42 CFR part 456, subpart K.
- Provide a detailed description of its drug utilization review program activities to the DHS on an annual basis.
- Conduct a prior authorization program that complies with the requirements of section 1927(d)(5) of the Act.

- Provide notice as described in section 1927(d)(5)(A) of the Act. Under this section, the plan may require as a condition of coverage or payment for a covered outpatient drug for which Federal Financial Participation (FFP) is available the approval of the drug before its dispensing for any medically accepted indication only if the system providing for such approval provides response by telephone or other telecommunication device within 24 hours of a request for prior authorization.

The health plan shall comply with section 1902(oo)(1)(A)(i)(I) of the Act, as added by section 1004 of the SUPPORT for Patients and Communities Act.

u. Preventive Services (See Appendix J for more details on preventive services)

These services include, but are not limited to: Initial and interval histories, comprehensive physical examinations, including development assessments; immunizations; family planning; screening for tuberculosis; and clinical preventive services that have an A or B recommendation by the U. S. Preventive Services Task Force.

v. Rehabilitation Services

This service includes physical and occupational therapy, audiology, and speech-language pathology. These services shall be provided by licensed physical therapist (PT), licensed occupational therapist registered (OTR), licensed audiologist,

and licensed speech pathologist respectively. A physical therapist assistant (PTA) or a certified occupational therapy assistant (COTA) may be utilized as long as working under the direct supervision of either a PT or OTR respectively.

Rehabilitation services are limited to those who expect to improve in a reasonable period of time. Prior authorization is required for all rehabilitation services except for the initial evaluation. Rehabilitation services for children under EPSDT have different requirements (see Section 41.100).

w. Smoking Cessation Services

The health plan shall make available a comprehensive smoking cessation program, limited to two (2) quit attempts per benefit period, for all members who smoke. Services shall be accessible statewide and include medications and counseling, preferably in a combined approach. The health plan's smoking cessation program may be developed within the health plan, contracted to another entity, or a combination of both. Limits provided below may be exceeded based on medical necessity.

Smoking Cessation services shall include:

- Counseling: at least four (4) in-person counseling sessions per quit attempt. Two (2) effective components of counseling, practical counseling (problem-solving/skills training) and social support

delivered as part of the treatment, shall be emphasized.

- Smoking cessation counseling services shall be provided by, but not limited to, the following licensed providers within the scope of practice under state law and who have been trained in this service:
    - Psychologist;
    - Clinical social worker in behavioral health;
    - Advanced Practice Registered Nurse;
    - Marriage Family Therapist; ~~and~~
    - Mental Health Counselor; and
    - Physician.
- Medications: those recommended in the most current Public Health Service guidelines as effective for smoking cessation to include both nicotine and non-nicotine agents. Effective combinations per the most current Public Health Service guidelines shall also be covered.

x. Sterilizations and Hysterectomies

In compliance with federal regulations, the health plan shall cover sterilizations for both men and women only if all of the following requirements are met:

- The member is at least twenty-one (21) years of age at the time consent is obtained;
- The member is mentally competent;

- The member voluntarily gives informed consent by completing the Sterilization Required Consent Form (DHS 1146);
- The provider completes the Sterilization Required Consent Form (DHS 1146);
- At least thirty (30) days, but not more than one-hundred eighty (180) days, have passed between the date of informed consent and the date of sterilization, except in the case of premature delivery or emergency abdominal surgery. A member may consent to be sterilized at the time of premature delivery or emergency abdominal surgery, if at least seventy-two (72) hours have passed since informed consent for sterilization was signed. In the case of premature delivery, the informed consent must have been given at least thirty (30) days before the expected date of delivery (the expected date of delivery must be provided on the consent form);
- An interpreter is provided when language barriers exist. Arrangements are to be made to effectively communicate the required information to a member who is visually impaired, hearing impaired or otherwise disabled;
- The member is not institutionalized in a correctional facility, mental hospital or other rehabilitative facility; and
- Meets the requirements in accordance with Sections 560:5-601 to 612, HRS.

The health plan shall cover a hysterectomy only if the following requirements are met:

- The member voluntarily gives informed consent by completing the Hysterectomy Acknowledgement form (DHS 1145);
- The member has been informed orally and in writing that the hysterectomy will render the individual permanently incapable of reproducing (this is not applicable if the individual was sterile prior to the hysterectomy or in the case of an emergency hysterectomy);
- The member has signed and dated a " Sterilization Required Consent Form" (DHS 1146) prior to the hysterectomy; and
- An interpreter is provided when language barriers exist. Arrangements are to be made to effectively communicate the required information to a member who is visually impaired, hearing impaired or otherwise disabled.

Regardless of whether the requirements listed above are met, a hysterectomy shall not be covered under the following circumstances:

- It is performed solely for the purpose of rendering a member permanently incapable of reproducing;
- There is more than one (1) purpose for performing the hysterectomy but the primary purpose is to render the member permanently incapable of reproducing; or
- It is performed for the purpose of cancer prophylaxis in the absence of the patient's having the BRCA gene.

The health plan shall maintain documentation of all sterilizations and hysterectomies and provide documentation to the DHS upon the request of the DHS.

All financial penalties assessed by the federal government and imposed on the DHS because of the health plan's action or inaction in complying with the federal requirements of this section shall be passed on to the health plan.

y. Sleep Laboratory Services

Sleep laboratory services are provided for the diagnosis and treatment of sleep disorders and shall be performed by sleep laboratories or sleep disorder centers.

Sleep laboratory service providers shall be accredited by the American Sleep Disorders Association.

z. Transportation Services

Transportation services include both emergency and non-emergency ground and air services.

The health plan shall provide transportation to and from medically necessary Medicaid covered medical appointments for members who have no means of transportation and who reside in areas not served by public transportation, or cannot access public transportation.

The health plan shall also provide transportation to members who are referred to a provider that is located on a different island or in a different service area. The health plan may use whatever modes of transportation that are available and can be safely utilized by the member. In cases where the member is a minor or requires assistance, the health plan shall provide for one (1) attendant to accompany the member to and from medically necessary visits to providers. The health plan is responsible for the arrangement and payment of the travel costs (airfare, ground transportation, lodging, and meals) for the member and the one (1) attendant associated with off-island or out-of-state travel due to medical necessity.

In the event there is insufficient access to specialty providers (including but not limited to psychiatrists and specialty physicians), the health plan shall arrange to transport providers.

Should the member be disenrolled from their health plan and enrolled into the Medicaid fee-for-service program or another health plan while off-island or out-of-state, the former health plan shall be responsible for the return of the member to the island of residence and for transitioning care to the Medicaid fee-for-service program or the other health plan.

aa. Urgent Care Services

The health plan shall provide urgent care services as necessary.

ab. Vision and Hearing Services

The health plan shall provide a routine eye exam provided by qualified optometrist once in a twelve (12) month period for members under age twenty-one (21) years and once in a twenty-four (24) month period for adults age twenty-one (21) and older. Visits done more frequently may be prior authorized and covered when medically necessary. Emergency eye care shall be covered without prior authorization.

Prescription lenses, cataract removal, and prosthetic eyes are covered for all members. Cornea (Keratoplasty) transplants shall be provided in accordance with the Hawaii Administrative Rules. Excluded vision services include:

- Orthoptic training;
- Prescription fee;
- Progress exams;
- Radial keratotomy;
- Visual training; and
- Lasik procedure.

Visual aids prescribed by ophthalmologists or optometrists (eyeglasses, contact lenses and miscellaneous vision supplies) are covered by the health plan, if medically necessary. These include costs for the lens, frames, or other parts of the glasses, as well as fittings and adjustments. Visual aids are covered once in a twenty-four (24) month period. Individuals under

forty (40) years of age require a medical justification for bi-focals.

Replacement glasses and/or new glasses with significant changes in prescription are covered within the benefit periods for both adults and children with prior authorization. Contact lenses are not covered for cosmetic reasons. Dispensing of the visual aids begins a new twenty-four (24) month period.

The health plan shall also provide hearing services to include screening, diagnostic, or corrective services/equipment/supplies provided by, or under the direction of, an otorhinolaryngologist or an audiologist to whom a patient is referred by a physician.

Hearing services include but are not limited to the following:

Service	≤ 3 years	≥ 4 years	< 21 years	≥ 21 years
Initial Evaluation/Selection	[redacted]		1X per year	1X per year
Electroacoustic Evaluation	4X per year	2X per year	[redacted]	
Fitting/Orientation/Hearing Aid Check	[redacted]		2X per 3 years	1X per 3 years

Hearing aid device coverage is for both analog and digital models. Hearing aids are covered once in a twenty-four (24) month period. Prior authorization is required for all hearing aid devices. The coverage of hearing devices shall include a service/loss/damage warranty, a trial or rental period, and reasonable reimbursement as set forth by MQD in the most

current hearing aid coverage policy memo. In addition, there should be consideration of medically justified requests for services outside capped dollar amounts or frequency of replacement.

40.740.2 Coverage Provisions for Standard Behavioral Health Services

40.740.2.a. *Standard Behavioral Health Services for Adults and Children*

The health plan shall be responsible for providing standard behavioral health services to all members, both adults and children. The health plan is not responsible for standard behavioral health services for members that are receiving their behavioral health services from the CCS program as described in Section 30.750. The health plan shall provide behavioral health services to persons who have been involuntarily committed for evaluation and treatment under the provisions of Chapter 334, HRS to the extent that these services are deemed medically necessary by the health plan's utilization review procedures. In the event that court ordered diagnostic, treatment or rehabilitative services are not determined to be medically necessary, the costs of continuing care under court order shall be borne by the health plan.

A member's access to behavioral health services shall be no more restrictive than for accessing medical services. The health plan shall make available triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions, when applicable. The health plan must not apply any financial requirement or

treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to enrollees (whether or not the benefits are furnished by the same health plan).

The health plan is not obligated to provide behavioral health services to those *adults* who have been criminally committed for evaluation or treatment in an inpatient setting under the provisions of Section 706-607, HRS or *children* who are committed to the Hawaii Youth Correctional Facility. These individuals shall be disenrolled from the program and shall become the clinical and financial responsibility of the appropriate State agency.

The psychiatric evaluation and treatment of members who have been criminally committed to ambulatory mental health care settings (i.e., those with legal encumbrances to the DOH) shall be the clinical responsibility of the appropriate State agency. The health plan shall remain responsible for providing medical services to these criminally committed members. In addition, the health plan may be billed for standard behavioral health services provided to these members.

The health plan shall provide the behavioral health services in accordance with the prescribed parameters and limitations. The health plan shall comply with all State and Federal laws pertaining to the provision of such services.

i. Inpatient Psychiatric Hospitalizations

Inpatient psychiatric hospitalization includes room/board, nursing care, medical supplies, equipment, medications and medication management, diagnostic services, psychiatric and other practitioner services, ancillary services, and other medically necessary services

ii. Ambulatory Mental Health Services

Ambulatory Mental Health Services includes twenty-four (24) hour access line, mobile crisis response, crisis stabilization, crisis management, and crisis residential services. Health plans shall have a contract for crisis services with the Department of Health, Adult Mental Health Division at the Medicaid fee-for-service rate.

iii. Psychotropic Medications and Medication Management

Medications and medication management is the evaluation, prescription, maintenance of psychotropic medications, medication management/counseling/education, promotion of algorithms and guidelines.

iv. Psychiatric or Psychological Evaluation and Treatment

The health plan may utilize a full array of effective interventions and qualified professionals such as psychiatrists, psychologists, licensed clinical social workers, licensed mental health

counselors, licensed marriage family therapists, and behavioral health nurse practitioners to evaluate for and provide treatment of behavioral health services to include individual and group counseling and monitoring.

v. Medically Necessary Alcohol and Chemical Dependency services

A member's access to substance abuse services shall be no more restrictive than for accessing medical services. Substance abuse services shall be provided in a treatment setting accredited according to the standards established by the State of Hawaii Department of Health Alcohol and Drug Abuse Division (ADAD). The health plan is encouraged to utilize currently existing publicly funded community-based substance abuse treatment programs, which have received ADAD oversight, through accreditation and monitoring. Substance abuse counselors shall be certified by ADAD. Health plans shall provide for both inpatient and outpatient substance abuse services

vi. Methadone Management Services

Methadone/LAAM services for members are covered for acute opiate detoxification as well as maintenance. The health plan may develop its own payment methodologies for Methadone/LAAM services.

40.740.2.b. *Additional Behavioral Health Services for Children*

Children/youth less than twenty-one (21) years old with a diagnosis of serious emotional behavioral disorders are eligible for additional behavioral health services within the Department of Health, Child and Adolescent Mental Health Division (CAMHD) Support for Emotional and Behavioral Development (SEBD) program. Refer to Section 30.820.1 for additional information on CAMHD.

40.740.2.c. *Additional Behavioral Health Services for Adults*

Adult members age twenty-one (21) years or older with a diagnosis of serious and persistent mental illness (SPMI) are eligible for comprehensive additional behavioral health services within the CCS Program. Refer to Section 30.750 for additional information on CCS.

40.740.2.d. *Covered Benefit Requirements for Parity in Mental Health and Substance Use Disorders*

The health plan shall cover, in addition to services under the state plan, any services necessary for compliance with the requirement for parity in mental health and substance use disorder benefits in 42 CFR part 438, subpart K, and ~~the~~ ~~contract~~ identifies the types and amount, duration and scope of services consistent with the analysis of parity compliance conducted by either the DHS or the health plan.

If the health plan does not include an aggregate lifetime or annual dollar limit on any medical/surgical benefits or includes an aggregate lifetime or annual dollar limit that applies to less than one-third of all medical/surgical benefits provided to

members through a contract with the state, it may not impose an aggregate lifetime or annual dollar limit respectively, on mental health or substance use disorder benefits.

If the health plan includes an aggregate lifetime or annual dollar limit on at least two-thirds of all medical/surgical benefits provided to members through a contract with the state, it must either apply the aggregate lifetime or annual dollar limit both to the medical/surgical benefits to which the limit would otherwise apply and to mental health or substance use disorder benefits in a manner that does not distinguish between the medical/surgical benefits and mental health or substance use disorder benefits; or not include an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is more restrictive than the aggregate lifetime or annual dollar limit, respectively, on medical/surgical benefits in accordance with 42 CFR 438.905(d).

If the health plan includes an aggregate lifetime limit or annual dollar amount that applies to one-third or more but less than two-thirds of all medical/surgical benefits provided to members, it must either impose no aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits; or impose an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is no more restrictive than an average limit calculated for medical/surgical benefits in accordance with 42 CFR 438.905(e)(ii).

The health plan must not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to enrollees (whether or not the benefits are furnished by the same health plan).

If a member is provided mental health or substance use disorder benefits in any classification of benefits (inpatient, outpatient, emergency care, or prescription drugs), mental health or substance use disorder benefits must be provided to the health plan member in every classification in which medical/surgical benefits are provided in accordance with 42 CFR 438.910(b)(2).

The health plan may not apply any cumulative financial requirements for mental health or substance use disorder benefits in a classification (inpatient, outpatient, emergency care, prescription drugs) that accumulates separately from any established for medical/surgical benefits in the same classification.

The health plan may not impose Non-Quantitative Treatment Limits (NQTL) as per section 51.570.11, for mental health or substance use disorder benefits in any classification unless, under the policies and procedures of the MCP as written and in operation, any processes, strategies, evidentiary standards, or

other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification.

40.740.3 Coverage Provisions for Long-Term Services and Supports (LTSS)

The health plan shall provide the LTSS for individuals in both HCBS and institutions as part of their benefit package as described in Section 40.730 when meeting the assessment requirements as described in Section 40.920. The health plan shall make available triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions, when applicable. HCBS should be provided to individuals that choose to receive their LTSS in the community instead of in an institutional setting. Additional information on requirements for assessments and service plans shall be found in Sections 40.920 and 40.930. The health plan shall comply with all State and Federal laws pertaining to the provision of such services. All authorized LTSS shall be documented in the member's service plan.

a. Acute Waitlisted ICF/SNF

Acute waitlisted ICF/SNF is either ICF or SNF level of care services provided in an acute care hospital in an acute care hospital bed. Health plans shall identify individuals who are acute waitlisted for discharge to a more appropriate location for treatment. Health plans shall report quarterly on the number of waitlisted patients and waitlist days for each month in the quarter as described in Section 51.530.2.

b. Adult Day Care

Adult day care is defined as regular supportive care provided to four (4) or more disabled adult participants. Services include observation and supervision by center staff, coordination of behavioral, medical and social plans, and implementation of the instructions as listed in the participant's service plan. Therapeutic, social, educational, recreational, and other activities are also provided as regular adult day care services.

Adult day care staff members may not perform healthcare related services such as medication administration, tube feedings, and other activities which require healthcare related training. All healthcare related activities must be performed by qualified and/or trained individuals only, including family members and professionals, such as an RN or LPN, from an authorized agency.

c. Adult Day Health

Adult day health refers to an organized day program of therapeutic, social, and health services provided to adults with physical, or mental impairments, or both which require nursing oversight or care. The purpose is to restore or maintain, to the fullest extent possible, an individual's capacity for remaining in the community.

Each program shall have nursing staff sufficient in number and qualifications to meet the needs of participants. Nursing services shall be provided under the supervision of a registered nurse. If there are members admitted who require skilled nursing services, the services will be provided by a registered nurse or under the direct supervision of a registered nurse.

In addition to nursing services, other components of adult day health may include: emergency care, dietetic services, occupational therapy, physical therapy, physician services, pharmaceutical services, psychiatric or psychological services, recreational and social activities, social services, speech-language pathology, and transportation services.

d. Assisted Living Facility Services

Assisted living facility (ALF) services include personal care and supportive care services (homemaker, chore, personal care services, meal preparation) that are furnished to members who reside in an ALF ALFs are defined in Section 30.200. Payment for room and board is prohibited. Members receiving ALF services must be receiving ongoing CCMA services.

e. Community Care Management Agency (CCMA) Services

CCMA services are provided to members living in Community Care Foster Family Homes (CFFH), Expanded Adult Residential Care Homes (E-ARCHs), ALFs and other community settings, as required. The following activities are provided by a CCMA: continuous and ongoing nurse delegation to the caregiver in accordance with HAR Chapter 16-89 Subchapter 15; initial and ongoing assessments to make recommendations to health plans for, at a minimum, indicated services, supplies, and equipment needs of members; service plan development in coordination with the member and/or their representative; ongoing face-to-face monitoring that includes "head to toe" physical assessment for skin breakdown, and implementation of the member's service plan; and interaction with the caregiver on adverse effects and/or changes in condition of members. CCMAs shall (1) communicate with a member's physician(s) regarding the member's needs including changes in medication and treatment orders, (2) work with families regarding service needs of member and serve as an advocate for their members, and (3) be accessible to the member's caregiver twenty-four (24) hours a day, seven (7) days a week.

f. Community Care Foster Family Home (CCFFH) Services

CCFFH services are personal care, nursing, homemaker, chore, and companion services and medication oversight (to the extent permitted under State law) provided in a certified private home by a principal care provider who lives in the home. The number of adults receiving services in CCFFHs is

currently up to three (3) adults who receive these services in conjunction with residing in the home. All CCFFH providers must provide individuals with their own bedroom unless the member consents to sharing a room with another resident. The total number of individuals living in the home, who are unrelated to the principal care provider, cannot exceed four (4). Members receiving CCFFH services must be receiving ongoing CCMA services.

g. Counseling and Training

Counseling and training activities include the following: member care training for members, family and caregivers regarding the nature of the disease and the disease process; methods of transmission and infection control measures; biological, psychological care and special treatment needs/regimens; employer training for consumer directed services; instruction about the treatment regimens; use of equipment specified in the service plan; employer skills updates as necessary to safely maintain the individual at home; crisis intervention; supportive counseling; family therapy; suicide risk assessments and intervention; death and dying counseling; anticipatory grief counseling; substance abuse counseling; and/or nutritional assessment and counseling on coping skills to deal with the stress caused by member's deteriorating functional, medical or mental status.

Counseling and training is a service provided to members, families/caregivers, and professional and paraprofessional caregivers on behalf of the member. Counseling and training

services may be provided individually or in groups. This service may be provided at the members residence or an alternative site. Training should be provided by qualified health professionals as defined in Appendix K.

h. Environmental Accessibility Adaptations

Environmental accessibility adaptations are those physical adaptations to the member's home, required by the individual's service plan, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, without which the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the individual. Window air conditioners may be installed when it is necessary for the health and safety of the member.

Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

i. Home Delivered Meals

Home delivered meals are nutritionally sound meals delivered to a location where an individual resides (excluding residential or institutional settings). The meals will not replace or substitute for a full day's nutritional regimen (i.e., no more than 2 meals per day). Home delivered meals are provided to individuals who cannot prepare nutritionally sound meals without assistance and are determined, through an assessment, to require the service in order to remain independent in the community and to prevent institutionalization.

j. Home Maintenance

Home maintenance is a service necessary to maintain a safe, clean and sanitary environment. Home maintenance services are those services not included as a part of personal assistance and include: heavy duty cleaning, which is utilized only to bring a home up to acceptable standards of cleanliness at the inception of service to a member; minor repairs to essential appliances limited to stoves, refrigerators, and water heaters; and fumigation or extermination services. Home maintenance is provided to individuals who cannot perform cleaning and minor repairs without assistance and are determined, through an assessment, to require the service in order to prevent institutionalization.

k. Moving Assistance

Moving assistance is provided in rare instances when it is determined through an assessment by the service coordinator

that an individual needs to relocate to a new home. The following are the circumstances under which moving assistance can be provided to a member: unsafe home due to deterioration; the individual is wheel-chair bound living in a building with no elevator; multi-story building with no elevator, where the client lives above the first floor; home unable to support the member's additional needs for equipment; member is evicted from their current living environment; or the member is no longer able to afford the home due to a rent increase. Moving expenses include packing and moving of belongings. Whenever possible, family, landlord, community and third party resources who can provide this service without charge will be utilized.

l. Non-Medical Transportation

Non-medical transportation is a service offered in order to enable individuals to gain access to community services, activities, and resources, specified by the service plan. This service is to be used only when transportation is not included in the HCBS service being accessed. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the Medicaid State Plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized. Members living in a residential care setting or a CCFFH are not eligible for this service.

m. Nursing Facility (NF), Skilled Nursing Facility (SNF), or Intermediate Care Facility (ICF) Services

Nursing facility services are provided to members who need twenty-four (24) hours a day assistance with ADLs and IADLs and need care provided by licensed nursing personnel and paramedical personnel on a regular, long-term basis. Nursing facility services are provided in a free-standing or a distinct part of a facility that is licensed and certified as meeting the requirements of participation to provide skilled nursing, health-related care and rehabilitative services on a regular basis in an inpatient facility. The care that is provided in a nursing facility includes independent and group activities, meals and snacks, housekeeping and laundry services, nursing and social work services, nutritional monitoring and counseling, pharmaceutical services, and rehabilitative services.

n. Personal Assistance Services - Level I and Level II

Personal assistance, sometimes called attendant care for children, are services provided in an individual's home to help them with their IADLs and ADLs.

Personal assistance services Level I are provided to individuals, requiring assistance with IADLs in order to prevent a decline in the health status and maintain individuals safely in their home and communities. Personal assistance services Level I is for individuals who are not living with their family who perform these duties as part of a natural support. Personal assistance services Level I is limited to ten (10) hours per week for individuals who do not meet institutional level of care. Personal

assistance services Level I may be self-directed and consist of the following:

i. Companion Services

Companion services, pre-authorized by the service coordinator in the member's service plan, means non-medical care, supervision and socialization provided to a member who is assessed to need these services. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping/ errands, but do not perform these activities as discrete services. Providers may also perform light housekeeping tasks that are incidental to the care and supervision of the individual.

ii. Homemaker/Chore Services

Homemaker/Chore services means any of the activities listed below, when the individual that is regularly responsible for these activities is temporarily absent or unable to manage the home and care for himself/herself or others. Homemaker/chore services, pre-authorized by the service coordinator in the member's service plan, are of a routine nature and shall not require specialized training or professional skills such as those possessed by a nurse or home health aide. The scope of homemaker/chore services specified in this section shall cover only the activities that need to be provided for the member, and not for other members of the household.

A. Routine housecleaning such as sweeping, mopping, dusting, making beds, cleaning the toilet and shower or bathtub, taking out rubbish;
B. Care of clothing and linen by washing, drying, ironing, mending;
C. Marketing and shopping for household supplies and personal essentials (not including cost of supplies);
D. Light yard work, such as mowing the lawn;
E. Simple home repairs, such as replacing light bulbs;
F. Preparing meals;
G. Running errands, such as paying bills, picking up medication;
H. Escort to clinics, physician office visits or other trips for the purpose of obtaining treatment or meeting needs established in the service plan, when no other resource is available;
I. Standby/minimal assistance or supervision of activities of daily living such as bathing, dressing, grooming, eating, ambulation/mobility and transfer;
J. Reporting and/or documenting observations and services provided, including observation of member self-administered medications and treatments, as appropriate; and
K. Reporting to the assigned provider, supervisor or designee, observations about changes in the member's behavior, functioning, condition, or self-care/home management abilities that necessitate more or less service.

Personal assistance services Level II are provided to individuals requiring assistance with moderate/substantial to total assistance to perform ADLs and health maintenance activities. Personal assistance services Level II shall be provided by a Home Health Aide (HHA), Personal Care Aide (PCA), Certified Nurse Aide (CNA) or Nurse Aide (NA) with applicable skills competency. Personal assistance services Level II may be self-directed and consist of the following:

A. Personal hygiene and grooming, including bathing, skin care, oral hygiene, hair care, and dressing;
B. Assistance with bowel and bladder care;
C. Assistance with ambulation and mobility;
D. Assistance with transfers;
E. Assistance with medications, which are ordinarily self-administered when ordered by member's physician;
F. Assistance with routine or maintenance healthcare services by a personal care provider with specific training, satisfactorily documented performance, care coordinator consent and when ordered by member's physician;
G. Assistance with feeding, nutrition, meal preparation and other dietary activities;
H. Assistance with exercise, positioning, and range of motion;
I. Taking and recording vital signs, including blood pressure;

J. Measuring and recording intake and output, when ordered;
K. Collecting and testing specimens as directed;
L. Special tasks of nursing care when delegated by a registered nurse, for members who have a medically stable condition and who require indirect nursing supervision as defined in Chapter 16-89, HAR;
M. Proper utilization and maintenance of member's medical and adaptive equipment and supplies. Checking and reporting any equipment or supplies that need to be repaired or replenished;
N. Reporting changes in the member's behavior, functioning, condition, or self-care abilities which necessitate more or less service; and
O. Maintaining documentation of observations and services provided.

When personal assistance services Level II activities are the primary services, personal assistance services Level I activities identified on the service plan, which are incidental to the care furnished or that are essential to the health and welfare of the member, rather than the member's family, may also be provided.

o. Personal Emergency Response Systems (PERS)

PERS is a twenty-four (24) hour emergency assistance service which enables the member to secure immediate assistance in the event of an emotional, physical, or environmental

emergency. PERS are individually designed to meet the needs and capabilities of the member and includes training, installation, repair, maintenance, and response needs. PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. The following are allowable types of PERS items:

A. 24-hour answering/paging;
B. Beepers;
C. Med-alert bracelets;
D. Medication reminder services;
E. Intercoms;
F. Life-lines;
G. Fire/safety devices, such as fire extinguishers and rope ladders;
H. Monitoring services;
I. Light fixture adaptations (blinking lights, etc.);
J. Telephone adaptive devices not available from the telephone company; and
K. Other electronic devices/services designed for emergency assistance.

All types of PERS, described above, shall meet applicable standards of manufacture, design, and installation. Repairs to

and maintenance of such equipment shall be performed by the manufacturer's authorized dealers whenever possible.

PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision. PERS services will only be provided to a member residing in a non-licensed setting except for an ALF.

p. Residential Care Services

Residential care services are personal care services, nursing, homemaker, chore, companion services and medication oversight (to the extent permitted by law) provided in a licensed private home by a principle care provider who lives in the home.

Residential care is furnished: 1) in a Type I Expanded Adult Residential Care Home (EARCH), allowing five (5) or fewer residents provided that up to six (6) residents may be allowed at the discretion of the DHS to live in a Type I home with no more than three (3) residents of whom may be NF LOC; or 2) in a Type II EARCH, allowing six (6) or more residents, no more than twenty percent (20%) of the home's licensed capacity may be individuals meeting a NF LOC who receive these services in conjunction with residing in the home. Members receiving residential care services must be receiving ongoing CCMA services.

q. Respite Care

Respite care services are provided to individuals unable to care for themselves and are furnished on a short-term basis because of the absence of or need for relief for those persons normally providing the care. Respite may be provided at three (3) different levels: hourly, daily, and overnight. Respite care may be provided in the following locations: individual's home or place of residence; CCFFH; E-ARCH; Medicaid certified NF; licensed respite day care facility; or other community care residential facility approved by the State. Respite care services are authorized by the member's PCP as part of the member's service plan. Respite services may be self-directed.

r. Skilled (or Private Duty) Nursing

Skilled nursing is a service provided to individuals requiring ongoing nursing care (in contrast to Home Health or part time, intermittent skilled nursing services under the Medicaid State Plan) listed in the service plan. The service is provided by licensed nurses (as defined in Chapter 16-89, HAR) within the scope of State law and authorized in the member's service plan. Skilled nursing services may be self directed under Personal Assistance Level II/Delegated using registered nurse delegation procedures outlined in Chapter 16-89, Subchapter 15, HAR.

s. Specialized Medical Equipment and Supplies

Specialized medical equipment and supplies entails the purchase, rental, lease, warranty costs, assessment costs,

installation, repairs and removal of devices, controls, or appliances, specified in the service plan, that enable individuals to increase and/or maintain their abilities to perform activities of daily living, or to perceive, control, participate in, or communicate in the environment in which they live.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. All items shall meet applicable standards of manufacture, design and installation and may include:

A. Specialized infant car seats;
B. Modification of parent-owned motor vehicle to accommodate the child, i.e. wheelchair lifts;
C. Intercoms for monitoring the child's room;
D. Shower seat;
E. Portable humidifiers;
F. Electric utility bills specific to electrical life support devices (ventilator, oxygen concentrator);
G. Medical supplies;
H. Heavy duty items including but not limited to patient lifts or beds that exceed $1,000 per month;
I. Rental of equipment that exceeds $1,000 per month such as ventilators;
J. Emergency back-up generators specific to electrical life support devices (ventilator, oxygen

concentrator); and

K. Miscellaneous equipment such as customized wheelchairs, specialty orthotics, and bath equipment that exceeds $1,000 per month.

Items reimbursed shall be in addition to any medical equipment and supplies furnished under the Medicaid State Plan and shall exclude those items which are not of direct medical or remedial benefit to the individual.

Specialized medical equipment and supplies shall be recommended by the member's PCP.

t. Subacute Facility services

Subacute facility services are provided in either a licensed nursing facility or a licensed and certified hospital in accordance with Hawaii Administrative Rules. Subacute facility services provides the member with services that meet a level of care that is needed by the member not requiring acute care, but who needs more intensive skilled nursing care than is provided to the majority of members in a skilled nursing facility. The subacute services shall be provided in accordance with the Hawaii Administrative Rules.

40.740.4 Coverage Provisions for Community Integration Services (CIS)

The health plan shall provide the following CIS in accordance with the prescribed parameters and limitations as part of their benefit package as described in Section 40.735. The health plan shall

comply with all State and Federal laws pertaining to the provision of such services, including federal rules on conflict of interest.

The health plan will use a standardized housing assessment tool developed by DHS that will be appended to the Health and Functional Assessment (HFA) described in Section 40.920. Health plan service coordinators who are social workers or registered nurses will be responsible for conducting assessments and re-assessments to determine whether a beneficiary is eligible for the service in accordance with Section 40.735. Re-assessments will occur, at minimum, every ninety (90) days.

In regard to conflicts of interest for the CIS population, the health plan service coordinator conducts the housing assessment and writes the plan of service with the beneficiary. The health plan will maintain contracts with case management/homeless agencies that will provide the other CIS services for the beneficiary.

Service providers must have the following qualifications:

Education (standard)	Experience (~~(~~standard)	Skills (preferred)	Services
Bachelor's degree in a human/social services field; may also be an Associate's degree in a relevant field, with field experience or a high school graduate with	1-year case management experience, 1-year field experience with a homeless or transitional housing agency, or Bachelor's degree in a related field	Knowledge of principles, methods, and procedures of services included under Community Integration Services, or comparable services meant to support client ability to	Pre-tenancy supports; tenancy sustaining services as outlined in Section 40.735.

Education (standard)	Experience (~~(~~standard)	Skills (preferred)	Services
field experience* working with homeless or transitional housing individuals. *Field experience may include community outreach; locating individuals on the street; completing homeless assessments - Vulnerability Index - Service Prioritization Decision Assistance Tool (VISPDT); finding short and long term housing; assisting individuals to apply for documents, benefits and housing.	and similar field experience.	obtain and maintain residence in independent community settings.	

40.750 Waiting List for members receiving HCBS and At-Risk services

The health plan may have a waiting list for HCBS for both institutional level of care and the at-risk population based upon guidance provided by DHS. Health plans shall submit their waiting list policies and procedures based upon objective criteria applied over all geographic areas served to DHS for review/approval at least sixty (60) days prior to implementation.
The health plan shall provide all other medically necessary primary and acute care services to members on the waiting list.

The DHS shall regularly monitor the health plan's management of its waiting lists. As a part of these monitoring activities, on a monthly basis, the health plan shall submit to the DHS the following information relevant to its waiting list:

- The names of members on the waiting list;
- The date the member's name was placed on the waiting list;
- The specific service(s) needed by the member; and
- Progress notes on the status of providing needed care to the member.

The DHS shall meet with the health plans on a quarterly basis to discuss issues associated with management of the waiting list. The DHS shall review the following at these quarterly meetings:

- Health plan's progress towards meeting annual thresholds; and
- Any challenges with meeting needs of the specific members on the waiting list.

Members who are on a health plan's waiting list may change to another health plan that does not have a waiting list as described in Sections 30.560 and 30.600.

40.760 In Lieu of Services

The health plan may cover, for enrollees, services or settings that are in lieu of services or settings covered under the State plan as follows:

- The DHS determines that the alternative service or setting is a medically appropriate and cost effective substitute for the covered service or setting under the State plan;
- The enrollee is not required by the health plan to use the alternative service or setting;
- The approved in lieu of services are authorized and identified in the health plan contract, and will be offered to enrollees at the option of the health plan; and
- The utilization and actual cost of in lieu of services is taken into account in developing the component of the rates that represents the covered State plan services, unless a statute or regulation explicitly requires otherwise.

40.800 Self-Direction

The health plan shall provide all members assessed to need personal assistance services (as defined in Section 40.740.3.n) and respite services (as defined in Section 40.740.3.q) the opportunity to have choice and control over their providers (referred to as self-direction). A member choosing self-direction shall be responsible for fulfilling the following functions:

- Recruiting/selecting providers;

- Determining provider duties;
- Determining a rate of pay that is at least the Federal or State minimum wage, whichever is higher;
- Scheduling providers;
- Instructing and training providers in preferred duties;
- Supervising providers;
- Evaluating providers;
- Verifying time worked by provider and approving time sheets; and
- Discharging providers.

The health plan shall assure that members that receive nurse delegable personal assistance services- Level II (i.e., tube feeding, suctioning, medication administration, etc.) shall meet nurse delegation requirements in accordance with Chapter 16-89, Subchapter 15, HAR.

A member may choose to designate one (1) individual to act as a surrogate on his/her behalf. The surrogate assumes all self-direction responsibilities for the member and cannot be paid for performing these functions. The surrogate may not serve as a paid provider of services for the member.

The service coordinator shall assist the member in facilitating self-direction and in accessing available resources and supports. The service coordinator shall also be responsible for monitoring the service plan to ensure that assessed needs are addressed and to ensure members' overall well-being.

As a part of the service plan process, members assessed to need personal assistance services or respite service, will be informed by the service coordinator of the self-direction option. Members expressing an interest in self-direction shall be required to complete the health plan's self-assessment form. The form is intended to determine a member's: 1) ability to make decisions regarding his/her health service; and 2) knowledge of available resources to access for assistance. If the self-assessment results reveal that the member is unable to self-direct his/her service but he/she is still interested in electing the option, the member will be required to appoint a surrogate to assume the self-direction responsibilities on his/her behalf.

Members who are not capable of completing a self-assessment form due to a physical or cognitive impairment or who choose not to complete the form but are interested in electing self-direction can do so if they appoint a surrogate to assume the responsibilities on their behalf.

The service coordinator shall document the member's decision to self- direct his/her service and the appointment of a surrogate (including the surrogate's name and relationship to the member) in the service plan.

A member can change a surrogate at any time. Changes in a surrogate shall be reported to the health plan within five (5) days. A service coordinator may recommend that a member change surrogates if he/she can document that the surrogate is not appropriately fulfilling his/her obligations. If, however, the

member chooses to continue using the surrogate, the documented incident(s), the service coordinator's recommendation, and the member's decision shall be noted in the service plan.

The budget for each member electing self-direction shall be sufficient to provide for the assessed service needs and to account for any employment taxes and withholdings. The member is not obligated to provide health insurance, worker's compensation or temporary disability insurance (TDI) benefits for his/her providers.

Self-directed providers shall receive overtime pay for authorized time-worked that exceeds forty (40) hours per week. The health plan shall educate the member that authorizing more than forty (40) hours per week for an individual self-directed provider, except in extraordinary circumstances acknowledged by the health plan and incorporated into the member's budget by the service coordinator, will decrease the hours of service that they may receive in subsequent weeks. The health plan shall educate the member to choose either an additional self-directed provider or an agency (to prevent overtime) in instances where the member is assessed to need and is authorized for more than forty (40) hours a week of personal assistance or respite services.

The service coordinator shall develop a budget for each member electing self-direction. The budget shall be based upon the member's assessed needs, a factor of the number of the units of service (i.e. hours, days) the member requires for each allowable service and the historical fee-for-service average unit cost of each

service. This combined total dollar value shall constitute the member's budget for self-direction and shall be discussed and shared with the member by the service coordinator. The service coordinator shall educate the member on choosing the rate of pay based upon member's budget that meets State and Federal minimum wage requirements.

The service coordinator shall closely monitor the adequacy and appropriateness of the services provided to determine the extent to which adjustments to the service plan will necessitate adjustments to the budget.

Members shall have the ability to hire family members (including spouses and parents of minors), neighbors, friends, etc. as service providers. For spouses or parents of minors (biological or adoptive parents of members under age eighteen (18)), to be paid as providers of self-directed services, the personal assistance services or respite service services must meet all of the following authorization criteria and monitoring provisions.

The service must:

- Meet the definition of service as defined in Sections 40.730 and 40.740;
- For personal assistance services Level II and respite service services, be necessary to avoid institutionalization;
- Be a service that is specified in the service plan;

- Be provided by a parent, spouse or child age eighteen (18) years or older who meets the State prescribed provider qualifications and training standards for that service;
- Be paid at a rate that does not exceed that which would otherwise be paid to a provider of a similar service; and
- NOT be an activity that the family would ordinarily perform or is responsible to perform. The health plan will need to make this decision on a case by case basis and will need to consider the extent to which an individual who is the same age without disability would need the requested level of service or assistance as the member with a disability.

The family member and other self-directed providers will comply with the following:

- A parent or parents in combination or a spouse may not provide more than forty (40) hours of services in a seven (7) day period. For parents, forty (40) hours is the total amount regardless of the number of children who receive services;
- The family member must maintain and submit all required documentation, such as time sheets, for hours worked; and
- Married individuals must be offered a choice of providers. If he/she chooses a spouse as his/her provider, it must be documented in the service plan.

The health plan shall be required to conduct the following additional monitoring activities when members elect to use a spouse or parents as paid providers:

- At least quarterly reviews of expenditures, and the health, safety and welfare status of the member;
- Face-to-face visits with the member on at least a quarterly basis; and
- Monthly reviews of hours billed for family provided service and the total amounts billed for all goods and services during the month.

Providers of self-direction must meet all applicable provider requirements as established by the State. Providers are not required to be a part of the health plan's network. However, the health plan shall enter into an agreement with each self-direction provider. The agreement shall specify the roles and responsibilities of both parties.

As part of the interview and hiring process, members shall, with the aid of the service coordinator:

- Develop interview questions;
- Screen and interview applicants; and
- Include in the service agreement between the health plan and the provider, the roles and responsibilities of both the member and the provider.

Members choosing to hire his/her family member may elect to forego bullets #1 and #2 above. However, a service agreement delineating the roles and responsibilities of both the member and the provider is still required.

A member may terminate his/her self-direction provider for violating the terms of the service agreement.

The health plan shall have the ability to terminate provision of self-direction services on behalf of a member for health and welfare issues. Health plans do not have the authority to terminate self-directed providers.

This term and condition shall be specified in the agreement between the provider and the health plan. A member's release of his/her self-direction provider will be documented in the service plan.

A back-up plan outlining how members will address instances when regularly scheduled providers are not available shall be included in the member's service plan. Back-up plans may involve the use of non-paid caregivers and/or paid providers.

The health plan shall perform the administrative functions associated with employing self-direction providers for the member, who is the employer of record, including:

- Paying providers;
- Monitoring completion of all time sheets;
- Assuring Tuberculosis (TB) test is completed;
- Validating active Cardiopulmonary Resuscitation (CPR) and First Aid training;
- Blood-borne pathogen training;
- Reviewing and verifying results of the status of criminal history record checks of providers per State requirements

(the members shall pay for the cost of background checks out of their budget);

- Reviewing and approving payment for allowable services; and
- Withholding, filing and paying applicable federal, State and employment taxes.

Members choosing to hire his/her friend or family member may elect to forego bullets #3, #4, #5, and #6 above. This waiver does not apply to any agency or their personnel. The member must sign a document identifying the employment functions that they are waiving.

The health plan may delegate these functions to another entity through a subcontract. The subcontractor agreement shall comply with all requirements outlined in Section 70.400.

The health plan shall require that all members and/or surrogates participate in a training program prior to assuming self-direction. At a minimum, self-direction training programs shall address the following:

- Understanding the role of members/surrogates in self-direction;
- Selecting and terminating providers;
- Being an employer and managing employees;
- Conducting administrative tasks such as staff evaluations and approval of time sheets; and
- Scheduling providers and back-up planning.

The health plan shall require that all self-directed providers participate in a training program prior to assuming self-direction. At a minimum, self-direction training programs shall address the following:

- Understanding the role of members/surrogates in self-direction;
- Understanding the role of the provider in self-direction, including criteria for job termination;
- Understanding the tasks that they are being compensated for (i.e., personal assistance or respite);
- Completing timesheets;
- Payment schedules;
- Process for notifying member if unable to perform assigned duties; and
- Skills competency to perform PA II and delegated tasks, if applicable.

All self-direction training programs must be developed as face-to-face presentations. The health plan may develop programs in alternative formats (i.e., web based) that may be made available upon request and per the recommendation of the service coordinator. The health plan may develop these programs internally or subcontract for this service. Additional and ongoing self-direction programs shall be made available at the request of a member, surrogate or service coordinator. All new training programs and materials and any changes to programs and

materials shall be submitted to the DHS for approval thirty (30) days prior to implementation.

Members assessed to need personal assistance services or respite care services may choose to undertake self-direction at any time. The member may also choose to terminate self-direction at any time. Termination of self-direction must be documented in writing by the member or surrogate. In this event, the service coordinator shall assist the member in accessing available network providers for personal assistance or respite care services. Members may utilize self-direction and other services simultaneously.

The health plan shall establish and maintain self-direction policies and procedures that include forms utilized and shall submit these to the DHS for review and approval by the due date identified in Section 51.700, Readiness Review. The policies and procedures shall include, at a minimum:

- Process to document choice of self-direction when member is assessed to need personal care or respite care services;
- Process to assess member's ability to implement self-direction, including a copy of the self-assessment form;
- Process to document member agreement to self-direct his/her service;
- Process for establishing and monitoring nurse delegation for required personal assistance services- Level II;
- Sample agreement between provider and health plan;

- Process for paying providers (including verifying hours worked);
- Topics, goals and frequency of member/surrogate training programs;
- Topics, goals and frequency of self-directed provider training programs; and
- Process for member termination from self-direction.

Changes to these policies and procedures or forms shall be submitted for approval to the DHS thirty (30) days prior to implementation of the change(s). Changes must be approved by DHS prior to implementation.

40.900 Service Coordination, Assessments & Service Plans

40.910 Service Coordination System

The health plan shall have a Service Coordination System that complies with the requirements in 42 CFR Section 438.208, and is subject to DHS approval. The DHS may revise the health plan's responsibilities within the service coordination system to align with Hawaii's implementation of an innovative delivery system that migrates these functions closer to the provider level as warranted The DHS shall inform its health plans of any changes at least one-hundred eighty (180) days prior to implementing any changes.

The Service Coordination system shall be developed to include the health plan's members with Special Health Care Needs (SHCN) (as described in Sections 40.910.1 and 40.910.2) and those receiving

LTSS. The health plan shall submit to the DHS its Service Coordination System policies and procedures by the due date identified in Section 51.700, Readiness Review. Any changes to these policies and procedures must be submitted to the DHS thirty (30) days prior to implementation of the change(s). Changes must be approved by DHS prior to implementation.

The health plan shall be responsible for coordinating the primary, acute and LTSS for those members that have been identified as having SHCN. The health plan shall use a patient-centered, holistic, service delivery approach to coordinating member benefits across all providers and settings.

Each member identified as having a SHCN shall be assigned a service coordinator who will assist in planning and coordinating his/her care. The service coordinator shall assist with coordinating QI services with Medicare, the DOH programs excluded from QI, other DHS programs such as Child Welfare Services and Adult Protective Services, and other community services to the extent they are available and appropriate for the member. Service coordination interaction shall primarily be face-to-face but may include other mediums (i.e., telephone, e-mail, text) to support face-to-face requirements.

Service coordinator responsibilities shall include:

- Providing service coordination to support the PCP and other providers in the network in providing good medical care to members;

- Coordinating a team of decision-makers to develop the service plan, including the PCP, other providers as appropriate, the member, and others as determined by the member including family members, caregivers and significant others;
- Conducting health and functional assessments;
- Developing the service plan based upon results of assessment;
- Monitoring progress with EPSDT requirements;
- Coordinating services with other providers and community programs such as Medicare, the DOH programs excluded from QI, other DHS programs such as Child Welfare Services and Adult Protective Services, Medicare Advantage plans, other health plan providers, Zero-To-Three, Healthy Start, DD/ID providers at DOH, CCS and CAMHD Programs to ensure continuity of care;
- Providing continuity of care when members are discharged from a hospital and prescribed medications that are normally prior authorized or not on the plan's formulary;
- Utilizing compiled data received from member encounters to assure the services being provided meet member needs;
- Facilitating access to services including community services;
- Providing assistance in resolving any concerns about service delivery or providers; and
- Assisting members to maintain continuous Medicaid benefits, this includes identifying at risk members and ensuring continuity of care and services as described in Section 50.220.

A summary of service coordinator responsibilities is located at Appendix L.

The service coordinator shall work closely with the member's PCP in up-dating and making changes to a member's service plan.

The health plan shall maintain sufficient service coordinators to meet members' needs. The health plan shall determine how best to utilize service coordinators and assign caseloads within the following parameters.

For purposes of establishing service coordinator ratios, the QI population is divided into seven (7) categories:

1. Children with SHCN;
2. Adults with SHCN;
3. Members receiving HCBS (both "at risk" and institutional LOC);
4. Institutional LOC members residing in an institutional setting;
5. Members choosing self-direction (both "at risk" and institutional LOC); ~~and~~
6. Dual eligible members; and
7. Members receiving CIS (SHCN, HCBS and self-direct).

The following service coordinator ratios are established for the QI program.

- For children with SHCNs, service coordinators may have up to 200 members (1:200).
- For adults with SHCNs, service coordinator may have up to 250 members (1:250).
- For members receiving HCBS, service coordinators may have up to 50 members (1:50).
- For members choosing self-direction, service coordinators may have up to 30 members (1:30).
- For institutional LOC members residing in an institutional setting, service coordinators may have up to 120 members (1:120).
- For dual eligible members, service coordinators may have up to 750 members (1:750).
- For members receiving CIS, service coordinators may have either 15 members (1:15) in Pre-Tenancy or 45 members (1:45) in Tenancy. These ratios are subject to change as determined by DHS.

Service coordinators shall be assigned to one of the seven (7) types of populations. The only service coordinators that can have mixed ratios are those providing services to members receiving:

- HCBS and those who choose self-direction. These service coordinators may have a ratio of no more than 40 members (1:40).
- CIS. These service coordinators may have a mixed SHCN, HCBS and self-direct caseload. CIS service coordinators may also have a mixed ratio of pre-tenancy and tenancy members of no more than 30 members (1:30)."

Service coordinators, other than CIS service coordinators, providing services to either adults or children with SHCNs and those receiving services in an institution shall not have mixed caseloads.

Adults and children with SHCN shall not have disease specific service coordinators with the potential for the member to interact with multiple service coordinators. The health plan shall take a patient-centered approach with a single primary service coordinator per member receiving the service.

As part of its service coordination system policies and procedures, the health plan shall include information on established qualifications for service coordinators. At a minimum, service coordinators must meet all State certification and licensure requirements for a social worker, licensed nurse, or other healthcare professional with a minimum of one (1) year of relevant healthcare experience.

The health plan shall provide ongoing training to service coordinators about their roles and responsibilities. Information about this ongoing training shall be included in the service coordination system policies and procedures.

The health plan shall provide continuity of service coordination for its members by limiting the number of internal service coordinator assignment changes unless due to member choice. Members and the DHS may request to change service coordinators at any time.

Requests may be made in writing or verbally and shall be documented in both the member record and service plan.

As part of its Service Coordination System policies and procedures, the health plan shall include policies and procedures for service coordinators that address:

- Service coordinator qualifications for each of the seven (7) categories of QI population;
- Methodology for assigning and monitoring service coordinator caseloads;
- Member assignment changes;
- Supervision of service coordinators;
- Training guidelines (including frequency of training courses, topics and course format) and sample program materials; and
- Process for ensuring continuity of care when service coordinator changes are made.
- Identification of individuals with SHCN as defined in Sections 40.910.1, 40.910.2, and 40.910.3.

The health plan shall also have procedures in place to ensure that, in the process of coordinating care, each member's privacy is protected consistent with confidentiality requirements in Section 71.700.

The health plan shall educate members on accessing services and assist them in making informed decisions about their care. The

health plan shall also educate providers on its processes and procedures for receiving and approving referrals for treatment.

The health plan shall report on its Service Coordination System to include those members with SHCN in Section 51.540.7, Reporting Requirements.

40.910.1. Service Coordination for Children

A child with SHCNs is an individual under twenty-one (21) years of age who has a chronic physical, developmental, behavioral, or emotional condition and who requires health and related services of a type or amount beyond that generally required by children. Service coordination for children who are receiving LTSS is addressed in Section 40.910.3. Health plans shall identify these members through its quality improvement and utilization review processes or by the individual's PCP. These children are then referred for service coordination and other medical services for management of these conditions. Parents or agencies such as Child Welfare Services may request service coordination, as applicable. The health plan shall develop policies and procedures to identify the following groups of children with SHCN:

- Children with conditions such as asthma, diabetes, hypertension, cancer, chronic obstructive lung disease, and children who become pregnant;
- Children with Hepatitis B, C or HIV/AIDS;
- Children who take medication for any behavioral/medical condition that has lasted, or is expected to last, at least twelve (12) months (excludes vitamins and fluoride);

- Children who are limited in their ability to do things that most children of the same age can do because of a serious medical/behavioral health condition that has lasted or is expected to last at least twelve (12) months;
- Children who need or receive speech therapy, occupational therapy, and/or physical therapy for a medical condition that has lasted or is expected to last at least twelve (12) months;
- Children who are outliers for emergency room utilization;
- Children being discharged from an acute care setting when LOS is greater than ten (10) days, and children with multiple admissions during a six (6) month period;
- Children who have a hospital readmission within the previous thirty (30) days; and
- Children who need or receive treatment or counseling for an emotional, developmental, or behavioral problem that has lasted or is expected to last at least twelve (12) months.

40.910.2. Service Coordination for Adults

An adult with SHCNs is an individual who is twenty-one (21) years of age or older and has chronic physical, behavioral, or social condition that requires health related services of a type or amount beyond that required by adults generally. These members shall be identified by the health plan through its quality improvement and utilization review processes or by the individual's PCP and referred for service coordination and other medical services for management of these conditions. The member, their authorized representative or agencies such as Adult Protective Services may request service coordination, as applicable. The health plan shall

develop policies and procedures to identify the following groups of adults with SHCN:

- Adults with high risk pregnancies, chronic medical conditions (i.e., asthma, diabetes, hypertension, and chronic obstructive lung disease), cancer, multiple chronic conditions; behavioral health conditions, including substance abuse, who are not receiving services through CCS; and social conditions such as homelessness and limited English proficiency
- Adults whose use of prescription medication includes the use of atypical antipsychotics, the chronic use of opioids, the chronic use of polypharmacy, and other chronic usage of specific drugs that exceed the use by other adults in the health plan as identified by the health plan (e.g. on ten (10) or more prescription medications);
- Adults with hepatitis B, C or HIV/AIDS;
- Adults whose utilization of emergency department services is beyond that generally used by other adults in the health plan;
- Adults being discharged from an acute care setting;
- Adults with a hospital readmission within the previous thirty (30) days;
- Adults whose utilization causes the member to be in the top two percent (2%) of all health plan members by utilization frequency and/or expenditures and increasing by one percent (1%) per year until reaching five percent (5%) for any of the following:
    - Outpatient medical visits;

- Outpatient behavioral health visits;
- Emergency department visits;
- Inpatient days;
- Prescription drugs; or
- Overall.

40.910.3. Service Coordination for individuals receiving LTSS

All members receiving LTSS shall receive a face to face service coordination home visit on a quarterly basis. The health plan shall have both a nurse and a social worker service coordinator for each individual receiving LTSS unless that individual is living in a residential setting such as a CCFFH, E-ARCH, ALF, or NF. Service coordinators for individuals living in a residential setting may be either a nurse or social worker depending upon needs of the member.

Additional information on the requirements of the partnership between the nurse and social worker service coordinator is found in Appendix L. In addition to the above requirements identified in Section 40.910, service coordinator responsibilities for members receiving LTSS shall include:

- Assuring institutional LOC assessment is completed in accordance with requirements established in Section 40.920.3, if applicable;
- Assuring that members receiving LTSS receive services through assessment and service planning as described in Sections 40.920.3 and 40.930;
- Providing options counseling regarding institutional placement and HCBS alternatives;
- Addressing social needs for member and their family;

- Assessing caregivers for potential burn-out for individuals living at home receiving HCBS; and
- Assisting members in transitioning to and from nursing facilities/residential facilities.

40.910.4 Service Coordination for dual eligible members

All dual eligible members shall have access to a service coordinator to assure coordination of Medicare and Medicaid services. Dual eligible members shall receive a face to face service coordination home visit annually. Dual eligible members may opt-out of service coordination either verbally or in writing. Health plans may assume that dual eligible members that they are unable to locate have opted-out of service coordination. Health plans shall maintain documentation of members that have opted-out of service coordination and include this information in the Special Health Care Needs report (Section 51.540.7).

Dual eligible members that are found to have SHCNs or are receiving LTSS (to include at-risk services) shall receive their service coordination through the applicable category.

Dual eligible members that are in a D-SNP for both their Medicare and Medicaid services may have their service coordinator through their D-SNP health plan.

40.910.5 Community Care Management Agency (CCMA) in Service Coordination System

A Community Care Management Agency (CCMA) is responsible for providing services to members living in a community care

foster family home (CCFFH), Expanded Adult Residential Care Home (E-ARCH), Assisted Living Facility (ALF), and other community settings. The CCMA responsibilities described in Section 40.740.3.e are similar to a service coordinator. CCMAs shall assume the service coordinator roles for members living in a residential setting listed above. CCMAs must follow the service coordination requirements found in Section 40.900 for members receiving HCBS. Health plans shall perform an on-site review at least once every three years with an annual desk review to assure compliance with 42 CFR §438.230.

40.910.6 Service Coordination for Community Integration Services (CIS)

CIS members are eighteen (18) years of age or older and meet the criteria described in Section 40.735. CIS service coordinators must follow the service coordination requirements found in Section 40.900 for members receiving LTSS (to include at-risk services) and SHCN as applicable. The level of coordination will vary in scope and frequency depending on the member's intensity of need. The health plan shall develop policies and procedures to ensure the following:

- Coordinated provision of CIS activities and services with the goal of promoting community integration, member advocacy, optimal coordination and monitoring of resources, and self-sufficiency for members who meet the eligibility requirements for pre-tenancy and tenancy housing supports.
- An active, assertive system of outreach is in place that provides the flexibility needed to reach CIS members requiring services who might not access services without intervention due to language barriers, acuity of condition,

dual diagnosis, physical/visual/hearing impairments, intellectual disability and/or lack of transportation.

40.920 Assessments

40.920.1. General Information

The health plan shall provide members with services that are appropriate to their medical and LTSS needs. Within fifteen (15) days of identifying that the member needs service coordination as described in Section 40.910, the health plan shall conduct a face-to-face Health and Functional Assessment (HFA). The HFA shall determine the health and functional capability of the member and the appropriate strategies and services to best meet those needs. The HFA shall take into consideration the health status (including but not limited to a review of the member's physical, cognitive, and bodily systems including vital signs and blood pressure, if necessary, daily functioning in activities of daily living and instrumental activities of daily living, medications, treatments, risk for falls, history of emergency department visits), environment, available supports, medical history, housing, financial, and social history of each member.

The health plan's service coordinators shall conduct face-to-face re-assessments for children and adults receiving service coordination every six-month or when a change in condition (i.e., significant change) occurs. The health plan's service coordinators shall conduct face-to-face re-assessments for dual eligible members receiving service coordination every twelve-months or

when a change in condition (i.e., significant change) occurs. The service coordinator shall conduct a face-to-face reassessment within ten (10) days when significant events occur in the life of a member, including but not limited to, the death of a caregiver, significant change in health status, change in living arrangement, institutionalization and change in provider (if the provider change affects the service plan).

The health plan shall use a standardized form developed by the DHS and have a process for conducting and completing the HFA. The DHS shall issue the standardized form to the health plans by the date identified in Section 51.800. The assessment process shall be submitted to the DHS for review and approval by the due date identified in Section 51.700, Readiness Review. Changes to the assessment process shall be submitted to the DHS for approval at least thirty (30) days prior to implementation of the change(s). Changes must be approved by DHS prior to implementation.

The health plan shall provide the results of its identification and assessment of any member with SHCNs to other QUEST Integration health plans so that those activities are not duplicated.

40.920.2. Assessment for receipt of HCBS when not meeting institutional LOC

The health plan may provide the following HCBS to individuals who are at risk of deteriorating to the institutional level of care (the "at risk" population):

- Adult day care
- Adult day health
- Home delivered meals
- Personal assistance
- Personal emergency response system (PERS)
- Skilled nursing

The DHS may impose limits on the number of hours of HCBS or the budget for such services. The DHS will provide health plans with information on "at risk" limits by the date identified in Section 51.800.

.Health plans shall assess members utilizing a tool provided by the DHS to determine if they meet the "at risk" criteria for services. The DHS shall issue the "at risk criteria" to the health plans by the date identified in Section 51.800.

For those members who are "at risk" and receiving HCBS, the service coordinator shall conduct a face-to-face quarterly assessment in order to review and revise the service plan, as needed, as described in Section 40.930. The service coordinator shall conduct a face-to-face reassessment within ten (10) days when significant events occur in the life of a member, including but not limited to, the death of a caregiver, significant change in health status, change in living arrangement, institutionalization and change in provider (if the provider change affects the service plan).

40.920.3. Assessment for receipt of LTSS when meeting institutional LOC

If the HFA identifies that the member will need institutional LOC services, the health plan shall be responsible for assessing QI members using the State's LOC evaluation tool (DHS 1147) or the health plan may delegate this responsibility to a qualified provider or subcontracted entity. The State's LOC Evaluation tool is the form used to determine institutional LOC. Once the LOC assessment is completed, the health plan or the delegated providers shall forward the completed tool to the DHS, or its designee, for LOC determination. The DHS, or its designee, will make the LOC determination. The State's LOC evaluation tool and process may be found at Appendix M.

The health plan shall offer and document in the member's record the choice of institutional services or HCBS to members who meet the institutional LOC when HCBS are available and are cost-neutral. The health plan shall document good faith efforts to establish cost-neutral service plans in the community. The health plan must receive prior approval from the DHS or its designee prior to disapproving a request for HCBS.

When the health plan identifies that the member will be receiving LTSS, the health plans shall submit a MEDICAID ELIGIBILITY FOR LONG-TERM CARE (LTC) SERVICES form (DHS 1148) to the DHS for long-term care eligibility determination. The health plan may start providing LTSS while the eligibility process is being conducted. The DHS 1148 may be found at Appendix N.

The health plan is not required to provide HCBS if:

- The member chooses institutional services;
- The member cannot be served safely in the community;
- The member (21 years or older) requires more than 90 days per benefit period of twenty-four (24) hours of HCBS (not including CCFFH or E-ARCH) per day; or
- There are not adequate or appropriate providers for needed services.

For institutionalized members who are preparing for discharge to the community, the service coordinator shall complete the HFA prior to the date of discharge.

For those members who meet institutional LOC and are receiving LTSS, the service coordinator shall conduct a face-to-face quarterly assessment in order to review and revise the service plan, as needed, as described in Section 40.930. For those members who meet institutional LOC, are receiving LTSS, and are living in a residential setting such as CCFFH, E-ARCH, ALF, or NF, the service coordinator shall conduct a face-to-face semi-annual assessment in order to review and revise the service plan as needed, as described in Section 40.930.

In addition to the items for inclusion on the assessment in Section 40.920, the assessment for those receiving HCBS shall include a "head to toe" physical assessment for potential skin breakdown. The service coordinator shall conduct a face-to-face reassessment within ten (10) days when significant events occur in the life of a member, including but not limited to, the death of a caregiver, significant change in health status, change in living

arrangement, institutionalization and change in provider (if the provider change affects the service plan).

The health plan shall conduct a HFA within seven (7) calendar days of initial enrollment for members whose eligibility is based upon receipt of HCBS. DHS shall inform the health plan of these members on the ELIGIBILITY FOR HOME AND COMMUNITY BASED SERVICES IN THE INITIAL MONTH OF ENROLLMENT FOR MEDICALLY NEEDY AND §435.217 ENROLLEES form (DHS 1148B). The 1148B may be found in Appendix N. The health plan shall confirm provision of HCBS to the DHS within twelve (12) days of initial enrollment through return of the DHS 1148B.

40.930 Service Plan

A service plan shall be developed for each QI member receiving service coordination. The service plan shall be a person-centered written document that analyzes the assessment describes the medical and social needs of the member, and identifies all of the services to be utilized to include but not limited to the frequency, quantity and provider furnishing the services. The service plan shall be based upon the HFA. The health plan shall use a standardized service plan developed by the DHS and have a process for completing the service plan. The DHS shall issue the standardized service plan to the health plans by the date identified in Section 51.800. The service plan process shall be submitted to the DHS for review and approval by the due date identified in Section 51.700, Readiness Review.

For members who do not meet an institutional LOC, the service plan shall provide the broad roadmap for service delivery and addressing the member's assessed needs. Service plans shall extend beyond services provided by the health plans to include community resources. Health plans shall use the standardized service plan template that at a minimum includes:

- Problem identification;
- Goals, objectives and desired outcomes;
- Interventions; and
- Needed services and service parameters.

The health plan shall develop and implement the service plan for members "at risk" or authorized at institutional LOC to include medical, social, HCBS, and institutional services that the member will receive. In developing the service plan, the health plan shall consider appropriate options for the member related to their medical, behavioral health, psychosocial, and individual needs at a specific point in time. In addition, the health plan shall develop goals that include longer term strategic planning. For members meeting an "at risk" or institutional LOC, the minimum service plan requirements cited above will also apply. In addition, the health plan shall include information such as:

- Health conditions and required course of treatment for specified conditions;
- Medication regimen;
- Back-up plan indicating alternative plans in instances when regularly scheduled providers are unavailable. Back-up

plans may involve the use of non-paid caregivers and/or paid caregivers; and

- Disaster planning.

In developing the service plan, the health plan shall consider the appropriate services and mix of services that will enable the member to remain in his or her home or other community placement in order to prevent or delay institutionalization whenever possible.

For members receiving CIS, the service plan shall include a housing support plan and a crisis plan.

The service plan shall be developed by the service coordinator in conjunction with the member, authorized representative, if applicable, and, as appropriate, the PCP and specialty providers. As appropriate and to the extent desired by the member, the health plan will allow the participation of family members, significant others, caregivers, etc, in the service plan process. The service plan shall be written in accordance with requirements described in Section 50.430. At a minimum, the service plan must be signed and dated by the service coordinator and the member, his or her authorized representative and any surrogate. A copy of the service plan shall be provided to the member and the PCP.

Service plans for members shall be updated with every assessment. In addition, service plans shall be updated:

- When significant events occur in the life of a member, to include but not limited to the death of a caregiver, change in health status, change in living arrangement, institutionalization and change in provider (if the provider change affects the service plan); or
- Every six (6) months, if a review and update has not occurred earlier due to the occurrence of a significant event defined above; or
- Every twelve (12) months, for dual eligible members if a review and update has not occurred earlier due to the occurrence of a significant event defined above.

Service plans for members "at risk" or meeting institutional LOC must be reviewed and revised, as needed, but at a minimum quarterly unless that individual is living in a residential setting such as a CCFFH, E-ARCH, ALF, or NF.

The health plan shall develop standards for the service plan development process and submit these to the DHS for review and approval by the due date identified in Section 51.700, Readiness Review. Changes to the process shall be forwarded to the DHS for approval thirty (30) days prior to implementation of any change(s). Changes must be approved by DHS prior to implementation.

41.100 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services for Children

The health plan shall provide EPSDT services to members younger than twenty-one (21) years of age (including foster children and subsidized adoptions). The health plan shall comply with Sections 1902(a)(43) and 1905(r) of the Social Security Act and Federal regulations at 42 CFR Part 441, Subpart B, that require EPSDT services, including outreach and informing, screening, tracking, and diagnostic and treatment services.

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 be responsible for medical services related to dental needs as described in Section 30.720.

The health plan shall submit its EPSDT plan to the DHS for review and approval by the date specified in Section 51.700, Readiness Review.

The health plan shall be responsible for training providers and monitoring compliance with EPSDT program requirements.

The health plan shall require that all providers participating in a health plan utilize the most current EPSDT screening form prescribed by the DHS when performing an EPSDT exam on EPSDT eligible members.

The health plan's outreach and information process shall include:

- Notification to all newly enrolled families with EPSDT-aged members about the EPSDT program within sixty (60) days of enrollment. This requirement includes informing pregnant women and new mothers either before or shortly after giving birth that EPSDT services are available; and
- Notification to EPSDT eligible members and their families about the benefits of preventive health care, about how to obtain timely EPSDT services (including translation and transportation services), and about receiving health education and anticipatory guidance. This includes informing pregnant women within twenty-one (21) days after confirmation of pregnancy and new mothers within fourteen (14) days after birth that EPSDT services are available.

The health plan's information shall:

- Be provided orally (on the telephone, face-to-face or films/tapes), or in writing. Information may be provided by

health plan personnel or health care providers. The health plan shall follow-up with families with EPSDT-eligible members who, after six (6) months of enrollment, have failed to access EPSDT screens and services;

- Be provided in non-technical language at or below a 6th (6.9 grade level or below) grade reading level and use accepted methods for informing persons who are blind or deaf, or cannot read or understand the English language, in accordance with Section 50.430; and
- Stress the importance of preventive care; describe the periodicity schedule; provide information about where and how to receive services; inform members that transportation and scheduling assistance is available upon request; describe how to access services; state that services are provided without cost; describe what resources are available for non-plan services; and describe the scope and breadth of the health services available. Annual informing by the health plan is required for EPSDT members who have not accessed services during the prior year.

The health plan shall conduct the following three (3) types of screens on EPSDT eligible members:

- Complete periodic screens according to the EPSDT periodicity schedule in Appendix O and the requirements detailed in the State Medicaid Manual. The health plan shall strive to provide periodic screens to one hundred percent (100%) of eligible members; minimum compliance is

defined as providing periodic screens to eighty percent (80%) of eligible members;

- Inter-periodic screens; and
- Partial screens.

The health plan shall provide all medically necessary diagnostic and treatment services to correct or ameliorate a medical, dental (as defined in Section 30.720), or behavioral health problem discovered during an EPSDT screen (complete periodic, inter-periodic, or partial). This includes, but is not limited to: initial or interval history; measurements; sensory screening; developmental assessments (including general developmental and autism screening); tuberculosis risk assessments and screening; lead risk assessments; psychosocial and behavioral assessments; alcohol and drug use assessments for adolescents; sexually transmitted infections and cervical dysplasia screening as appropriate; complete physical examinations; age appropriate surveillance; timely immunizations; procedures such as hemoglobin and lead level as appropriate; referral to a "dental home;" referral to State or specialty services; service coordination assistance if needed; age appropriate anticipatory guidance; diagnosis and treatment of any issues found in general developmental and autism screening; and diagnosis and treatment of acute and chronic medical, dental (as defined in Section 30.720), and behavioral health conditions. Screening for developmental delays and behavioral health conditions, shall be done using standardized, validated screening tools as recommended by current national guidelines and the State's EPSDT program.

If it is determined at the time of the screening that immunization is needed and appropriate to provide at that time, the health plan shall insure that the provider administers the immunizations. With the exception of the services provided by the DOH, the health plan shall be responsible for providing all services listed in Sections 40.710 and 40.740.1 on Medical Services, Sections 40.720 and 40.740.2 on Behavioral Health Services, and Sections 40.730 and 40.740.3 on LTSS to EPSDT eligible members under EPSDT.

The health plan shall provide additional medical services determined as medically necessary to correct or ameliorate defects of physical, mental/emotional, or dental illness (as defined in Section 30.720) and conditions discovered as a result of EPSDT screens. Examples of services are prescription drugs not on the health plan's formulary if approved by the FDA for the indication for which prescribed, durable medical equipment typically not covered for adults, and certain non-experimental medical and surgical procedures.

Health plans shall cover services under EPSDT if the services are determined to be medically necessary to treat a condition detected at an EPSDT screening visit or other medical appointment.

The health plan is responsible for behavioral health services for all children with mental and behavioral conditions. Some children who meet criteria as identified in Section 30.820.1 require more intensive services, which can be provided through CAMHD's Support for Emotional and Behavioral Development (SEBD)

program. Children who are eligible for the SEBD program can obtain their behavioral health needs through CAMHD's SEBD program. See Section 30.820.1 and 40.720.2.a for details on Behavioral Health Benefits. These children are complex and often need the collaboration of multiple agencies for effective intervention. The health plan must, along with CAMHD, have a process in place for collaboration with other agencies (DOE, DOH, and Child Welfare) to assure coordinated care for the member. The health plan is responsible for coordinating services for individuals determined to be eligible for the SEBD program by the health plan with the medically necessary outpatient behavioral health services that are required for the educational needs of the member provided by DOE and DOH.

If a child is determined not to be eligible for SEBD, the health plan is responsible for all medically necessary behavioral health services.

The health plan is not responsible for providing health interventions that are not medically necessary or deemed experimental as per Section 432E.1-4, HRS.

The health plan shall establish a process that provides information on compliance with EPSDT requirements. The process shall track and be sufficient to document the health plan's compliance with these sections.

The health plan shall submit an annual CMS 416 report to the DHS. The DHS, at its sole discretion, may add additional data to

the CMS 416 report if it determines that it is necessary for monitoring and compliance purposes.

In addition to the CMS 416 report, the health plan shall also submit to DHS, EPSDT data in an electronic format, to be specified by DHS. This data will be aggregated by DHS and generated reports provided to the health plan for purposes of targeted provider and client oversight, education, and outreach.

Appendix O provides additional information on the EPSDT services to be provided.

41.200 Other Coordination Activities

41.210 Women, Infants, and Children (WIC) Coordination

The health plan shall coordinate the referral of potentially eligible women, infants, and children to the Supplemental Nutrition Program for WIC program and the provision of health data within the timeframe required by WIC, from their providers.

41.220 Foster Care/Child Welfare Services (CWS) Children

In addition to providing all medically necessary services under EPSDT, the health plan shall be responsible for providing the pre-placement physicals (prior to placement) and comprehensive examinations (within forty-five (45) days after placement into a foster care home) including medication dispensed when a physical examination shows a medical need, for children with an active case with CWS. A comprehensive examination shall have all of the components of an EPSDT visit, including referrals for more in-

depth developmental and behavioral assessment and management if needed, and the health plan shall reimburse the provider the same rate as for an EPSDT visit. The health plan shall have procedures in place to assist CWS workers in obtaining a necessary physical examination within the established timeframe through a provider in its network. Physical examinations may take place in either an emergency department or physician's office. A provider specializing in child protection, (e.g., provider from Kapi'olani Child Protection Center), may also perform the exams. The health plan shall be responsible for the pre-placement and the forty-five (45) day comprehensive exams regardless of whether the provider is the child's primary care physician and regardless of whether the provider is in or out-of-network. Any out-of-network provider must be a licensed provider and must understand and perform all the components of a comprehensive EPSDT examination, including referrals for more in-depth developmental and behavioral assessment and management if needed.

The health plan shall be familiar with the medical needs of CWS children and shall identify person(s) within the health plan that may assist the foster parent/guardian and case worker to obtain appropriate needed services for the foster child. If a PCP change is necessary and appropriate (e.g., the child has been relocated), the health plan shall accommodate the PCP change request without restrictions.

The case worker may also request a change in health plan outside of the annual plan change period without limit if it is in the best

interest of the child. Disenrollment shall be at the end of the month in which the request is made.

41.230 Collaboration with the Alcohol and Drug Abuse Division (ADAD)

The ADAD provides substance abuse treatment programs, which may be accessed by the members. The health plan has the following responsibilities as it relates to coordinating with ADAD and providing services to its members:

- Providing assistance to members who wish to obtain a slot, either by helping them contact ADAD or its contractor or referring the member to a substance abuse residential treatment provider to arrange for the utilization of an ADAD slot;
- Providing appropriate medically necessary substance abuse treatment services while the member is awaiting an ADAD slot;
- Covering all medical costs for the member while the member is in an ADAD slot;
- Coordinating with the ADAD provider following the member's discharge from the residential treatment program; and
- Placing the member into other appropriate substance abuse treatment programs following discharge from the residential treatment program.

41.240 Kapi'olani Cleft and Craniofacial Clinic and DOH/Family Health Services Division/Children with Special Health Needs (CSHN) Branch

See Section 30.820.3 regarding health plan responsibilities for members with cleft and craniofacial disorders receiving care through the Kapi'olani Cleft and Craniofacial Clinic with DOH/CSHN Branch coordination.

41.300 Other Services to be provided

41.310 Cultural Competency

The health plan shall have a comprehensive written cultural competency plan that shall:

- Identify the health practices and behaviors of the members;
- Design programs, interventions, and services, which effectively address cultural and language barriers to the delivery of appropriate and necessary health services;
- Describe how the health plan will ensure that services are provided in a culturally competent manner to all members so that all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, understand their condition(s), the recommended treatment(s), and the effect of the treatment on their condition, including side effects;
- Describe how the health plan will effectively provide services to people of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes, affirms and respects the worth of the individual members and protects and preserves the dignity of each; and
- Comply with, and ensure that providers participating in the health plan's provider network comply with, Title VI of the Civil Rights Act of 1964, 42 U.S.C. Section 2000d, 45 CFR

Part 80 and 42 CFR Sections 438.6(d)(4), 438.6(f), 438.100(d), and 438.206(c)(2).

The health plan shall provide all in-network providers with a summary of the cultural competency plan that includes a summary of information on how the provider may access the full cultural competency plan from the health plan at no charge to the provider.

The health plan shall submit the cultural competency plan to the DHS for review and approval by the date specified in Section 51.700, Readiness Review.

41.320 Disease Management

The health plan shall have disease management programs for asthma and diabetes. The health plan shall select at least one (1) other programs from the following: heart disease, hypertension, high-risk pregnancy, or obesity management. However, the health plan may request approval from DHS to change the one (1) other program based upon member needs after providing services for the first year of the contract. In addition, the health plan shall have a hospital discharge management program to ensure that a member's PCP is notified of the discharge, receives the discharge summary in a timely manner, and the patent is seen by the PCP within seven (7) days following discharge.

The health plan's disease management programs shall:

- Have a systematic method of identifying and enrolling members in each program;

- Utilize evidence-based clinical practice guidelines;
- Emphasize the prevention of exacerbation and complications of the diseases;
- Incorporate educational components for both members and providers;
- Utilize an integrated, comprehensive approach to patient care that extends beyond a focus on the prescription drug line item;
- Take a member-centered approach to providing care by addressing psychological aspects, caregiver issues and treatment of diseases using nationally recognized standards of care;
- Incorporate culturally appropriate interventions, including but not limited to taking into account the multi-lingual, multi-cultural nature of the member population;
- Focus interventions on the member through activities such as disease and dietary education, instruction in health self-management, and medical monitoring;
- Have established measurable benchmarks and goals which are specific to each disease and are used to evaluate the efficacy of the disease management programs; and
- Be analyzed to determine if costs have been lowered by reducing the use of unnecessary or redundant services or by avoiding costs associated with poor outcomes.

The health plan shall develop policies and procedures for its disease management programs. The health plan shall submit these policies and procedures to the DHS for review and approval by the date specified in Section 51.700, Readiness Review.

The health plan shall annually review the disease management programs and revise as necessary based upon new treatments and innovations in the standard of care.

41.330 Certification of Physical/Mental Impairment

The health plan shall provide for all evaluations and re-evaluations of disability (determinations of continued mental or physical impairment) for their members (evaluations submitted to the ADRC).

41.400 Second Opinion

The health plan shall provide for a second opinion in any situation when there is a question concerning a diagnosis, the options for surgery or the treatment of a health condition when requested by the member, any member of the health care team, a parent(s) or legal guardian(s), or a DHS social worker exercising custodial responsibility. A qualified health care professional within the network shall provide the second opinion or the health plan shall arrange for the member to obtain a second opinion outside the provider network. The second opinion shall be provided at no cost to the member.

41.500 Out of State/Off Island Coverage

The health plan shall provide any medically necessary covered treatments or services that are required by the member. If these services are not available in the State or on the island in which the member resides, the health plan shall provide for these

services whether off-island or out-of-state. This includes referrals to an out-of-state or off-island specialist or facility, transportation to and from the referral destination for an off-island or out-of-state destination, lodging, and meals for the member and one (1) attendant, if applicable. However, if the service is available on a member's island of residence, the health plan may require the member to obtain the needed services from specified providers as long as the provider is in the same geographic location as the member and the member can be transferred.

The health plan shall provide out-of-state and off-island emergency medical services and post-stabilization services within the United States for all members as well as all out-of-state and off-island medically necessary EPSDT covered services to members under age twenty-one (21) years. The health plan may require prior authorization for non-emergency out-of-state or off-island services.

The health plan shall be responsible for the transportation costs to return the individual and their one (1) attendant, if applicable, to the island of residence upon discharge from an off-island or out-of-state facility when services were approved by the health plan or from an out-of-state or off-island facility when the services were emergent or post-stabilization services. Transportation costs for the return of the member to the island of residence shall be the health plan's responsibility even if the member is being or has been disenrolled from the health plan during the out-of-state or off-island stay.

Medical services outside of the United States or in a foreign country are not covered for either children or adults.

41.600 Advance Directives

The health plan shall maintain written policies and procedures for advance directives as defined in Section 30.200 in compliance with 42 CFR Sections 422.128, 438.6(i)(1) to (4) and in Subpart I of Part 489. For purposes of this section, the term "MA organization" in 42 CFR Section 422.128 shall refer to the health plan. Such advance directives shall be included in each member's medical record. The health plan shall provide these policies to all members eighteen (18) years of age or older and shall advise members of:

- Their rights under the law of the State of Hawaii, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives;
- The health plan's written policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience. See 42 CFR Section 422.128(b)(1)(ii); and
- The health plan shall inform individuals that complaints concerning noncompliance with the advance directive requirements may be filed with the State survey and certification agency found in the Office of Health Care Assurance in the Department of Health.

The information must include a description of current State law and must reflect changes in State laws as soon as possible, but

no later than ninety (90) days after the effective date of the change.

The health plan shall not condition the provision of care or otherwise discriminate against an individual based on whether or not a member has executed an advance directive. The health plan shall ensure compliance with requirements of the State of Hawaii law regarding advance directives.

The health plan shall educate its staff about its advance directive policies and procedures, situations in which advance directives may be of benefit to members, and the health plan's responsibility to educate and assist members who choose to make use of advance directives. The health plan shall educate members about their ability to direct their care using this mechanism and shall specifically designate which staff members or network providers are responsible for providing this education. The health plan shall provide these policies and procedures to its providers and upon request to CMS and DHS.

41.700 Transition of Care to and from the Health Plan

41.710 Transition to the Health Plan

In the event a member entering the health plan is receiving medically necessary covered services in addition to or other than prenatal services (see below for members in the second and third trimester receiving prenatal services) the day before enrollment into the health plan, the health plan shall be responsible for the costs of continuation of such medically necessary services, without any form of prior approval and without regard to whether

such services are being provided by contract or non-contract providers. Health plans shall be responsible for medically necessary services provided during prior period coverage and retroactive enrollment. Health plans shall ensure that during transition of care, their new members:

- Receive all medically necessary emergency services;
- Receive all prior authorized LTSS, including both HCBS and institutional services;
- Adhere to a member's prescribed prior authorization for medically necessary services, including prescription drugs, or courses of treatment; and
- Provide for the cost of care associated with a member transitioning to or from an institutional facility in accordance with the requirements prescribed in Section 50.210.

The health plan shall provide continuation of services for individuals with SHCN and LTSS for at least ninety (90) days or until the member has received a health and functional assessment (HFA) by their service coordinator. The health plan shall provide continuation of other services for all other members for at least forty-five (45) days or until the member's medical needs have been assessed or reassessed by the PCP who has authorized a course of treatment. 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.

41.720 Transition from the Health Plan

If the member moves to a different service area in the middle of the month and enrolls in a different 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 at the time of transition, until discharge or level of care changes, whichever occurs first. Otherwise, the new health plan shall be responsible for all services to the member as of member's date of enrollment. If the member moves to a different service area and remains with the same health plan, the health plan shall remain responsible for the care and cost of the services provided to the member.

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.

41.730 Transition of Care Policies and Procedures

The health plan shall develop transition of care policies and procedures that address all transition of care requirements in this RFP and submit these policies and procedures for review and approval by the due date identified in Section 51.700, Readiness Review. The transition of care policy shall be consistent with the requirements set forth below.

The transition of care policy must include the following:

- The enrollee has access to services consistent with the access they previously had, and is permitted to retain their current provider for a period of time if that provider is not in the provider network;
- The enrollee is referred to appropriate providers of service that are in the provider network;
- The enrollee's previous provider(s) shall fully and timely comply with requests for historical utilization data from enrollee's new provider(s) in compliance with Federal and State law.
- The enrollee's new provider(s) shall be able to obtain copies of the enrollee's medical records consistent with Federal and State law, as appropriate.
- Any other necessary procedures as specified by the Secretary to ensure continued access to services to prevent serious detriment to the enrollee's health or reduce the risk of hospitalization or institutionalization.

The transition of care policy shall be publicly available and provide instructions to members on how to access continued services upon transition.

SECTION 50 HEALTH PLAN ADMINISTRATIVE REQUIREMENTS

50.100 Dual-Eligible Special Needs Plan (D-SNP)

Health plans shall have a dual-eligible special needs plan for Medicare and Medicaid beneficiaries in Hawaii no later than January 1, 2016. Each health plan's QUEST Integration contract shall include terms sufficient to meet any Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) requirements identified by CMS.

50.200 Health Plan Enrollment Responsibilities

The health plan shall accept individuals enrolled into their health plan by the DHS without restriction, unless otherwise authorized or prohibited by the DHS. The health plan shall not discriminate against individuals enrolled, based upon health status or need for health care services, religion, race, color, creed, national origin, ancestry, sex, including gender identity or expression, sexual orientation, income status, or disability. The health plan shall not use any policy or practice that has the effect of discriminating based upon race, religion, color, creed, national origin, ancestry, sex, including gender identity or expression, sexual orientation, income status, health care status, or disability.

The health plan shall accept daily and monthly transaction files from the DHS as the official enrollment record. The health plan shall issue a new member enrollment packet within ten (10) days of receiving the notification of enrollment from DHS. This packet shall include the following:

- A confirmation of enrollment;
- A health plan membership card that includes the member number, which does not have to be the same as the Medicaid ID number which has been assigned by the DHS, and an expiration date which is the member's eligibility review date in the next calendar year;
- A Member Handbook as described in Section 50.440;
- A flyer or other handout that is separate from the member handbook that includes:
    - An explanation of the role of the PCP and the procedures to be followed to obtain needed services;
    - Information explaining that the health plan shall provide assistance in selecting a PCP and how the member can receive this assistance; and
    - Information explaining that the health plan shall auto-assign a member to a PCP if the member does not select a PCP within ten (10) days;
- A PCP selection form;
- A flyer or other handout that is separate from the member handbook that includes:
    - An explanation of the member's rights, including those related to the grievance and appeals procedures;
    - A description of member responsibilities, including an explanation of the information a member must provide to the health plan and the DHS upon changes in the status of the member including marriage, divorce, birth of a child, adoption of a child, death of a spouse or child, acceptance of a job, obtaining other health insurance, change in address and telephone number, etc.;

- Information on how to obtain advance directives at the time of enrollment in accordance with 42 CFR Section 438.6(i); and
- How to access assistance for those with limited English proficiency;

- A provider directory that includes the names, location, telephone numbers of, and non-English languages spoken by contracted providers in the member's service area including identification of providers that are not accepting new patients.

50.210 Health Plan Responsibilities Related to Enrollment Changes Occurring When a Member is Hospitalized

The health plan shall be responsible for all inpatient services, as well as any transportation, meals and lodging for one (1) attendant, if applicable, for all members who are enrolled in its health plan on the date of admission to an acute care hospital subject to applicable benefit limits. In the event a member transfers into another health plan, another Medicaid program (i.e., SHOTT), the FFS program, or is otherwise disenrolled during an acute hospital stay, the health plan in which the member was enrolled on admission, shall remain responsible for acute inpatient services until change in level of care (subsequent to health plan change) or discharge, whichever comes first.

The new health plan is not responsible for providing acute inpatient services to members who are hospitalized at the time of enrollment when the member was previously in another QI health plan or FFS program. However, the new health plan is responsible for providing acute waitlisted services upon enrollment.

The new health plan, other Medicaid program (i.e., SHOTT), or the FFS program into which the hospitalized member has been enrolled shall be responsible for professional fees, outpatient prescription drugs, and transportation, meals and lodging for the one (1) attendant, if applicable, from the date of enrollment into the health plan. QUEST Memo ADM-1009 describes scenarios related to this section found in Appendix P. Any updates to QUEST ADM-1009 shall be enacted as part of this section of the RFP.

50.220 Member Survey

The health plan shall issue a written survey or a welcome call within ten (10) days of receiving the notification of enrollment from DHS to identify if the member (or their child) has any special health care needs. The health plan may send the written survey in the new member enrollment packet as described in Section 50.200. The health plan may choose to only utilize welcome calls instead of written surveys.

The health plan shall make a welcome call for those who do not respond to the survey, if applicable. If special health care needs are identified, the health plan will assign a licensed or qualified professional as the member's service coordinator and perform a face-to-face assessment as described in Section 40.920.

50.230 PCP Selection

The health plan shall provide assistance in selecting a PCP and shall provide the member ten (10) calendar days from the date identified on enrollment packet described in Section 50.200 to select a PCP not including mail time. The standard number of days

the health plan shall use for mail time is five (5) days. If a PCP is not selected within ten (10) days, excluding mail time, the health plan shall assign a PCP to the member based on the geographic area in which the member resides. The health plan shall follow additional requirements identified in Section 40.250 when assigning a PCP.

50.240 Member Status Change

The health plan shall forward to the DHS, in a timely manner, any information that affects the status of members in its health plan. The health plan shall complete the required form DHS 1179 for changes in member status and submit the information by fax, courier services, or mail to the appropriate MQD eligibility office. Change in address shall be communicated to the MQD electronically on its FTP site on a monthly basis on the fifteenth (15) of the month or next business day utilizing the format provided by the DHS. In addition, the health plan shall notify the member that it is also his or her responsibility to provide the information to the DHS. Examples of changes in the member's status are provided in Section 30.570. The health plan shall submit policies and procedures and member surveys to the DHS for review and approval by the due date identified in Section 51.700, Readiness Review.

50.250 Enrollment for Newborns

The health plan shall notify the DHS of a member's birth of a newborn on form DHS 1179 when the health plan has access to the first name of the newborn or within thirty (30) days of birth,

whichever is sooner. If the health plan submits the first name of the newborn as Baby Boy or Baby Girl at thirty (30) days, the health plan shall submit the first name of the child to DHS on form DHS 1179 as soon as they receive it.

50.260 Enforcement of Documentation Requirements

The health plan shall assist the DHS in meeting all citizenship, alien status, photo and identification documentation requirements prescribed in Section 6037 of the DRA and in other federal law.

50.270 Decision Assistance Booklet

The health plan shall provide information to the DHS for inclusion in the decision assistance booklet distributed by the DHS to potential and current members at the time of health plan selection. The decision assistance booklet shall be in a format and timeframe prescribed by the DHS. The DHS shall prorate the total cost of printing the informational booklet equally among the number of health plans participating in the QI program.

50.300 Disenrollment

50.310 Acceptable Reasons for Health Plan Disenrollment Requests

The DHS is solely responsible for making all disenrollment determinations and decisions. The health plan shall notify the DHS in the event it becomes aware of circumstances that might affect a member's eligibility or whether there has been a status change such that a member would be disenrolled from the health plan. The list of appropriate reasons for disenrollment is provided in Section 30.600.

50.320 Unacceptable Reasons for Health Plan Initiated Disenrollment Requests

The health plan shall not request disenrollment of a member for discriminating reasons, including:

- Pre-existing Medical Conditions;
- Missed appointments;
- Changes to the member's health status;
- Utilization of medical services;
- Diminished mental capacity; or
- Uncooperative or disruptive behavior resulting from the member's special needs.

50.330 Aid to Disabled Review Committee (ADRC)

Please refer to Section 30.900 on health plan responsibilities for the ADRC process.

50.340 State of Hawaii Organ and Tissue Transplant (SHOTT) Program

Please refer to Section 30.710 for health plan administrative requirements for SHOTT.

50.400 Member Services

50.410 General Requirements

The health plan shall ensure that members are aware of their rights and 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, how to report suspected fraud and abuse, and how to access language assistance services for individuals with limited English proficiency. The health plan shall convey this information via written materials and other methods that may include telephone, internet, or face-to-face

communications that allow the members to ask questions and receive responses from the health plan.

When directed by the DHS, and whenever there has been a "significant" change as defined in Section 30.200, the health plan shall notify its members in writing of any change to the program information members receive. The health plan shall provide this information to members at least thirty (30) days prior to the intended effective date of the change.

The health plan shall develop member services policies and procedures that address all components of member services. The health plan shall submit these policies and procedures to the DHS for review and approval by the due date identified in Section 51.700, Readiness Review. These policies and procedures must include, but are not limited to, policies and procedures on:

- Member call center staffing and monitoring;
- Member call center activities to ensure metrics as required in Section 50.480 are met;
- The availability and how to access interpretation services for non-English speakers, translation services, and services for individuals with visual and hearing impairments;
- Member rights and how they are protected;
- Up-dating and ensuring accuracy of information on the member portal of the web-site; and
- Methods to ensure member materials are mailed in a timely manner.

Health plans shall ensure members have access to Indian Health Services pursuant to, and shall comply with all requirements of, Title 42, United States Code, Section 1396o(a), and Title V of the American Recovery and Reinvestment Act of 2009, Section 5006.

50.420 Member Education

The health plan shall educate its members on the importance of good health and how to achieve and maintain good health. Educational efforts shall emphasize the following but are not limited to: the availability and benefits of preventive health care; the importance and schedules for screenings receiving an A or B recommendation from the U.S. Preventive Services Task Force; the importance of early prenatal care; and the importance of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services including timely immunizations. The health plan shall also provide educational programs and activities that outline the risks associated with the use of alcohol, tobacco and other substances.

The health plan shall educate its members on the concepts of managed care and the procedures that members need to follow such as informing the health plan and the DHS of any changes in member status, the use of the PCP as the primary source of medical care and the scope of services provided through the health plan. This includes education in the areas of member rights and responsibilities, availability and role of SC services and how to access these services, the grievance and appeal process, identifying fraud and abuse by a provider and how the member

can report fraud and abuse, and the circumstances/situations under which a member may be billed for services or assessed charges or fees including information that a member cannot be terminated from the program for non-payment of non-covered services and no-show fees.

As part of these educational programs, the health plan may use classes, individual or group sessions, videotapes, written material and media campaigns. All instructional materials shall be provided in a manner and format that is easily understood.

The DHS shall review and approve materials prior to the health plan or their subcontractor distributing them or otherwise using them in educational programs. The health plan shall submit its member education materials including training plan and curricula for review and approval by the due date identified in Section 51.700, Readiness Review.

50.430 Requirements for Written Materials

The health plan shall use easily understood language and formats for all member written materials.

The health plan shall make all written materials available in alternative formats and in a manner that takes into consideration the member's special needs, including those who are visually impaired or have limited reading proficiency. The health plan shall notify all members and potential members that information is

available in alternative formats and provide information on how to access those formats.

The health plan shall make all written information for members available in languages comply with Section 1157 of the Patient Protection and Affordable Care Act. When the health plan is aware that the member needs written information in one of these alternate languages, the health plan shall send all written information in this language (not English) to that member within seven (7) days of the request or next business day. The health plan may provide information in other prevalent non-English languages based upon its member population as required in Title VI of the Civil Rights Act of 1964, 42 U.S.C. Section 2000d, 45 CFR Part 80.

All written materials distributed to members shall include a language block that informs the member that the document contains important information and directs the member to call the health plan to request the document in an alternative language or to have it orally translated. The language block shall be printed, at a minimum, in the non-English languages identified in paragraph three (3) of this section.

The health plan shall certify that a qualified individual has reviewed the translation of the information into the different languages for accuracy. The health plan shall submit certification and translation of information into different languages to the DHS for review and approval by the due date identified in Section 51.700, Readiness Review.

All written materials shall be worded such that the materials are understandable to a member who reads at the 6th (6.9 or below) grade reading level. Suggested reference materials to determine whether this requirement is being met are the:

- Fry Readability Index;
- PROSE The Readability Analyst (software developed by Education Activities, Inc.);
- McLaughlin SMOG Index; or
- Flesch-Kincaid Index.

All written material including changes or revisions must be submitted to the DHS for prior approval before being distributed. The health plan shall also receive prior approval for any changes in written materials provided to the members before distribution to members.

50.435 Interpretation Services

The health plan shall provide oral interpretation services to individuals with limited English proficiency and individuals with disabilities at no cost to the individual. The health plan shall notify its members and potential members of the availability of free interpretation services, sign language and TDD services, and inform them of how to access these services.

In order to provide effective communication, the health plan shall provide free aids and services to individuals with disabilities. This shall include such things as:

- Qualified sign language interpreters;
- TTY/TDD services; and
- Written information in other formats (large print, audio, accessible electronic formats, other formats).

The health Plan shall provide free language services to individuals whose primary language is not English. This can include things such as: Qualified interpreters."

The health plan shall meet the following oral interpretation special requirements:

- Offer oral interpretation services to individuals with limited English proficiency (LEP) regardless of whether the individual speaks a language that meets the threshold of a prevalent non-English language; and
- Document the offer of an interpreter regardless of whether the member indicated an ability to provide his or her own, and whether an individual declined or accepted the interpreter service.

The health plan is prohibited from requiring or suggesting that LEP individuals provide their own interpreters or utilize friends or family members.

The health plan shall submit its policies and procedures on assuring both oral interpretation and written translation of materials consistent with requirements described in Sections 50.430 and 50.435 for review and approval by the due date identified in Section 51.700, Readiness Review.

50.440 Member Handbook Requirements

The health plan shall mail to all newly enrolled members a Member Handbook within ten (10) days of receiving the notice of member enrollment from the DHS. The health plan shall inform enrolled members that the Member Handbook is available in paper form without charge and will be provided upon request within five (5) business days. Annually, the health plan shall mail or provide a web-link to the electronic form of the Member Handbook to all enrolled members. The health plan may consolidate Member Handbooks to a family, including the parents and children (under the age of 19), as long as they are living in the same household.

Pursuant to the requirements set forth in 42 CFR Section 438.10, the Member Handbook shall include, but not be limited to:

- A table of contents;
- Information about the roles and responsibilities of the member;
- General information on managed care;
- Information about the role and selection of the PCP to include auto-assignment;
- How to change your PCP;
- Information on how to contact the toll-free call center both during and outside of business hours;
- Information about reporting changes in family status and family composition;
- Appointment procedures including the minimum appointment standards as identified in Section 40.230;

- Information that a provider cannot charge the member a "no-show" fee;
- Information on benefits and services that includes basic definitions;
- Information on how to access services, including EPSDT services, non-emergency transportation services and maternity and family planning services;
- An explanation of any service limitations or exclusions from coverage;
- Information on how to obtain services that the health plan does not cover because of moral or religious objections, if applicable;
- Benefits provided by the health plan not covered under the contract;
- The health plan's responsibility to coordinate care;
- Information on services that are not provided by the health plan that the member may have access to (i.e., Early Intervention Program) and how to obtain these services including transportation;
- A notice stating that the health plan shall be liable only for those services authorized by the health plan;
- A description of all pre-certification, prior authorization or other requirements for treatments and services;
- The policy on referrals for specialty care and for other covered services not furnished by the member's PCP;
- Information on how to obtain services when the member is out-of-state or off-island;
- Information on cost-sharing and other fees and charges;

- A statement that failure to pay for non-covered services shall not result in a loss of Medicaid benefits;
- Notice of all appropriate mailing addresses and telephone numbers, to be utilized by members seeking information or authorization, including the health plan's toll-free telephone line;
- A description of member rights and responsibilities as described in Section 50.450;
- Information on advance directives;
- Information on how to access interpreter and sign language services, how to obtain information in alternative languages and formats, and that these services are available at no charge;
- Information on the extent to which, and how, after-hours and emergency services are provided, including the following:
    - What constitutes an urgent and emergency medical condition, emergency services, post-stabilization services in accordance with 42 CFR 422.113(c), and availability of a twenty-four (24) hour triage nurse;
    - The fact that prior authorization is not required for emergency services;
    - The process and procedures for obtaining emergency services, including the use of the 911 telephone systems or its local equivalent;
    - The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered herein; and

- The fact that a member has a right to use any hospital or other appropriate health care setting for emergency services.

- Information on the member grievance system policies and procedures, as described in Section 51.100. This description must include the following:
  - The right to file a grievance and appeal with the health plan;
  - The requirements and timeframes for filing a grievance or appeal with the health plan;
  - The availability of assistance in filing a grievance or appeal with the health plan;
  - The toll-free numbers that the member can use to file a grievance or an appeal with the health plan by phone;
  - The right to a State administrative hearing, the method for obtaining a hearing, and the rules that govern representation at the hearing;
  - Notice that if the member files an appeal or a request for a State administrative hearing within the timeframes specified for filing, the member may request continuation of benefits as described in Section 51.155 and may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member; and
  - Any appeal rights that the State chooses to make available to providers to challenge the failure of the health plan to cover a service.

- Additional information that is available upon request, including information on the structure and operation of the health plan and information on physician incentive plans as set forth in 42 CFR Section 438.6(h).

The Member Handbook shall be submitted to the DHS for review and approval by the due date identified in Section 51.700, Readiness Review.

50.450 Member Rights

The health plan shall have written policies and procedures regarding the rights of members and shall comply with any applicable federal and State laws and regulations that pertain to member rights. These rights shall be included in the Member Handbook. At a minimum, said policies and procedures shall specify the member's right to:

- Receive information pursuant to 42 CFR Section 438.100(a)(1)(2) and Sections 50.430 and 50.435 of this RFP;
- 432E, HRS, Patients' Bill of Rights and Responsibilities;
- Be treated with respect and with due consideration for the member's dignity and privacy;
- Have all records and medical and personal information remain confidential;
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;

- Participate in decisions regarding his or her health care, including the right to refuse treatment;
- Be free from any form of restraint or seclusion as a means of coercion, discipline, convenience or retaliation, as specified in federal regulations on the use of restraints and seclusion;
- Request and receive a copy of his or her medical records pursuant to 45 CFR Parts 160 and 164, subparts A and E, and request to amend or correct the record as specified in 45 CFR Sections 164.524 and 164.526;
- Be furnished health care services in accordance with 42 CFR Sections 438.206 through 438.210;
- Freely exercise his or her rights, including those related to filing a grievance or appeal, and that the exercise of these rights shall not adversely affect the way the member is treated;
- Have direct access to a women's health specialist within the network;
- Receive a second opinion at no cost to the member;
- Receive services out-of-network if the health plan is unable to provide them in-network for as long as the health plan is unable to provide them in-network and not pay more than he or she would have if services were provided in-network;
- Receive services according to the appointment waiting time standards;
- Receive services in a culturally competent manner;
- Receive services in a coordinated manner;
- Have his or her privacy protected;
- Be included in service plan development, if applicable;

- Have direct access to specialists (if he or she has a special healthcare need);
- Not have services arbitrarily denied or reduced in amount, duration or scope solely because of diagnosis, type of illness, or condition;
- Not be held liable for:
    - The health plan's debts in the event of insolvency;
    - The covered services provided to the member by the health plan for which the DHS does not pay the health plan;
    - Covered services provided to the member for which the DHS or the health plan does not pay the healthcare provider that furnishes the services; and
    - Payments of covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount the member would owe if the health plan provided the services directly; and
- Only be responsible for cost sharing in accordance with 42 CFR Sections 447.50 through 447.60.

50.455 Verification of Services (VOS)

Verification of Services (VOS) in required by 42 CFR 455.20 (a), that states "The agency must have a method for verifying with members whether services billed by providers were received."

The health plan shall send by mail VOS each month to at least twenty-five percent (25%) of their members who received services. The health plan shall randomly select members who

received inpatient, outpatient, HCBS, prescription drugs, and institutional services (i.e., nursing facility) at least forty-five (45) days after the claim(s) was submitted. The health plan shall include in each VOS a cover letter explaining the document, providing a telephone number for the member to call if they did not receive the services, and including a language block. The VOS shall include a summary of the claim(s) or explanation of benefits for the month prior to mailing. Whether the method of verification is by explanation of benefits or a summary of the claim(s) the verification shall include the service furnished, name of the provider furnishing the service, date on which service was furnished and amount of payment made to the provider for the service. The health plan shall encourage members to respond to the VOS by calling the health plan if the billing information is not correct.

VOS is recognized as a valuable tool used to preserve and maintain program integrity in the QUEST Integration program. If a member responds that the service was not received or provided, the health plan shall report this finding to their fraud and abuse staff. Once received by the fraud and abuse staff, steps should be initiated by the health plan to investigate accuracy of information provided by the member. The health plan shall report information on their VOS program as part of their fraud and abuse program as described in Section 51.300.

50.460 Provider Directory

The health plan shall produce a provider directory for the DHS to assist members in selecting a health plan. The health plan shall organize the provider directory by island and then by provider

type/specialty. The health plan shall include the following in the provider directory:

- The provider's name as well as any group affiliation;
- Street address(es);
- Telephone number(s);
- Web site URL; as appropriate
- Specialty; as appropriate
- Whether the provider will accept new enrollees;
- Cultural and linguistic capabilities, including languages (including American Sign Language) by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training; and
- Whether the provider's facility/office has Americans with Disabilities (ADA) accommodations.

The provider directory shall include above information for each of the following provider types.

- Physicians, including specialists;
- Hospitals;
- Pharmacies;
- Behavioral health providers; and
- LTSS providers.

The health plan shall make available and maintain an updated provider directory on their web-site in a machine readable file and format as specified by the Secretary that includes all identified information above. This directory shall be updated at least

monthly. Information on how to access this information shall be clearly stated in both the member and provider areas of the web-site. When the web-site is not accessible during business hours, (7:45 a.m. (H.S.T.) through 4:30 p.m. (H.S.T.)), the health plan shall have member and provider service representatives who can access provider directory information for its members, providers and the State.

The health plan shall mail a hard copy or provide a web-link of its provider directory to their members as part of the new member enrollment packet as described in Section 50.200. The health plan shall update its hard copy of the provider directory within 30 calendar days after the receipt of updated provider information. Annually, the health plan shall mail or provide a web-link to the electronic form of the Provider Directory to all enrolled members. The Member Handbook must include language that the provider directory is available in paper form upon request and electronic form.

50.470 Member Identification (ID) Card

The health plan shall mail a member ID card to all new or renewing members within ten (10) days of their selecting a PCP or the health plan auto-assigning them to a PCP. The member ID card must, at a minimum, contain the following information:

- Member number;
- Member name;
- Effective date;
- PCP name and telephone number;

- Third Party Liability (TPL) information;
- Health plan's call center telephone number; and
- 24-hour nurse call center telephone number.

The health plan shall reissue a member ID card within ten (10) days of notice if a member reports a lost card, there is a member name change, the PCP changes, for any other reason that results in a change to the information on the member ID card, or for renewal with continuing eligibility.

The health plan shall submit a front and back sample member ID card to the DHS for review and approval by the due date identified in Section 51.700, Readiness Review.

50.480 Member Toll-Free Call Center

The health plan shall operate a toll-free call center located in Hawaii to respond to member questions, comments and inquiries. The toll-free call center services shall be available and accessible to members from all islands the health plan serves.

The toll-free call center shall handle calls from non-English speaking callers, as well as calls from members who are hearing impaired. The health plan shall develop a process to handle non-English speaking callers.

The health plan's toll-free call center systems shall have the capacity to:

- Track call center metrics identified by the DHS;

- Allow DHS to monitor remotely by the date identified in Section 51.800; and
- Have the ability for the calling member to receive an automatic call back so that the member does not need to remain on hold.

The call center shall 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 call center staff shall be trained to respond to member questions in all areas, including, but not limited to, covered services and the provider network.

The health plan shall meet the following call center standards:

- The call abandonment rate is five percent (5%) or less;
- The average speed of answer is thirty (30) seconds or less;
- The average hold time is two (2) minutes or less; and
- The blocked call rate does not exceed one percent (1%).

The health plan may have an overflow call center located outside of Hawaii within the United States. However, this call center may not receive more than five percent (5%) of the calls coming into the health plans call center. In addition, the overflow call center shall meet all metrics identified above.

The health plan shall have an automated system or answering service available between the hours of 4:30 p.m. (H.S.T.) and 7:45 a.m. (H.S.T.), Monday through Friday and during all hours on weekends and State holidays. This automated system or

answering service shall provide callers with operating instructions on what to do in case of an emergency, shall provide an option to talk directly to a nurse or other clinician (as described below) and shall include a voice mailbox or other method for members to leave messages. The health plan shall ensure that the voice mailbox has adequate capacity to receive all messages. The health plan shall ensure that representatives return all calls by close of business the following business day.

In addition, 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 department visits 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.

The toll-free nurse line shall meet the following standards:

- The call abandonment rate is five percent (5%) or less;
- The average speed of answer is thirty (30) seconds or less;
- The average hold time is two (2) minutes or less; and
- The blocked call rate does not exceed one percent (1%).

The health plan shall submit its policies and procedures on member call center to the DHS for review and approval by the due

date identified in Section 51.700, Readiness Review. In addition, the health plan shall submit reports on the member call center, nurse line and any overflow call center as described in Section 51.540.2.

50.490 Internet Presence/Web-Site

The health plan shall have a member portal on its web-site that is available to all members which contains accurate, up-to-date information about the health plan, services provided, the provider network, FAQs, and contact phone numbers and e-mail addresses. The member web portal shall allow members to view explanation of benefits (EOB) for the past twelve (12) months, review prior authorization requests (approval or denials), contact their service coordinator, if applicable, review their service plan, if applicable, and communicate changes to the health plan (i.e., demographics, change in family size, change in PCP, request change in service coordinator, etc.).

The section of the web-site relating to QUEST Integration shall comply with the marketing policies and procedures and requirements for written materials described in this contract and all applicable State and Federal laws.

The health plan shall submit to the DHS, for review and prior approval, all screen shots relating to the QUEST Integration program by the due date identified in Section 51.700, Readiness Review. In addition, the health plan shall submit access to the member web-site (even if in a test environment) to the DHS for

review and approval by the due date identified in Section 51.700, Readiness Review.

50.500 Value-Based Purchasing

50.510 Background

Value-based purchasing (VBP) links a provider's reimbursement to improved performance or aligning payment with quality and efficiency. This form of payment holds health care providers accountable for both the cost and quality of care that they provide. VBP attempts to reduce inappropriate care and to identify and reward the best-performing providers. 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. VBP can occur through reimbursement mechanisms for physicians, hospitals, and other health care providers. DHS may require the health plan to align standard metrics and reporting for providers participating in a VBP agreement with other federal or community programmatic required metrics and reporting to reduce administrative burden for the provider community. Health plans shall submit data to DHS upon request to include but not limited to timely, actionable reports on conditions or criteria determined by DHS.

50.520 Primary Care Providers

The medical home is a model to facilitate the provision of outpatient high quality and high efficient care. The required criteria that follow are based on national standards. Providers shall use a medical home model that is based on the domains of patient-centered, accessible, comprehensive, coordinated, evidence-based, and performance measurement. The elements for each of these domains are provided below:

Patient Centered:

- Include patient, and family as appropriate, in shared decision making
- Provide culturally sensitive and competent care including language access
- Provide processes to promote patient self-management
- Refer to community resources/supports as indicated

Accessible:

- Address patients' concerns in a timely manner
- Maintain open scheduling and/or expanded office hours
- Maintain after hours accessibility
- Develop and maintain multiple options for communication

Comprehensive:

- Maintain a whole person orientation
- Be first contact for undifferentiated problems
- Be responsible for addressing the vast majority of physical and behavioral health care needs
- Provide preventive, acute, and chronic care

Coordinated:

- Provide or ensure provision of care across health care spectrum of services and settings
- Track and follow up tests and referrals
- Facilitate transition of care and reconcile service plan
- Identify high-risk patients

Evidence-Based:

- Adopt and implement evidence-based guidelines
- Utilize evidence-based clinical decision support tools
- Proactively manage evidence-based population health and disease management
- Implement effective practice organization and workflow processes

Performance Measurement

- Utilize electronic health record with registry functionality
- Utilize validated measures, particularly patient-oriented outcome measures when possible
- Report on performance
- Have continuous quality improvement process

Incentivizing increased quality and efficiency of care including proactive population management shall be based on outcomes, including both patient-oriented outcomes and utilization. Payment reform is a quintessential component of enabling the medical home. For example, the health plan may utilize a monthly

patient management reimbursement to the provider that is reconciled with earned financial incentives. Such financial incentives could be based on achieving thresholds on certain quality measures and/or could be based on reduction in overall utilization compared to that predicted. The available incentive amount may be dependent on the degree of fiscal risk the provider assumes.

A medical home shall receive increased reimbursement compared to a practice that does not meet the criteria to be a medical home, and there shall be two tiers of medical homes with higher payment to the Tier 1 Medical Home compared to the Tier 2 Medical Home:

- Tier 1 Medical Home: To be considered a Tier 1 medical home, a provider/practice must meet all elements for each of the domains of patient centered, accessible, comprehensive, and coordinated; and must meet three elements for each for the domains of evidence-based and performance measurement. NCQA PCMH level 2 or 3 recognition and Accreditation Association for Ambulatory Health Care accreditation shall be considered to meet these requirements. In addition, the provider/practice must meet the Office of the National Coordinator requirements for meaningful use of an electronic health record that includes exchanging vaccination information with the Department of Health. Health plans must participate in health information exchange.

- Tier 2 Medical Home: To be considered a Tier 2 medical home, a provider/practice must meet three elements for each of the

domains of patient centered, accessible, comprehensive, and coordinated; and must meet two elements for each for the domains of evidence-based and performance measurement. NCQA PCMH level 1 recognition, Accreditation Association for Ambulatory Health Care certification, and URAC's Patient Centered Health Care Home achievement shall be considered to meet these requirements.

50.530 Hospitals

To incentivize the provision of high quality, highly efficient care, health plans shall not reimburse hospitals on a per diem basis, particularly where acuity adjusted diagnosis-based reimbursement methodologies have been well developed. However, the health plans may reimburse on a per diem basis for services for which such methodologies are not well developed and for specific situations such as wait-listed patients.

Any financial incentives for performance shall be consistent with validated measures that the Centers for Medicare & Medicaid Services (CMS) has incorporated for its Medicare Hospital Value-Based Purchasing (HVBP) Program in order to decrease the administrative burden and to the extent possible align measures with those already being reported. Expecting hospitals to arrange for timely follow up of discharged patients with their PCP is encouraged.

50.540 Vertically Integrated Organizations

Health plans are encouraged to pursue a shared risk and shared savings program with integrated care organizations if available. Such a health care delivery model may be provider led, and the

organization assumes responsibility, i.e., becomes accountable for providing at a minimum primary, acute, and chronic care services.

50.550 Value-Driven Health Care Schedule

The health plan shall incorporate value-driven health care concepts as described in Section 50.500 and its subsections for a minimum percentage of contracts with networked hospitals and primary care providers according to the following table:

Beginning of contract year:	Percentage of primary care providers and of hospitals
1	50%
2	65%
3	80%

The health plans shall incorporate at a minimum the measures specified by DHS, as applicable, into the provider contracts.

The health plan shall submit its value-based purchasing plan to the DHS for review and approval by the date identified in Section 51.700, Readiness Review.

50.600 Marketing and Advertising

50.610 Allowable Activities

The health plan shall be permitted to perform the following marketing activities:

- Distributing general information through mass media (i.e., newspapers, magazines and other periodicals, radio, television, the Internet, public transportation advertising, and other media outlets);

- Distributing brochures and displaying posters at provider offices and clinics that inform patients that the clinic or provider is part of the health plan's provider network, provided that all health plans in which the provider participates have an equal opportunity to be represented; and
- Attending activities that benefit the entire community such as health fairs or other health education and promotion activities.

If the health plan performs an allowable activity, the health plan shall conduct these activities in the entire region in which it is operating.

All materials shall comply with the information requirements in 42 CFR Section 438.10 and as detailed in Section 50.430 of this RFP.

50.620 Prohibited Activities

The health plan is prohibited from engaging in the following activities:

- Directly or indirectly engaging in door-to-door, telephone, mailings or other cold-call marketing activities to potential members;
- Offering any favors, inducements or gifts, promotions, or other insurance products that are designed to induce enrollment in the health plan, and that are not health related and worth more than ten dollars ($10) cash;
- Distributing information that contains any assertion or statement (whether written or oral) that the health plan is

endorsed by CMS, the Federal or State government, or DHS;

- Distributing information or materials that seek to influence enrollment in conjunction with the sale or offering of any private insurance;
- Distributing information and materials that contain statements that the DHS determines are inaccurate, false, or misleading. Statements considered false or misleading include, but are not limited to, any assertion or statement (whether written or oral) that the member must enroll in a specific health plan to obtain benefits, or to avoid losing benefits, or that any particular health plan is endorsed by the federal or state government, or similar entity;
- Distributing materials that, according to the DHS, mislead or falsely describe the health plan's provider network, its performance/quality, the participation or availability of network providers, the qualifications and skills of network providers (including their bilingual skills), or the hours and location of network services;
- Failing to receive DHS approval on all marketing materials; and
- Editing, modifying, or changing in any manner marketing materials previously approved by the DHS without the consent and approval of the DHS.

The State may impose financial sanctions, as described in Section 72.220, up to the federal limit, on the health plan for any violations of the marketing and advertising policies.

50.630 State Approval of Materials

All printed materials, advertisements, video presentations, and other information prepared by the health plan that pertain to or reference the programs or the health plan's program business shall be reviewed and approved by the DHS before use and distribution by the health plan. The health plan shall not advertise, distribute or provide any materials to its members or to any potential members that relate to QUEST Integration that have not been approved by the DHS. All materials shall be submitted to the DHS for review and approval by the due date identified in Section 51.700, Readiness Review.

In addition, the health plan shall submit to the DHS any marketing materials it has received from a provider or subcontractor for review and prior approval.

50.640 Marketing for Initial Enrollment and Annual Plan Change (APC)

The health plan shall submit all potential marketing materials to DHS for review and approval using the protocol determined by the DHS by the date identified in Section 51.800. The DHS shall not accept materials for Initial Enrollment or APC after this date. The DHS shall utilize criteria identified in Section 50.600 and Section 50.430 to approve materials.

Health plans shall only use DHS approved materials for marketing during Initial Enrollment and APC. Health plans that do not follow this policy shall be subject to sanctions as described in Section 72.220.

50.700 Quality Improvement

50.710 Accreditation

The health plan shall be accredited by the National Committee for Quality Assurance (NCQA) for its QUEST Integration program no later than when their current accreditation expires. For health plans undergoing accreditation for NCQA, health plans shall submit reports documenting the status of the accreditation process as required in Section 51.550.1.

The health plan must provide and/or authorize NCQA to provide the State a copy of its most recent accreditation review, including:

(1) Accreditation status, survey type, and level (as applicable);

(2) Accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings; and

(3) Expiration date of the accreditation.

50.720 General Provisions

The health plan shall provide for the delivery of quality care that is accessible and efficient, provided in the appropriate setting, according to professionally accepted standards, and in a coordinated and continuous rather than episodic manner.

The health plan shall provide quality care that includes, but is not limited to:

- Providing adequate capacity and service to ensure member's timely access to appropriate needs, services/care;
- Ensuring coordination and continuity of care;
- Ensuring that member's rights are upheld and services are provided in a manner that is sensitive to the cultural needs of members, pursuant to Section 41.310;
- Encouraging members to participate in decisions regarding their care and educating them on the importance of doing so;
- Placing emphasis on health promotion and prevention as well as early diagnosis, treatment and health maintenance;
- Ensuring appropriate utilization of medically necessary services; and
- Ensuring a continuous quality improvement approach.

The health plan shall execute processes to assess, plan, implement, evaluate, and, as mandated, report quality management and performance improvement activities as specified by the State and that adhere to the requirements prescribed in 42 CFR Sections 438.240(a)(1) and (e)(2), including:

- Seeking input from, and working with, members, providers, MQD staff and its designees and community resources and agencies to actively improve the quality of care provided to members;
- Conducting Performance Improvement Projects (PIPs);
- Conducting QM monitoring and evaluation activities;

- Investigating, analyzing, tracking and trending quality of care issues, abuse and/or grievances that include:
    - Sending acknowledgement letter to the originator of the concern;
    - Documenting all steps utilized during the investigation and resolution process;
    - Following-up with the member to assist in ensuring immediate healthcare needs are met;
    - Sending closure/resolution letter that provides sufficient detail to ensure that the member has an understanding of the resolution of his/her issue, any responsibilities he/she has in ensuring all covered, medically necessary care needs are met, and a contact name and telephone number to call for assistance or to express any unresolved concerns;
    - Documenting implemented corrective action plan(s) or action(s) taken to resolve the concern; and
    - Determining and evaluating evidence of the resolution implemented;
- Implementing the DHS mandated performance measures~~;~~ ~~and~~ which requires CMS approval as described in 42 CFR Section 438.340; and
- Establishing and implementing credentialing, recredentialing and provisional credentialing processes for providers and organizations according to 42 CFR Sections 438.206(b)(6), 438.214(b) and Section 40.400.

The health plan shall submit a written Quality Assessment and Performance Improvement (QAPI) description that addresses its

strategies for performance improvement and conducting the quality management activities described in this section. In addition, the health plan shall submit an evaluation of the previous year's QAPI program.

50.730 Quality Assessment and Performance Improvement (QAPI) Program

The health plan shall have an ongoing QAPI Program for all services it provides to its members. The QAPI Program shall be comprehensive in range and scope. It shall cover all demographic groups, care settings, and types of services. It shall address clinical medical care, behavioral health care, member safety, and non-clinical aspects of service, including the availability, accessibility, coordination, and continuity of care. It shall consist of the systematic internal processes and mechanisms used by the health plan for its own monitoring and evaluation of the impact and effectiveness of the care/services it provides according to established standards. The principles of continuous quality improvement shall be applied throughout the process, from developing, implementing, monitoring, and evaluating the QAPI Program to identifying and addressing opportunities for improvement. The QAPI program designates and specifies the roles/responsibilities of a physician and behavioral health practitioner as well as the Quality Improvement Committee and all subcommittees.

The health plan shall submit its QAPI Program documentation for review to DHS with its RFP proposal. The health plan shall then submit its QAPI Program for review and approval by DHS by the date specified in Section 51.700, Readiness Review. Upon request

by the DHS, the health plan shall submit information on its QAPI program. The health plan also ensures that a QAPI program work plan is developed and evaluated on an annual basis and is updated as needed.

The health plan shall comply with the following requirements set forth in 42 CFR Section 438.330:

1. Conducting performance improvement projects (PIPs) described in 42 CFR Section 438.330(d);
2. Submitting performance measurement data Healthcare Effectiveness Data and Information Set (HEDIS)measures described in 42 CFR Section 438.330(c);
3. Establishing mechanisms for detecting both under-utilization and over-utilization of services;
4. Establishing mechanisms for assessing the quality and appropriateness of care furnished to members with special health care needs, as defined by the State in the quality strategy under 42 CFR Section 438.340;
5. Establishing mechanisms to assess the quality and appropriateness of care furnished to members using long-term services and supports, including assessment of care between care settings and a comparison of services and supports received with those set forth in the member's treatment/service plan; and
6. Participating in efforts by the DHS to prevent, detect, and remediate critical incidents [consistent with assuring beneficiary health and welfare per 42 CFR Sections

441.302 and 441.730(a)] that are based, at minimum, on the requirements on the DHS for home and community-based waiver programs per 42 CFR Section 441.302(h).

When establishing its QAPI program standards, the health plan shall comply with applicable provisions of Federal and State laws and current NCQA Standards/Guidelines for Accreditation of Managed Care Organizations.

The DHS reserves the right to require additional standards or revisions to established standards and their respective elements to ensure compliance with changes to Federal or State statutes, rules, and regulations as well as to clarify and to address identified needs for improvement.

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 by the date specified in Section 51.700, Readiness Review. 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:

- 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
- An annual on-site visit and/or documentation/record reviews to monitor/evaluate the quality of the delegated organization's assigned processes;
- The annual on-site visit may be deemed if the delegate is accredited by NCQA; and
- Evaluation of the content and frequency of reports from the delegated organization.

In accordance with 42 CFR Section 438.330(e), Program Review by the State, the DHS shall review, at least annually, the impact and effectiveness of each health plan's QAPI Program. The scope of the DHS review also includes monitoring of the systematic processes developed and implemented by the health plan to conduct its own internal evaluation of the impact and effectiveness of its QAPI program as well as to effect necessary improvements.

The DHS shall evaluate the health plan's QAPI Program utilizing a variety of methods, including but not limited to:

- Reviewing QAPI documents;
- Reviewing and evaluating the QAPI Program reports regularly required by the DHS (e.g. member grievances and appeals reports, provider complaints and claims reports,

reports of suspected cases of fraud and abuse, the performance measures (HEDIS) report, performance improvement project (PIP) reports, QAPI Program Description Report, etc.);

- Reviewing, evaluating, or validating implementation of specific policies and procedures or special reports relating to areas such as:
    - Member rights and protections;
    - Services provided to members with special health care needs;
    - Utilization management (e.g., under-utilization and over-utilization of services);
    - Access to care standards, including the:
        - Availability of services;
        - Adequate capacity and services;
        - Continuity and coordination of care;
        - Coverage and authorization of services;
    - Structure and Operation Standards, including:
        - Provider selection;
        - Member information;
        - Confidentiality;
        - Enrollment and disenrollment;
        - Grievance systems;
        - Subcontractual relationships and delegation;
    - Measurement and Improvement Standards;
    - Practice guidelines;
    - QAPI Program;
    - Health information systems;

- Conducting on-site reviews to interview health plan staff for clarification, to review records, or to validate implementation of processes/procedures; and
- Reviewing medical records.

The DHS may elect to monitor the activities of the health plan using its own personnel or may contract with qualified personnel to perform functions specified by the DHS. Upon completion of its review, the DHS or its designee shall submit a report of its findings to the health plan.

50.740 Medical Records Standards

As part of its QAPI Program, 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 identified below:

- Require that the medical record is maintained by the provider;
- Assure that DHS personnel or personnel contracted by the DHS shall have access to all records, as long as access to the records is needed to perform the duties of this contract and to administer the QUEST Integration program for information released or exchanged pursuant to 42 CFR Section 431.300. The health plan shall be responsible for being in compliance with any and all State and Federal laws regarding confidentiality;

- Provide DHS or its designee(s) with prompt access to members' medical records;
- Provide members with the right to request and receive a copy of his or her medical records, and to request they be amended, as specified in 45 CFR Part 164; and
- Allow for paper or electronic record keeping.

As part of the record standards, the health plan shall require that providers adhere to the following requirements:

- All medical records are maintained in a detailed and comprehensive manner that conforms to good professional medical practice;
- All medical records are maintained in a manner that permits effective professional medical review and medical audit processes;
- All medical records are maintained in a manner that facilitates an adequate system for follow-up treatment;
- All medical records shall be legible, signed and dated;
- Each page of the paper or electronic record includes the patient's name or ID number;
- All medical records contain patient demographic information, including age, sex, address, home and work telephone numbers, marital status and employment, if applicable;
- All medical records contain information on any adverse drug reactions and/or food or other allergies, or the absence of known allergies, which are posted in a prominent area on the medical record;

- All forms or notes have a notation regarding follow-up care, calls or visits, when indicated;
- All medical records contain the patient's past medical history that is easily identified and includes serious accidents, hospitalizations, operations and illnesses. For children, past medical history including prenatal care and birth;
- All pediatric medical records include a completed immunization record or documentation that immunizations are up-to-date;
- All medical records include the provisional and confirmed diagnosis(es);
- All medical records contain medication information;
- All medical records contain information on the identification of current problems (i.e., significant illnesses, medical conditions and health maintenance concerns);
- All medical records contain information about consultations, referrals, and specialist reports;
- All medical records contain information about emergency care rendered with a discussion of requirements for physician follow-up;
- All medical records contain discharge summaries for: (1) all hospital admissions that occur while the member is enrolled; and (2) prior admissions as appropriate;
- All medical records for members eighteen (18) years of age or older include documentation as to whether or not the member has executed an advance directive, including an advance mental health care directive;

- All medical records shall contain written documentation of a rendered, ordered or prescribed service, including documentation of medical necessity; and
- All medical records shall contain documented patient visits, which includes, but is not limited to:
    - A history and physical exam;
    - Treatment plan, progress and changes in treatment plan;
    - Laboratory and other studies ordered, as appropriate;
    - Working diagnosis(es) consistent with findings;
    - Treatment, therapies, and other prescribed regimens;
    - Documentation concerning follow-up care, telephone calls, emails, other electronic communication, or visits, when indicated;
    - Documentation reflecting that any unresolved concerns from previous visits are addressed in subsequent visits;
    - Documentation of any referrals and results thereof, including evidence that the ordering physician has reviewed consultation, lab, x-ray, and other diagnostic test results/reports filed in the medical records and evidence that consultations and significantly abnormal lab and imaging study results specifically note physician follow-up plans;
    - Hospitalizations and/or emergency department visits, if applicable; and

- All other aspects of patient care, including ancillary services.

As part of its medical records standards, the health plan shall ensure that providers facilitate the transfer of the member's medical records (or copies) to the new PCP within seven (7) business days from receipt of the request.

As part of its medical records standards, the health plan shall comply with medical record retention requirements in Section 70.500.

The health plan shall submit its medical records standards to the State by the due date identified in Section 51.700, Readiness Review. If the health plan includes the medical records standards in the QAPI, it is permissible to submit a memo identifying where, in the QAPI program description, the medical records standards appear.

50.750 Performance Improvement Projects (PIPs)

As part of its QAPI Program, the health plan shall conduct two (2) PIPs in accordance with 42 CFR Section 438.240(d) that are designed to achieve, through ongoing measurements and interventions, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction. The PIPs shall include the following:

- A study topic identified by the health plan, CMS, or DHS;

- A clearly definable answerable study question;
- A correctly identified study population;
- The use of objective, measurable, and clearly defined quality indicators to measure performance;
- Valid sampling techniques;
- Accurate and complete data collection;
- The implementation of appropriate planned system interventions to achieve improvement in quality;
- An evaluation of the effectiveness of the intervention, including sufficient data and barrier analysis;
- An achievement of real improvement that is sustained; and
- A plan and activities that shall increase or sustain improvement.

The health plan shall report the status and results of each project to the State as requested. Each PIP must be completed in the time period determined by DHS so as to allow information on the progress of PIPs in aggregate to produce new information annually on quality of care according to 42 CFR Section 438.240(d)(2).

PIPs may be specified by the DHS and by CMS. All health plans shall have the same PIP topics and shall coordinate as appropriate when beneficial to members and providers. In these cases, the health plan shall meet the goals and objectives specified by the DHS and CMS. The health plan shall submit to the DHS and the EQRO any and all data necessary to enable validation of the health plan's performance under this section, including the status and results of each project.

The health plan shall submit its PIP topic suggestions to the State and its PIP standards and proposed PIPs for the selected topics to the State by the due date identified in Section 51.700, Readiness Review.

50.760 Practice Guidelines

The health plan shall include, as part of its QAPI Program, practice guidelines that meet the following requirements as stated in 42 CFR Section 438.236 and current NCQA standards. Each adopted practice guidelines shall be:

- Relevant to the health plan's membership;
- Based on valid and reliable clinical evidence or a consensus of health care professionals in a particular field;
- Adopted in consultation with in-network providers;
- Reviewed and updated periodically as appropriate; and
- Disseminated to all affected providers, and upon request, to members and potential members.

Additionally, in compliance with 42 CFR Section 438.236, the health plan shall ensure that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

The DHS shall determine practice guidelines that health plans shall work collaboratively to develop. The DHS shall choose at least two (2) clinical practice guidelines for medical conditions and at least two (2) for behavioral health conditions. Health plans shall follow current NCQA and BBA standards for adopting and disseminating guidelines. The health plan shall submit its policies

and procedures addressing the stated requirements, a list of all current practice guidelines as well as the practice guidelines adopted specifically for two (2) medical conditions and two (2) behavioral health conditions by the date specified in Section 51.700, Readiness Review.

For each practice guideline adopted, and required, the health plan shall:

- Describe the clinical basis upon which the practice guideline is based;
- Describe how the practice takes into consideration the needs of the members;
- Describe how the health plan shall ensure that practice guidelines are reviewed in consultation with health care providers;
- Describe the process through which the practice guidelines are reviewed and updated periodically;
- Describe how the practice guidelines are disseminated to all relevant providers and, upon request, to potential members; and
- Describe how the health plan shall ensure that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

The health plan shall ensure that all decisions for utilization management, member education, coverage of services, and other

areas to which the guidelines apply shall be consistent with the guidelines.

50.770 Performance Measures

The health plan shall comply with all the DHS quality management requirements to improve performance for DHS established performance measures. Performance measures may be based on CMS core measures or initiatives, State priorities, or areas of concern that arise from previous measurements. Both clinical (i.e., comprehensive diabetes care measures, cardiovascular disease measures) and utilization measures (i.e., emergency department visits, hospital readmissions) are included. The following include sets of performance measures that the health plan shall be required to provide:

- 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.

- The DHS shall identify the measures that may be used on support auto-assign algorithms as described in Section 30.530.

The health plan shall submit to the DHS and the EQRO any and all data necessary to enable validation of the health plan's performance under this section.

50.780 Performance Incentives

The health plan may be eligible for performance incentives as described in Section 60.200.

50.790 Non-duplication Strategy

The non-duplication regulation provides states the option to use information from Medicaid and a private accreditation review to avoid duplication with the review of select standards required under 42 CFR Section 438.360 . The health plan may be eligible for consideration for 'deemed' compliant status for certain standards at the discretion of DHS as defined in DHS policies and as described in the State's approved Quality Strategy.

50.800 Utilization Management Program (UMP)

The health plan shall have in place a utilization management program (UMP) that is linked with and supports the health plan's QAPI Program. The UMP shall be developed to assist the health plan in objectively and systematically monitoring and evaluating the necessity, appropriateness, efficiency, timeliness and cost-effectiveness of care and services provided to members. The UMP shall be used by the health plan as a tool to continuously improve quality clinical care and services as well as maximize appropriate use of resources.

As part of the UMP, the health plan shall define their implementation of medically necessary services in a manner that:

- Is no more restrictive than the definition of medically necessary services as defined in Section 30.200; and
- Addresses the extent that the health plan covers services related to the following:
    - The prevention, diagnosis, and treatment of health impairments;
    - The ability to achieve age-appropriate growth and development; and
    - The ability to attain, maintain, or regain functional capacity.

The health plan shall have a written UMP description, a corresponding workplan, UMP policies and procedures, and mechanisms to implement all UMP activities. The UMP description and workplan may be separate documents or may be integrated as part of the written QAPI Program description and workplan. The health plan's UMP shall include structured, systematic processes that employ objective evidenced-based criteria to ensure that qualified licensed health care professionals make utilization decisions regarding medical necessity and appropriateness of medical, behavioral health, and LTSS in a fair, impartial, and consistent manner.

The health plan shall ensure that applicable evidence-based criteria are applied with consideration given to characteristics of

the local delivery system available for specific members as well as member-specific factors, such as member's age, co-morbidities, complications, progress of treatment, psychosocial situation, and home environment. The health plan shall also have formal mechanisms to evaluate and address new developments in technology and new applications of existing technology for inclusion in the benefit package to keep pace with changes and to ensure equitable access to safe and effective care.

The health plan shall annually review and update all UMP criteria and application procedures in conjunction with review of the health plan's clinical practice guidelines, disease management programs, and evaluation of new technologies. Practitioners with appropriate clinical expertise shall be involved in developing, adopting, and reviewing the criteria used to make utilization decisions. The health plan shall provide UMP criteria to providers and shall ensure that members and providers seeking information about the UMP process and the authorization of care/services have access to UMP staff.

The health plan's utilization review/management activities shall include:

- Prior authorization/pre-certifications;
- Concurrent reviews;
- Retrospective reviews;
- Discharge planning;
- Service Coordination; and
- Pharmacy Management.

The UMP shall include mechanisms to detect under-utilization, over-utilization, and inappropriate utilization as well as processes to address opportunities for improvement. The health plan shall perform:

- Routine, systematic monitoring of relevant utilization data;
- Routine analysis of all data collected to identify causes of inappropriate utilization patterns;
- Implementation of appropriate interventions to correct any patterns of potential or actual under-utilization or over-utilization; and
- Systematic measurement of the effectiveness of interventions aimed at achieving appropriate utilization.

The health plan shall evaluate and analyze practitioners' practice patterns, and at least on an annual basis, the health plan shall produce and distribute to providers, profiles comparing the average medical care utilization rates of the members of each PCP to the average utilization rates of all health plan members. Additionally, feedback shall be provided to providers when specific utilization concerns are identified, and interventions to address utilization issues shall be systematically implemented.

The health plan shall ensure that pharmaceutical management activities promote the clinically appropriate use of pharmaceuticals. There shall be policies, procedures, and mechanisms to ensure that the health plan has criteria for adopting pharmaceutical management procedures and that there

is clinical and scientifically-based evidence for all decisions. The policies must include an explanation of any limits or quotas and an explanation of how prescribing practitioners must provide information to support an exceptions request. The health plan shall ensure that it has processes for determining and evaluating classes of pharmaceuticals, pharmaceuticals within the classes, and criteria for coverage and prior authorization of pharmaceuticals. The health plan shall ensure that it has processes for generic substitution, therapeutic interchange, and step-therapy protocols.

The health plan shall not develop a compensation structure that creates incentives for the individuals or entities conducting UMP (or service coordination) activities to deny, limit, or discontinue medically necessary services to any member.

The health plan shall submit its written UMP description, corresponding workplan, and UMP policies and procedures to the DHS for review and prior approval by the date identified in Section 51.700, Readiness Review. If the health plan includes the UMP in the QAPI, it is permissible to submit a memo identifying where, in the QAPI program description, the UMP information appears.

50.900 Authorization of Services

The health plan shall have in place written prior authorization/pre-certification policies and procedures for processing requests for initial and continuing authorization of services in a timely manner. The procedures shall be developed to reduce administrative

burden on the providers. The health plan shall utilize any DHS-required standardized format for authorization of services.

A member shall be able to make a request to the health plan for the provision of a service. As part of these prior authorization policies and procedures, the health plan shall have in effect mechanisms to: (1) ensure consistent application of review criteria for authorization decisions; ~~and~~ (2) consult with the requesting provider when appropriate; and (3) authorize LTSS based on a member's assessment and consistent with the person-centered service plan. The health plan shall submit these policies and procedures to MQD for review and approval by the due date identified in Section 51.700, Readiness Review.

The health plan shall ensure that all prior authorization/ pre-certification decisions, including but not limited to any decisions to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, shall be made by a health care professional who has appropriate expertise in addressing the member's medical, behavioral health, or long-term services and supports needs. Medical necessity approvals may be made by licensed clinical staff or unlicensed staff under the supervision of licensed staff. Medical necessity denials must be made by licensed clinical staff. All denials of medical, behavioral health, and LTSS shall be reviewed and approved by the health plan medical director. In addition, all administrative denials for children under the age of 21 shall be reviewed and approved by the health plan medical director.

The health plan shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. The health plan may place appropriate limits on a service based on criteria such as medical necessity, or for utilization control provided that: (1) the services furnished can reasonably be expected to achieve their purpose; (2) the services supporting members with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects ongoing need for such services and supports; and (3) family planning services are provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used consistent with 42 CFR §441.20.

The health plan shall not require prior authorization of emergency services~~,~~ or urgent care services but may require prior authorization of post-stabilization services as specified in Sections 40.740.1.e and 40.740.1.aa.

The health plan shall notify the provider of prior authorization/pre-certification determinations in accordance with the following timeframes:

- For standard authorization decisions, the health plan shall provide notice as expeditiously as the member's health condition requires but no longer than fourteen (14) calendar days following the receipt of the written request for service. An extension may be granted for up to fourteen (14) additional calendar days if the member or the provider

requests the extension, or if the health plan justifies a need for additional information and the extension is in the member's best interest. If the health plan extends the timeframe, it shall give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision. The health plan shall issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

- In the event a provider indicates, or the health plan determines that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the health plan shall make an expedited authorization determination and provide notice as expeditiously as the member's health condition requires but no later than seventy two (72) hours after receipt of the request for service. The health plan may extend the seventy two (72) hour timeframe by up to an additional fourteen (14) calendar days if the member requests an extension, or if the health plan justifies to the DHS a need for additional information and the extension is in the member's best interest. If the health plan extends the timeframe, it shall give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision. The health plan shall issue and carry out its determination as expeditiously as the member's

health condition requires and no later than the date the extension expires.

- Authorization decisions related to coverage of 1) environmental accessibility adaptations; 2) moving assistance; 3) specialized medical equipment, orthotics or prosthetics that require personalized fitting or customization specific to the member; or 4) out-of-network non-emergent procedures, including out-of-state procedures, shall be provided within the standard authorization timeframes set forth in the first bullet point of this section. The health plan will follow DHS policy guidance regarding implementation of authorization for these services that is found in Appendix Q. The DHS will monitor timely provision of implementation of these services through the LTSS report identified in Section 51.530.2.

Service authorization decisions not reached within the timeframes specified above and in accordance with the DHS policy guidance shall constitute a denial and thus an adverse benefit determination, on the date that the time frames expire.

The health plan must notify the member and provider of the concurrent review determination within twenty four (24) hours from the time of request receipt.

The health plan's prior authorization requirements shall comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910(d).

51.100 Member Grievance System

51.105 General Requirements

The health plan shall have a formal grievance system that is consistent with the requirements of the State of Hawaii and 42 CFR Part 438, Subpart F. The member grievance system shall include an inquiry process, a grievance process and appeals process. In addition, the health plan's grievance system shall provide information to members on accessing 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 use templates developed by the DHS for communication to members regarding grievance system processes. The DHS shall issue these templates to health plans by the date identified in Section 51.800.

The health plan shall develop policies and procedures for its grievance system and submit these to the DHS for review and approval by the due date identified in Section 51.700, Readiness Review. The health plan shall submit an updated copy of these policies and procedures within thirty (30) days of any modification for review and approval. Changes must be approved by DHS prior to implementation.

The health plan shall address, log, track and trend all expressions of dissatisfaction, regardless of the degree of seriousness or regardless of whether the member or provider expressly requests filing the concern or requests remedial action. The formal grievance system must be utilized for any expression of dissatisfaction and any unresolved issue.

The health plan shall give members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

The health plan shall acknowledge receipt of each filed grievance and appeal in writing within five (5)[1] business days of receipt of the grievance or appeal. The health plan shall have procedures in place to notify all members in their primary language of grievance and appeal resolutions as described in Sections 50.430 and 50.435. These procedures shall include written translation and oral interpretation activities.

The health plan shall ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be given timely and accessible peer to peer option that discusses the denial and

[1] The first day shall be the day after the day of receipt of a grievance or appeal. For example, and assuming there are no intervening holidays, if an appeal is received on Monday, the five (5) business day period for acknowledgment of receipt of the appeal is counted from Tuesday. Therefore, the acknowledgment must be sent to the member by the following Monday.

be made and reviewed by a healthcare professional that has appropriate medical knowledge and clinical expertise in treating the member's condition or disease. All denials of medical, behavioral health, and LTSS shall be reviewed and approved by the health plan medical director. In addition, all administrative denials for children under the age of twenty-one (21) shall be reviewed and approved by the health plan medical director.

The health plan shall ensure that individuals who make decisions on grievances and appeals were not involved in any previous level of review or decision-making, nor is a subordinate of any such individual. The individual making decisions on grievances and appeals shall be the healthcare professionals who have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease. These decision makers on grievances and appeals of adverse benefit determination shall take into account all comments, documents, records, and other information submitted by the member and/or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination. This requirement applies specifically to reviewers of:

- An appeal of a denial that is based on a lack of medical necessity;
- A grievance regarding denial of expedited resolution of an appeal; or
- A grievance or appeal that involves clinical issues.

A member, a member's authorized representative, or a provider acting on behalf of the member with the member's authorization, is deemed to have exhausted the health plan's grievance and appeal process if the health plan fails to adhere to the notice and timing requirements set by MQD, and may file for a State administrative hearing.

51.110 Recordkeeping

The health plan shall maintain records of its members' grievances and appeals for a period of no less than ten (10) years in accordance with 42 CFR 438.3(u) and this RFP's requirements for recordkeeping and confidentiality of members' medical records.

The record of each grievance or appeal must contain, at a minimum, all of the following information:

- A general description of the reason for the appeal or grievance;
- The date received;
- The date of each review or, if applicable, review meeting;
- Resolution at each level of the appeal or grievance, if applicable;
- Date of resolution at each level, if applicable; and
- Name of the covered person for whom the appeal or grievance was filed.

The record must be accurately maintained in a manner accessible to the State and available upon request to CMS**.**

51.115 Inquiry Process

The health plan shall have an inquiry process to address all inquiries as defined in Section 30.200. As part of this process, the health plan shall ensure that, if at any point during the contact, the member expresses a complaint of any kind, the inquiry becomes a grievance or appeal and the health plan shall give the member, a member's authorized representative, or a provider acting on behalf of the member with the member's consent, their grievance and appeal rights. The inquiry can be in writing or as a verbal request over the telephone.

51.120 Authorized Representative of a Member

Members shall be allowed to authorize another person to represent their interests during any stage of the grievance system process as their authorized representative. The health plan shall submit policies and procedures related to processing of authorization of representation as part of their Grievance System policies and procedures to MQD for review and approval by the due date identified in Section 51.700, Readiness Review to include but not limited their authorized representative form.

Members shall be allowed, in person or by telephone, to verbally identify another person who may communicate with the health plan on the member's behalf, for any matter that does not require a written request or written designation of an authorized representative under this RFP and contract.

51.125 Grievance Process

A grievance may be filed about any matter other than an adverse benefit determination, as defined in Section 30.200. Subjects for grievances include, but are not limited to:

- The quality of care of a provider;
- Rudeness of a provider or a provider's employee; or
- Failure to respect the member's rights regardless of whether remedial action is requested.

Grievance includes a member's right to dispute an extension of time proposed by the health plan to make an authorization decision.

A member or a member's authorized representative may file a grievance orally or in writing with the health plan at any time. The health plan shall accept any grievance filed on the member's behalf from a member's representative even without verbal or written consent of the member. However, the health plan shall send the outcome of any grievance filed by a member's representative without oral or written consent (i.e., AOR form) to the member.

The health plan shall ensure that decision makers on grievances take into account all comments, documents, records, and other information submitted by the enrollee or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

The health plan shall have in place written policies and procedures for processing grievances in a timely manner to include if a grievance is filed by a provider on behalf of the member or member's authorized representative and there is no documentation of a written form of authorization, such as an AOR form.

As part of the grievance system policies and procedures, the health plan shall have in effect mechanisms to: (1) ensure reasonable attempts were made to obtain a written form of authorization; and (2) consult with the requesting provider when appropriate. The health plan shall submit these policies and procedures as part of their Grievance System policies and procedures to MQD for review and approval by the due date identified in Section 51.700, Readiness Review.

In addition to meeting all requirements detailed in Section 51.100, in fulfilling the grievance process requirements the health plan shall:

- Send a written acknowledgement of the grievance within five (5) business days of the member's expression of dissatisfaction;
- Convey a disposition, in writing, of the grievance resolution as expeditiously as the member's health condition requires and within thirty (30) days of the initial expression of dissatisfaction; and

- Include clear instructions as to how to access the State's grievance review process on the written disposition of the grievance.

The health plan's resolution of the grievance shall be final unless the member or member's representative wishes to file for a grievance review with the State.

51.130 State Grievance Review

As part of its grievance system, the health plan shall inform members of their rights to seek a grievance review from the State in the event the disposition of the grievance does not meet the satisfaction or expectations of the member. The health plan shall provide its members with the following information about the State grievance review process:

- Health plan members may request a State grievance review, within thirty (30) days of the member's receipt of the grievance disposition from the health plan. A State grievance review may be made by contacting the MQD office at or mailing a request to:

Med-QUEST Division
Health Care Services Branch
PO Box 700190
Kapolei, HI 96709-0190
Telephone: 808-692-8094

- The MQD shall review the grievance and contact the member with a determination within ninety (90) days from the day the request for a grievance review is received; and
- The grievance review determination made by MQD is final.

51.135 Appeals Process

An appeal may be filed when the health plan issues a notice of action to a health plan member.

A member, a member's authorized representative, or a provider acting on behalf of the member with the member's authorization, may file an appeal within sixty (60) days of the notice of adverse benefit determination. An oral appeal may be submitted in order to establish the appeal submission date; however, this must be followed by a written signed appeal request. The health plan shall assist the member, provider or other authorized representative in this process.

The health plan shall ensure that decision makers on appeal take into account all comments, documents, records, and other information submitted by the enrollee or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

In addition to meeting the general requirements detailed in Section 51.105, the health plan shall:

- Ensure that oral inquiries seeking to appeal an action are treated as appeals and confirmed in writing, unless the member, provider or other authorized representative requests expedited resolutions;
- As part of the grievance system policies and procedures, the health plan shall have in effect mechanisms to ensure reasonable attempts were made to obtain a written confirmation of the appeal;
- Send an acknowledgement of the receipt of the appeal within five (5) business days from the date of the receipt of the written or oral appeal;
- Provide the member and his or her authorized representative a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The health plan must inform the member or the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in §438.408(b) and (c) in the case of expedited resolution;
- Provide the member and his or her authorized representative, upon request, the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the health plan. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals; and
- Include as parties to the appeal, the member and his or her authorized representative, or the legal representative in the case of a deceased member's estate.

For standard resolution of an appeal, the health plan shall resolve the appeal and provide a written notice of disposition to the parties as expeditiously as the member's health condition requires, but no more than thirty (30) days from the day the health plan receives the appeal.

The health plan may extend the resolution time frame by up to fourteen (14) additional days if the member requests the extension, or the health plan shows (to the satisfaction of MQD, upon its request for review) that there is need for additional information and how the delay shall be in the member's best interest. For any extension not requested by a member, the health plan shall give the member written notice of the reason for the delay in two (2) calendar days.

The health plan shall include the following in the written notice of the resolution:

- The results of the appeal process and the date it was completed; and
- For appeals not resolved wholly in favor of the member:
    - The right to request a State administrative hearing with the Administrative Appeals Office (AAO), and clear instructions about how to access this process;
    - The right to request to receive benefits while the hearing is pending and how to make the request; and
    - A statement that the member may be held liable for the cost of those benefits if the hearing decision is not in the member's favor.

The health plan shall notify the member, provider or other authorized representative in writing within thirty (30) days of the resolution.

51.140 Expedited Appeal Process

The health plan shall establish and maintain an expedited review process for appeals. The member, his or her provider or other authorized representative acting on behalf of the member with the member's written authorization may file an expedited appeal either orally or in writing. No additional follow-up shall be required. An expedited appeal is only appropriate when the health plan determines (for a request from the member) or the provider indicates (in making the request on the member's behalf) that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

The health plan shall ensure that punitive action is not taken against a provider who requests an expedited resolution or who supports a member's appeal.

For expedited resolution of an appeal, the health plan shall resolve the appeal and provide written notice to the affected parties as expeditiously as the member's health condition requires, but no more than seventy two (72) hours from the time the health plan received the appeal. The health plan shall make reasonable

efforts to also provide oral notice to the member with the appeal determination.

The health plan shall include the following in the written notice of the resolution:

- The results of the appeal process and the date it was completed; and
- For appeals not resolved wholly in favor of the member:
    - The right to request a State administrative hearing as described in Section 51.150, and clear instructions about how to access this process;
    - The right to request an expedited State administrative hearing;
    - The right to request to receive benefits while the hearing is pending, and how to make the request; and
    - A statement that the member may be held liable for the cost of those benefits if the hearing decision upholds the health plan's action.

The health plan may extend the expedited appeal resolution time frame by up to fourteen additional (14) days if the member requests the extension or the health plan needs additional information and demonstrates to the MQD how the delay shall be in the member's best interest. For any extension not requested by the member or if the health plan denies a request for expedited resolution of an appeal, it shall:

- Transfer the appeal to the time frame for standard resolution;

- Make reasonable efforts to give the member prompt oral notice of the delay or denial;
- Within two (2) days give the member written notice of the reason for the decision to extend the timeframe or deny a request for expedited resolution of an appeal;
- Inform the member orally and in writing that they may file a grievance with the health plan for the delay or denial of the expedited process, if he or she disagrees with that decision; and;
- Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.

The health plan shall notify the MQD within twenty-four (24) hours, regarding expedited appeals if an expedited appeal has been granted by the health plan or if an expedited appeal time frame has been requested by the member or the provider. The health plan shall provide the reason it is requesting a fourteen additional (14) day extension to the MQD. The health plan shall notify the MQD within twenty-four (24) hours (or sooner if possible) from the time the expedited appeal is upheld. The DHS shall provide information on the method of notification to the MQD by the date identified in Section 51.800.

The health plan shall provide the member a reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing. The health plan shall inform the member of limited time available to present this information.

51.145 State Administrative Hearing for Regular Appeals

If the member is not satisfied with the health plan's written notice of disposition of the appeal, he or she may file for a State administrative hearing up to one hundred twenty (120) days from the receipt of the notice of disposition (denial) as part of the member's internal appeal procedure. At the time of the denied appeal determination, the health plan shall inform the member, the member's provider or other authorized representative, or the legal representative of a deceased member's estate that he or she may request information on exhausting the health plan's one level of appeal and the right to a state fair hearing after receiving notice that the adverse benefit determination is upheld. The member, or his or her authorized representative, may access the State administrative hearing process by submitting a letter to the Administrative Appeals Office (AAO) up to one hundred twenty (120) days from the receipt of the member's appeal determination.

In addition to the hearing guidance listed in the Hawaii Administrative Rules (HAR) §17-1703.1, the following shall be added in accordance with 42 CFR 431.220 and 42 CFR 431.244.

1. Member's claim for services is denied or is not acted upon with reasonable promptness
2. Member believes the health plan has taken an action erroneously
3. Member believes a skilled nursing facility or nursing facility has erroneously determined that he or she must be transferred or discharged

4. Member believes the State has made an erroneous determination with regards to the preadmission and annual resident review requirement of section 1919(e)(7) of the Act

5. Member in a non-emergency medical transportation PAHP (as defined in 42 CFR §438.9) who has an action.

Hearing Decisions must be based exclusively on evidence introduced at the hearing as reiterated below:

1. The transcript or recording of testimony and exhibits, or an official report containing the substance of what happened at the hearing;
2. All papers and requests filed in the proceeding; and
3. The recommendation or decision of the hearing officer**.**

The health plan shall provide the following address to the members:

State of Hawaii Department of Human Services
Administrative Appeals Office
PO Box 339
Honolulu, HI 96809-0339

The State shall reach its decision within ninety (90) days of the date the member filed the request for an administrative hearing with the State. The disposition of the appeal at the State administrative hearing level shall prevail.

51.150 Expedited State Administrative Hearings

The member may file for an expedited State administrative hearing only when the member requested or the health plan has provided an expedited appeal and the action of the appeal was determined to be adverse to the member (Action Denied). The member may file for an expedited State administrative hearing process by submitting a letter to the Administrative Appeals Office (AAO) within one hundred twenty (120) days from the receipt of the member's appeal determination.

The health plan shall provide the following address to the members:

State of Hawaii Department of Human Services
Administrative Appeals Office
PO Box 339
Honolulu, HI 96809-0339

An expedited State administrative hearing must be heard and determined within three (3) business days after the date the member filed the request for an expedited State administrative hearing with no opportunity for extension on behalf of the State. The health plan shall collaborate with the State to ensure that the best results are provided for the member and to ensure that the procedures comply with State and Federal regulations.

In the event of an expedited State administrative hearing the health plan shall submit information that was used to make the determination, (e.g. medical records, written documents to and from the member, provider notes, etc.). The health plan shall submit this information to the MQD within twenty-four (24) hours of the decision denying the expedited appeal.

51.155 Continuation of Benefits During an Appeal or State Administrative Hearing

A member or a member's authorized representative may request for a continuation of benefits. The health plan shall continue the member's benefits if the following conditions have been met:

- The member timely files for continuation of benefits, meaning on or before the later of the following;
  - Within ten (10) days of the health plan mailing the notice of adverse benefit determination; or
  - The intended effective date of the health plan's proposed adverse benefit determination.
- The appeal or request for State administrative hearing is filed in a timely manner.
- The appeal or request for State administrative hearing involves the termination, suspension, or reduction of a previously authorized services;
- The services were ordered by an authorized provider; and
- The original authorization period has not expired.

If the health plan continues or reinstates the member's benefits while the appeal or State administrative hearing is pending, the health plan shall continue all benefits until one of the following occurs:

- The member withdraws the appeal or request for a State administrative hearing;
- The member does not request a State administrative hearing within ten (10) days from when the health plan

mails a notice of an adverse benefit determination; or

- A State administrative hearing decision unfavorable to the member is made.~~; or~~

If the final resolution of the appeal or State administrative hearing is adverse to the member, that is, upholds the health plan's adverse benefit determination, the health plan may, consistent with the State's usual policy on recoveries and as specified in the health plan's contract, recover the cost of services furnished to the member while the appeal and State administrative hearing were pending, to the extent that they were furnished solely because of the requirements of this section.

If the health plan or the State reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the health plan shall authorize or provide these disputed services promptly, and as expeditiously as the member's health condition requires, but no later than seventy two (72) hours from the date it receives notice reversing the determination.

If the health plan or the State reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the health plan shall pay for those services.

51.165 Notice of Adverse Benefit Determination

The health plan shall give the member and the referring provider a written notice of an adverse benefit determination within the

time frames specified below. The notice to the member or provider shall include the following information:

- The adverse benefit determination the health plan has made or intends to make;
- The reason for the adverse benefit determination, including the right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits;
- The member's or provider's right to an appeal with the health plan;
- The member's or provider's right to request an appeal;
- Procedures for filing an appeal with the health plan;
- Member may represent himself or use legal counsel or an authorized representative;
- The circumstances under which an appeal process can be expedited and how to request it; and
- The member's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with State policy, under which the member may be required to pay the costs of these services.

The notice of action to the member shall be written pursuant to the requirements in Section 50.430 of this RFP.

The health plan shall mail the notice within the following time frames:

- For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least ten (10) days prior to the date the adverse benefit determination is to start except:
    - By the date of action for the following reasons:
        - The health plan has factual information confirming the death of a member;
        - The health plan receives a clear written statement signed by the member that he or she no longer wishes services or gives information that requires termination or reduction of services and indicates that he or she understands that this must be the result of supplying that information;
        - The member has been admitted to an institution that makes him or her ineligible for further services;
        - The member's address is unknown and the post office returns health plan mail directed to the member indicating no forwarding address;
        - The member has been accepted for Medicaid services by another local jurisdiction;
        - The member's provider prescribes a change in the level of medical care;
        - There has been an adverse determination made with regard to the preadmission screening

requirements for nursing facility admissions on or after January 1, 1989; or

- In the case of adverse actions for nursing facility transfers, the safety or health of individuals in the facility would be endangered, the member's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the member's urgent medical needs, or the member has not resided in the nursing facility for thirty (30) days.

- The period of advanced notice is shortened to five (5) days if there is alleged fraud by the member and the facts have been verified, if possible, through secondary sources.

- For denial of payment: at the time of any action affecting the claim.
- For standard service authorization decisions that deny or limit services: as expeditiously as the member's health condition requires, but not more than fourteen (14) days following receipt of request for service, with a possible extension of up to fourteen (14) additional days (total time frame allowed with extension is twenty-eight (28) days from the date of the request for services) if: (1) the member or provider requests an extension; or (2) the health plan justifies a need for additional information and how the extension is in the member's best interest. If the health plan extends the time frame, it must: (1) give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a

grievance if he or she disagrees with that decision to extend the time frame; and (2) issue and carry out its determination as expeditiously as the member's health condition requires but no later than the date the extension expires.

- For expedited authorization decisions: as expeditiously as the member's health condition requires but no later than seventy two (72) hours after receipt of the request for service. The health plan may extend the seventy two (72) hour timeframe by up to an additional fourteen (14) calendar days if the member requests an extension, or if the health plan justifies to the DHS a need for additional information and how the extension is in the member's best interest.

For service authorization decisions not reached within the time frames specified above (which constitute a denial and, thus, an adverse benefit determination), on the date that the timeframes expire.

51.200 Information Technology

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 the Health Insurance Portability and Accountability Act (HIPAA).

51.220 Expected Functionality

The DHS expects health plan information systems to facilitate and to integrate the following essential health plan service coordination functions: (1) member health status assessments (both HFA and for LTSS); (2) determination of the optimal mix of health care services needed to improve the health status of said members; (3) service plan in a concise printable or electronic format; (4) coordination and oversight of the delivery of said services; and (5) the analysis and reporting of service utilization and outcomes data required to manage these functions effectively.

To achieve this objective, the health plan shall have a system capable of adapting to DHS formats, sharing information electronically with DHS, and readily accessible yet secured information systems that enable the efficient execution of the aforementioned functions.

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. Specific technical specifications and instructions are provided in the HPMMIS Health Plan Manual available on the Med-QUEST web site. The SFT server allows the MQD and the health plan to securely transfer member, provider, and encounter data via the internet.

51.240 Compliance with the Health Insurance Portability and Accountability Act (HIPAA)

The health plan shall implement the electronic transaction and code set standards and other "Administrative Simplification" provisions, privacy and security provisions of HIPAA, Public Law 104-191, as specified by CMS.

51.250 Possible Audits of Health Plan Information Technology

The health plan shall institute processes to ensure the validity and completeness of the data submitted to the DHS. The DHS or its contractors may conduct general data validity and completeness audits using industry standard sampling techniques. The DHS reserves the right to have access to the health plan's system at any time when deemed necessary under this contract.

51.260 Health Plan Information Technology Changes

The health plan shall notify the DHS and obtain prior approval for any proposed changes to its information system that could impact any process or program under this contract.

51.270 Disaster Planning and Recovery Operations

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. The health plan shall provide the DHS with a copy of its documentation describing its disaster planning and recovery operations by the due date identified in Section 51.700, Readiness Review.

51.280 Health Information Exchange

The health plan shall be able to provide administrative data on a patient's utilization including diagnoses, procedures, and service location to an individual's PCP or his or her designee to improve care management. In addition, the health plan shall participate in the state-designated entity's health information exchange to accept claim submission, quality measure reporting, and other exchange of clinical information in order to improve care for the member.

51.300 Fraud & Abuse

51.310 General Requirements

The health plan shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud and abuse activities. This should include a description of the specific controls in place for prevention and detection from potential or suspected fraud and abuse, such as: claims edits, post-processing review of claims, prior authorization, written provider and member material regarding fraud and abuse referrals. In addition, as part of these internal controls and policies and procedures, the health plan shall have ways to verify services were actually provided using random sampling of all members though VOS requirements identified in Section 50.455. The health plan shall have a compliance officer and sufficient staffing (as required in Section 51.400) and resources to identify and investigate unusual incidents and develop and implement corrective action plans to assist the health plan in preventing and detecting potential fraud and abuse activities. The health plan shall

describe its organizational arrangement identifying personnel roles and responsibilities for preliminary investigation(s) of provider fraud and abuse. The health plan's fraud and abuse activities shall comply with the program integrity requirements outlined in 42 CFR Section 438.608.

For the purposes of this section, waste, abuse, and fraud shall have the following definitions:

- Waste: Overutilization, underutilization, or misuse of resources and typically is not a criminal or intentional act.
- Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. All suspected fraud and abuse committed by a member should be reported to the appropriate entity. The health plan shall report eligibility fraud affecting medical assistance to the Investigations Office (INVO) of the Benefit, Employment and Support Services Division (BESSD). The reporting shall be done either through written notification or a telephone call to the INVO

Hotline. The health plan shall report member fraud for instances such as fraudulently obtaining controlled substances, other medical services, or collusion between provider and member to obtain services to the DSH after a preliminary investigation is complete.

The health plan and all subcontractors shall cooperate fully with Federal and State agencies in investigations and subsequent legal actions to include but not limited to the DHS and the Secretary. Such cooperation shall include providing, upon request, information, access to records, access to claims, and access to interview health plan employees and consultants, including but not limited to those with expertise in the administration of the program and/or medical or pharmaceutical questions or in any matter related to an investigation.

51.320 Reporting and Investigating Suspected Provider Fraud, Waste and Abuse

If the health plan becomes aware of suspected fraud, waste or abuse from any source or identifies any questionable practices, it shall conduct a preliminary investigation. Criminal intent to commit fraud is not determined by either the MQD or the health plan. Based on all the evidence gathered, the MQD or the health plan only determines that an identified activity has the potential to be fraudulent and is not the result of an unintentional error. Health plans are required to report all plausible incidences of suspected fraud or abuse to the MQD, promptly, within two weeks (14 calendar days) of making such a determination. It is possible the health plan may need to report the suspected activity immediately, such as when patient safety is at risk,

evidence is being destroyed, or there is ongoing significant monetary loss.

The health plan shall use the report form to be provided by the DHS to report or refer suspected cases of Medicaid fraud or abuse. At a minimum, this form shall require the following information for each case:

- Subject (Name and ID number);
- Source of complaint;
- Type of provider;
- Health plan contact;
- Contact information for health plan staff with practical knowledge of the workings of the relevant programs;
- Date reported to state;
- Description of suspected intention misconduct, with specific details;
    - Category of service.

    - Factual explanation of the allegation. (The health plan (HP) should provide as much detail as possible concerning the names, positions and contact information of all relevant persons; a complete description of the alleged scheme as it is understood by the HP, including, when possible, one or more examples of specific claims that are believed to be fraudulent; the manner in which the HP came to learn of the conduct; and the actions

taken by the HP to investigate the allegations.)

- Date(s) of conduct. (When exact dates are unknown, the HP should provide its best estimate.)

- Specific statutes, rules, regulations, or policies violated includes all applicable for Federal/Medicaid as well as health plan policies;
- Amount paid to the provider during the past 3 years or during the period of the alleged misconduct, whichever is greater;
- Sample/exposed dollar amount when available;
- Legal and administrative disposition of the case; and

Copies of any and all communications between the health plan and the provider concerning the conduct at issue (including, provider enrollment documentation, and any education given to the provider as a result of past problems; as well as advisory bulletins, policy updates, or any other general communication to the provider community regarding questionable behavior. Letters, emails, faxes, memos, and phone logs are all sources of communication).

In addition to the information required on the form, this report shall include any and all evidence obtained in the preliminary investigation including but not limited to, copies of claims and medical records reviewed, summary of interviews conducted, and copies of audit results or review board determinations.

Once the health plan has determined the activity has the potential to be fraudulent, it shall not contact the provider who is the subject of the investigation about any matters related to the investigation, enter into or attempt to negotiate any settlement or agreement, or accept any monetary or other thing of valuable consideration offered by the provider who is the subject of the investigation in connection with the incident.

In addition the health plan is required to recover or report all overpayments. "Overpayment" as used in this section is defined in 42 CFR 438.2. All overpayments identified by the health plan shall be reported to DHS as specified in section 51.500. The overpayment shall be reported in the reporting period in which the overpayment is identified. It is understood the health plan may not be able to complete recovery of overpayment until after the reporting period. The health plan must report to DHS the full overpayment identified. The health plan may negotiate and retain a lesser repayment amount with the provider, however, the full overpayment amount will be used when setting capitation rates for the health plan. The health plan shall have in place a process for providers to report to the health plan when it has received an overpayment, and a process for the provider to return the overpayment to the health plan within 60 calendar days after the date on which the overpayment was identified. The health plan shall require the provider to notify the health plan in writing of the reason for the overpayment. DHS, or its contractor, may recover any overpayments made to the health plan, and the method of recovery shall be determined by DHS.

The health plan shall also report annually to DHS on all recoveries as specified in section 51.500. This report shall specify overpayments identified as fraud, waste, and abuse. The health plan shall check the reporting of overpayments recoveries for accuracy and shall provide such accuracy report to the DHS upon request. The health plan shall certify that the report contains all overpayments and those overpayments are reflected in either the claims data submitted in the report, or listed as an itemized recovery.

The health plan is prohibited from recovering overpayments that are being investigated by the State, are the subject of pending Federal or State litigation or investigation, or are being audited by the Hawaii Recovery Audit Contractor (RAC) or other State contracted auditor. Once the health plan receives notice from DHS or other State or Federal agency of such action, the health plan shall cease any ongoing recovery efforts and coordinate with the notifying agency. Recoveries retained under False Claims Act cases or through other investigations are not subject to this policy.

If DHS determines there is a credible allegation of fraud against a provider, payments to the provider must be suspended absent a good cause exception. DHS will be responsible for the determination of a credible allegation of fraud and any good cause exception. The DHS will notify the health plan in writing if payments to a provider are to be suspended and the effective date of the payment suspension. The health plan shall have in place policies and controls to prevent payments to providers under

payment suspension. DHS will notify the health plan in writing if the payment suspension may be terminated. If the health plan fails to suspend payments to a provider after being notified in accordance with this section, any payments made to the provider during the effective suspension may be recovered from the health plan, and sanctions may be imposed in accordance with section 72.200.

51.330 Compliance Plan

The health plan shall have a written fraud and abuse compliance plan that shall have stated program goals and objectives, stated program scope, and stated methodology. Refer to CMS publications: "Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care", A product of the National Medical Fraud and Abuse Initiative, October 2000 as well as the CMS publication: "Guidelines for Constructing a Compliance Program for Medicaid and Prepaid Health Plans", a product of the Medicaid Alliance for Program Safeguards, May 2002 for reference regarding Compliance Plans. The health plan shall submit its compliance plan to the DHS for review and approval by the due date identified in Section 51.700, Readiness Review.

At a minimum, the health plan's fraud and abuse compliance plan shall:

- Require the reporting of suspected and/or confirmed fraud and abuse be done as required in Sections 51.310 and 51.320;

- Submit health plan disclosures timely as described in Section 51.570.6;
- Ensure that all of its officers, directors, managers and employees know and understand the provisions of the health plan's fraud and abuse compliance plan;
- Have processes in place to monitor all providers and their officers/directors/agents/managing employees as described in Sections 40.210 and 40.400;
- Require the designation of a compliance officer and a compliance committee that are accountable to senior management;
- Ensure and describe effective training and education for the compliance officer and the organization's employees;
- Ensure that providers and members are educated about fraud and abuse identification and reporting, and include information in the provider and member material;
- Ensure effective lines of communication between the compliance officer and the organization's employees;
- Ensure the enforcement of standards through well-publicized disciplinary guidelines;
- Ensure provision of internal monitoring and auditing with provisions for prompt response to potential offenses, and for the development of corrective action initiatives relating to the health plan's fraud and abuse efforts;
- Possess written policies, procedures and standards of conduct that articulate the organization's commitment to comply with all Federal and State standards related to Medicaid managed care organizations;

- Ensure that no individual who reports health plan violations or suspected fraud and abuse is retaliated against;
- Include a monitoring program that is designed to prevent and detect potential or suspected fraud and abuse. This monitoring program shall include but not be limited to:
    - Monitoring the billings of its providers to ensure members receive services for which the health plan is billed;
    - Requiring the investigation of all reports of suspected fraud and over billings (upcoding, unbundling, billing for services furnished by others, and other overbilling practices);
    - Reviewing providers for over-utilization or under-utilization;
    - Verifying with members the delivery of services as claimed; and
    - Reviewing and trending consumer complaints on providers;
- Ensure that all suspected instances of internal and external fraud and abuse relating to the provision of, and payment for, Medicaid services including, but not limited to, health plan employees/management, providers, subcontractors, vendors, be reported to DHS. Additionally, any final resolution reached by the health plan shall include a written statement that provides notice to the provider that the resolution in no way binds the State of Hawaii nor precludes the State of Hawaii from taking further action for the circumstances that brought rise to the matter; and

- Ensure that the health plan shall cooperate fully in any investigation by federal and state oversight agencies and Federal and State law enforcement agencies and any subsequent legal action that may result from such an investigation.

51.340 Employee Education About False Claims Recovery

The health plan shall comply with all provisions of Section 1902(a)(68) of the Social Security Act as it relates to establishing written policies for all employees (including management), and of any subcontractor or designee of the health plan, that includes the information required by Section 1902(a)(68) of the Social Security Act.

51.350 Child and Adult Abuse Reporting Requirements

The health plan shall report all cases of suspected child abuse to the Child Welfare Services Section of the DHS, and all suspected dependent adult abuse to the Adult Protective Services Section of the DHS as required by State and Federal statutes.

The health plan shall ensure that its network providers report all cases of suspected child abuse to the Child Welfare Services Section of the DHS, and all suspected dependent adult abuse to the Adult Protective Services Section of the DHS as required by State and Federal statutes.

51.400 Health Plan Personnel

51.410 General Requirements

The health plan shall have in place, either directly or indirectly, the organizational, management and administrative systems capable of fulfilling all contractual requirements.

For the purposes of this contract, the health plan shall not employ or contract with any individual that has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity or from participating in non-procurement activities under Section 103D-702, HRS; has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid, or title XXI program in the last 10 years; and has been excluded through Federal databases to include but not limited to LEIE, SAM, or any such databases.

The health plan is responsible for operating its health plan in the State of Hawaii. The health plan shall have an office on each island that they are providing services to at least 5,000 members. The office shall be open during regular business hours (i.e., Monday to Friday 7:45 am to 4:30 pm excluding State holidays) to provide face-to-face customer service to the health plan's members.

The following table represents a listing of required staff. Specifically, the health plan shall have all positions marked "Yes" in the "Hawaii" column in the table below filled by individuals residing and working full-time in the State of Hawaii. As part of this request, the health plan shall include a description of the processes in place that assure rapid responsiveness to effect

changes for contract compliance. The health plan shall be solely responsible for any additional charges associated with on-site audits or other oversight activities that result when required systems and activities are located outside of the State of Hawaii.

For those positions where there is a "Yes" in the "report if person in position changes" column in the table below, the health plan shall notify the MQD in writing within seven (7) days of learning of an intended resignation or other change in the status of the position. The health plan shall include the name of the interim contact person in the notification. In addition, the health plan shall, upon DHS request, provide a written plan for filling the vacant position, including expected timelines. The name of the permanent employee shall be submitted as soon as the new hire has occurred.

The health plan shall submit a resume and job description for all positions marked "Yes" in the resume column. The job description shall identify the education and experience requirements as well as the requirements for fulfilling the position requirements. For those positions not requiring a resume, the health plan shall submit job descriptions.

Some positions indicate the number of FTE that shall be required for this procurement. For example, a 1.0 FTE is a person that only performs work on this procurement. A 0.5 FTE can perform other work duties other than this procurement.

Positions	Resume (Y/N)	Hawaii (Y/N)	Report if person in position changes (Y/N)
Administrator/CEO/COO/Executive Director of members not receiving LTSS (1.0 FTE)	Yes	Yes	Yes
Administrator/CEO/COO/Executive Director of members receiving LTSS (1.0 FTE)	Yes	Yes	Yes
Medical Director (1.0 FTE)	Yes	Yes	Yes
Financial Officer/CFO	Yes	Yes	Yes
Quality Management Coordinator (1.0 FTE)	Yes	Yes	Yes
Behavioral Health Coordinator (0.5 FTE)	Yes	Yes	Yes
Pharmacy Coordinator/ Director/ Manager (1.0 FTE)	Yes	Yes	Yes
Prior Authorization/Utilization Management/Medical Management Director (1.0 FTE)	Yes	Yes	Yes
Prior Authorization/Utilization Management/Medical Management/Concurrent Review Staff	No	Yes Not less than 6 positions	No
EPSDT Coordinator (1.0 FTE)	Yes	Yes	Yes
Member Services Director (1.0 FTE)	Yes	Yes	Yes
Member Services' staff (to include call center staff)	No	Yes Not less than 6 positions	No
Service Coordinator Director (1.0 FTE)	Yes	Yes	Yes
Service Coordinator Managers	Yes	Yes 1 per county of service provision	Yes
Service Coordinators	No	Yes Adequate to meet staffing ratios defined in Section 40.910	No

Positions	Resume (Y/N)	Hawaii (Y/N)	Report if person in position changes (Y/N)
Provider Services/Contract Manager (1.0)	Yes	Yes	Yes
Provider Services/Contract staff	No	Yes Not less than 8 positions	No
Claims Administrator/Manager*	No	No	Yes
Claims Processing Staff	No	No	No
Encounter processors	No	No	No
Grievance Coordinator (1.0 FTE)	Yes	Yes	Yes
Credentialing Program Coordinator	Yes	No	Yes
Business continuity planning and recovery coordinator	Yes	No	Yes
Compliance Officer (1.0 FTE)	Yes	Yes	Yes
Information Technology (IT) Director or Chief Information Officer (CIO)	Yes	No	Yes
IT Hawaii Manager	Yes	Yes	Yes
IT Staff	No	Not less than 2 positions	No

* The Claims Administrator/Manager does not need to reside in Hawaii as long as there is a manager in Hawaii (i.e., Provider Services Manager) who can address claims issues during Hawaii business hours.

The health plan shall ensure that all staff have the necessary qualifications (i.e., education, skills, and experience) to fulfill the requirements of their respective positions. The health plan shall conduct initial and ongoing training of all staff to ensure they have the education, knowledge and experience to fulfill the requirements of this contract.

Except as otherwise noted, a specific number of staff or FTEs are not required; the health plan shall ensure that adequate staff is

available and assigned to appropriate areas to fulfill the required functions specified in this contract. The health plan shall increase staffing in specific areas if determined by DHS that contractual requirements are not being met.

The health plan shall submit both a staffing and training plan to include the staffing for the QUEST Integration line of business to the DHS for review and approval by the due date identified in Section 51.700, Readiness Review.

51.420 Specific Descriptions

The health plan shall have at least two dedicated employees (e.g., Administrator, Chief Executive Officer, Chief Operating Officer, Executive Director, etc.) who have clear authority over the general administration and day-to-day business activities of this RFP. One dedicated employee for the members who are not receiving LTSS and one dedicated employee for the members who are receiving LTSS (both institutional and non-institutional LOC).

The health plan shall have on staff a Medical Director licensed to practice medicine in the State of Hawaii. The Medical Director shall oversee the quality of care furnished by the health plan and ensure care is provided by qualified medical personnel. The Medical Director shall address any potential quality of care problems and direct QAPI activities. The Medical Director shall work closely with the MQD Medical Director and participate in DHS Medical Director meetings, Provider Advisory Board meetings and

any committee meetings relating to the programs when requested by the DHS.

The health plan shall have a chief financial officer who is responsible for all accounting and finance operations, including all audits.

The health plan shall have a quality management coordinator or director who is responsible for all quality improvement activities. This person shall be a physician or registered nurse licensed in the State of Hawaii.

The behavioral health coordinator shall be responsible for all behavioral health services. This person shall be a physician, psychologist, registered nurse (may have additional training, e.g., advanced practice nurse practitioner), or licensed clinical social worker licensed in the State of Hawaii with experience related to the behavioral health population.

The health plan shall have an employed or contracted pharmacy coordinator/director/manager. This person shall be a licensed pharmacist in the State of Hawaii and shall serve as a contact for the health plan's providers, pharmacists, and members.

The health plan shall have a prior authorization/utilization management/medical management director. This person shall oversee all activities related to prior authorizations and concurrent and post-payment reviews, to include UM line personnel. In

addition, this person shall be responsible for overseeing the hiring, training and work of all line personnel performing these functions.

The health plan shall have an EPSDT coordinator who is responsible for overseeing all EPSDT activities. This person shall serve as the liaison to the State of Hawaii for these activities.

The health plan shall have a member services director who is responsible for all member services activities, including but not limited to call center staffing, member handbook updates, and translation activities. In addition, this person shall oversee the hiring, training and work of all line personnel performing member services functions.

The health plan shall have a service coordinator director and managers who are responsible for all service coordinator activities including but not limited to assessments, service plan development, self-direction, and addressing concerns of their members. The director and managers should be either a registered nurse or licensed social worker who has experience with serving LTSS members in the community.

The health plan shall have a provider services manager who is responsible for the provider network activities and provider education. This person shall oversee the hiring, training and work of all line personnel performing provider services functions.

The health plan shall have a grievance coordinator who oversees all member grievance system activities. This person shall also be responsible for the provider grievance and appeals system.

The health plan shall have a compliance officer who is responsible for all fraud and abuse detection activities, including the fraud and abuse compliance plan.

The health plan shall have an IT director who is responsible for all IT activities. This person need not be located in the State of Hawaii; however, if he or she is not, the health plan shall have an IT Hawaii manager who is located in the State of Hawaii. If the IT director lives in Hawaii, then the health plan does not need to have an IT manager.

51.500 Reporting Requirements

51.510 General Requirements

The health plan shall submit to the DHS all requested reports identified below and in the time frames identified in this Section. 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 this Section.

All reporting data shall be submitted to the DHS in electronic format of either Word 2010 or lower (.docx), or Excel 2010 or lower (.xlsx). Reporting data shall not be submitted in .pdf files,

with read only, or protected formatting. All reporting data shall be provided to the Health Care Services Branch (HCSB) within the Med-QUEST Division who will then distribute internally as required.

As described in Section 51.610, the DHS may impose financial penalties for failure to submit accurate or complete reports according to the time frames identified; submit electronic reports in .pdf or read only formatting; fail to submit reports in electronic format; or send reports to other branches or offices other than HCSB.

Data received from the health plan on quality, performance, patient satisfaction, or other measures shall be used for monitoring, public reporting, and financial incentives. DHS shall also share information among health plans to promote transparency and sharing of benchmarks/best practices. DHS shall publicly report measures in formats such as a consumer guide, public report, or otherwise, on MQD's website in accordance with 42 CFR 438.602(g).

The health plan shall submit the following reports electronically to the DHS via the health plans File Transfer Protocol (FTP) site according to the specified schedule. The HCSB shall distribute the reports internally within the MQD to the required reviewer.

Category	Report	RFP Section	Due Dates	Reviewer
Provider Network/ Services	Provider Network Adequacy and Capacity Report	51.520.1	April 30 July 31 October 31 January 31	HCSB
Provider Network/ Services	GeoAccess or Similar Report	51.520.2	April 30 July 31 October 31 January 31	HCSB
Provider Network/ Services	PCP Assignment Report	51.520.3	The 15th of each month	HCSB
Provider Network/ Services	Timely Access Report	51.520.4	April 30 July 31 October 31 January 31	HCSB
Provider Network/ Services	FQHC or RHC Services Rendered Report- Annual	51.520.5	May 31	Finance Office (FO)
Provider Network/ Services	FQHC or RHC Services Rendered Report- Quarterly	51.520.5	April 30 July 31 October 31 January 31	FO
Provider Network/ Services	Provider Suspensions and Terminations	51.520.6	Within three business days of suspension or termination	Finance- Fiscal Integrity Staff (FIS)
Provider Network/ Services	Provider Suspensions and Terminations Report	51.520.6	April 30 July 31 October 31 January 31	HCSB and Finance- FIS
Provider Network/ Services	Provider Grievance and Claims Report	51.520.7	April 30 July 31 October 31 January 31	HCSB
Provider Network/ Services	Value-Driven Health Care	51.520.8	April 30 July 31 October 31 January 31	Clinical Standards Office (CSO)

Category	Report	RFP Section	Due Dates	Reviewer
Covered Benefits and Services	CMS 416 Report-EPSDT	51.530.1	February 28	HCSB
Covered Benefits and Services	Long Term Services and Supports (LTSS) Reports	51.530.2	April 30 July 31 October 31 January 31	HCSB
Covered Benefits and Services	Going Home Plus Reports	51.530.3	April 15 July 15 October 15 January 15	HCSB
Member Services	Call Center Report	51.540.1	April 30 July 31 October 31 January 31	HCSB
Member Services	Interpretation Services Report	51.540.2	April 15 July 15 October 15 January 15	HCSB
Member Services	Requests for Documents in Alternate Languages Report	51.540.3	April 15 July 15 October 15 January 15	HCSB
Member Services	Member Grievance and Appeals Report	51.540.4	April 30 July 31 October 31 January 31	HCSB
Member Services	CAHPS® Consumer Survey	51.540.5	Annually, if applicable	HCSB
Member Services	Special Health Care Needs Report	51.540.6	April 30 July 31 October 31 January 31	HCSB
Member Services	1179 Summary of Change of Member Demographics	51.540.7	The 15th of each month	Eligibility Branch (EB)

Category	Report	RFP Section	Due Dates	Reviewer
Member Services	ADRC Report	51.540.8	April 30 July 31 October 31 January 31	Clinical Standards Office (CSO)
QAPI Program	Accreditation Update	51.550.1	April 30 July 31 October 31 January 31	HCSB
QAPI Program	QAPI Program Report	51.550.2	June 15	HCSB
QAPI Program	PIP Report	51.550.3	July 1	HCSB
QAPI Program	Healthcare Effectiveness Data and Information Set (HEDIS) Report	51.550.4	June 15	HCSB
UM/PA	Prior Authorization Requests Denied/ Deferred Report	51.560.1	April 30 July 31 October 31 January 31	HCSB
UM/PA	Report of Over-utilization and Under- Utilization of Drugs	51.560.2	April 30 July 31 October 31 January 31	CSO
UM/PA	Report of Over-utilization and Under- Utilization of Services	51.560.3	April 30 July 31 October 31 January 31	HCSB
Admini-stration & Financial	Fraud, Waste, and Abuse Summary Report	51.570.1	April 30 July 31 October 31 January 31	Finance- FIS
Admini-stration & Financial	Provider Education & Training Report	51.570.2	April 30 July 31 October 31 January 31	Finance-FIS
Admin-stration & Financial	Employee Suspension and Termination Report	51.570.3	April 30 July 31 October 31 January 31	Finance-FIS

Category	Report	RFP Section	Due Dates	Reviewer
Administration & Financial	QUEST Integration Financial Reporting Guide	51.570.4	May 15 August 15 November 15 February 28 Annual report April 30 calendar fiscal year October 31 State fiscal year	Finance
Administration & Financial	TPL Cost Avoidance Report	51.570.5	The 15th of each month and quarterly	Finance
Administration & Financial	Disclosure of Info on Annual Business Transaction	51.570.6	Annually and within thirty (30) days after any change in ownership of the health plan	Finance
Administration & Financial	Encounter Data/Financial Summary Reconciliation Report	51.570.7	April 30 July 31 October 31 January 31	Finance
Administration & Financial	Medicaid Contracting Report	51.570.8	December 31	HCSB
Administration & Financial	QUEST Integration Dashboard	51.570.9	The 15th of each month	HCSB
Administration & Financial	Medical Loss Ratio Report	51.570.10	First day of the 10th month in the year following the service year	Finance-FIS
Member Services	Mental Health and Substance Use Disorder Parity Report	51.570.11	January 31	HCSB

Category	Report	RFP Section	Due Dates	Reviewer
Admini-stration & Financial	Overpayments Report	51.570.12	Last day of February	Finance-FIS

Additional information about the contents of each report is provided below. The health plan shall be submit each report described below using a format provided by the DHS.

51.520 Provider Network and Service Reports

51.520.1 Provider Network Adequacy and Capacity Report

The health plan shall submit a *Provider Network Adequacy and Capacity Report* that demonstrates that the health plan offers an appropriate range of preventive, primary care, specialty services, and LTSS that 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.

The health plan shall submit these reports on electronic media in the format specified by the DHS. The information shall, at a minimum, include:

- A listing of all providers and include the specialty or type of practice of the provider;
- The provider's location;
- Mailing address including the zip code;
- Telephone number;
- Professional license number and expiration date;

- Number of members from its plan that are currently assigned to the provider (PCPs only);
- Indication as to whether the provider has a limit on the number of the patients he/she will accept;
- Indication as to whether the provider is accepting new patients;
- Foreign language spoken (if applicable);
- Verification of valid license for in-state and out-of-state providers;
- Verification that provider or affiliated provider is not on the Federal or State exclusions lists; and
- Verification that officers/directors/anyone with a controlling interest/managing employees are not on the Federal or State exclusions lists.

The health plan shall provide a narrative that describes the health plan's strategy to maintain and develop their provider network to include but not limited to:

- Take into account the numbers of network providers who are not accepting new patients;
- Consider the geographic location of providers and members, considering distance, travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for members with disabilities;
- Current network gaps and the methodology used to identify them;
- Immediate short-term interventions when a gap occurs including expedited or temporary credentialing; and

- Interventions to fill network gaps and barriers to those interventions.

51.520.2 GeoAccess (Or Similar Program) Reports

The health plan shall submit reports using GeoAccess or similar software that allow DHS to analyze, at a minimum, the following:

- The number of providers by specialty and by location with a comparison to the zip codes of members;
- The number of providers by specialty and by location that are accepting new members with a comparison to the zip codes of members;
- Number of members from its plan that are currently assigned to the provider (PCPs only);
- Indication as to whether the provider has a limit on the number of QUEST Integration program members he/she will accept;
- Indication as to whether the provider is accepting new patients; and
- Non-English languages spoken (if applicable).

The health plan shall assure that the providers listed on the GeoAccess reports are the same providers that are described in the Provider Network Adequacy and Capacity Report.

In addition to the due date as identified in Section 51.510, these reports shall be submitted to the DHS at the following times:

- Upon the DHS request;
- Upon enrollment of a new population in the health plan;
- Upon changes in services, benefits, geographic service area, composition of or payment to its provider network; and
- Any time there has been a significant change in the health plan's operations that would affect adequate provider capacity and services. A significant change is defined as any of the following:
    - A decrease in the total number of PCPs by more than five percent (5%) per island (for the island of Hawaii the health plan shall report on this for East Hawaii and West Hawaii);
    - A loss of providers in a specific specialty where another provider in that specialty is not available on the island;
    - A loss of a hospital; or
    - Enrollment of a new population in the health plan.

51.520.3 PCP Assignment Report

The health plan shall submit *PCP Assignment Report* that provide the following information on activities from the previous month:

- The total number serving as a PCP to include the PCP to member ratio;
- The number and percent of members that chose or were auto-assigned to a PCP;
- The number of PCP change requests received and processed;

- The medical specialties with the largest number of PCP assignments; and
- Information on the highest utilized PCP.

51.520.4 Timely Access Report

The health plan shall submit *Timely Access Report* that monitor the time lapsed between a member's initial request for an appointment and the date of the appointment. The data may be collected using statistically valid sampling methods (including periodic member and provider surveys). Using data collected during the previous quarter, the report shall include the:

- Total number of appointment requests;
- Total number and percent of requests that meet the waiting time standards identified in Section 40.230 (for each provider type/class, e.g., specialists, PCP adult, PCP pediatric sick, etc.);
- Total number and percent of requests that exceed the waiting time standards (for each provider type/class);
- Average wait time for PCP routine visits; and
- Average wait time for requests that exceed the waiting time standards (for each provider type/class).

If the health plan is not meeting timely access in any one area (i.e., specialists), the DHS may require additional data collection (i.e., a report by specialty type).

51.520.5 FQHC or RHC Services Rendered Report

The health plan shall submit *FQHC or RHC Services Rendered Report.* The report shall provide data on activities during the quarter and calendar year (January through December) and shall include the following information:

- The contract status of the FQHC/RHC (i.e., if the FQHC is participating or non-participating as a provider in the health plan's network);
- The total dollar amount of payments made to an FQHC/RHC, listed by FQHC/RHC;
- All visits and payments (including capitated payments) made to any FQHC/RHC, regardless of whether the FQHC/RHC is included in the health plan's contracted provider network; and
- The number of unduplicated visits provided to the health plan's members.

51.520.6 Provider Suspensions and Termination Report

The health plan shall notify the DHS within three (3) business days of any provider suspensions and terminations, both voluntary and involuntary because of suspected or confirmed fraud or abuse. The immediate notification shall include provider's name, provider's specialty, reason for the action and the effective date of the suspension or termination. In addition, the health plan shall submit a *Provider Suspensions and Terminations Report* that lists by name, all provider suspensions or terminations. This report

shall include all providers, each provider's specialty, their primary city and island of services, reason(s) for the action taken as well as the effective date of the suspension or termination. If the health plan has taken no action against providers during the quarter this shall be documented in the *Provider Suspensions and Terminations Report*. The health plan shall submit information on all providers that are denied credentialing for any reason on their quarterly report.

51.520.7 Provider Grievances and Claims Report

The health plan shall submit *Provider Grievances Report* that includes the following information from the previous quarter:

- The total number of resolved grievances by category (benefits and limits; eligibility and enrollment; member issues; health plan issues);
- The total number of unresolved grievances by category (benefits and limits; eligibility and enrollment; member issues; health plan issues) and the reason code explaining the status (i.e., grievance is expected to be resolved by the reporting date and grievance is unlikely to be resolved by the reporting date);
- Status of provider grievances that had been reported as unresolved in previous report(s);
- Status of delays in claims payment, denials of claims payment, and claims not paid correctly which includes the following:
    - The number of claims processed for each month in the reporting quarter;

- The number of claims paid for each month in the reporting quarter;
- The percentage of claims processed (at 30 and 90 days) after date of receipt for each month of the reporting quarter;
- The number of claims denied for each month in the reporting quarter; and
- The percentage of claims denied for each of the following reasons: (1) prior authorization/referral requirements were not met for each month in the reporting quarter; (2) submitted past the filing deadline for each month in the reporting quarter; (3) provider not eligible on date of service for each month in the reporting quarter; (4) member not eligible on date of service; and (5) member has another health insurer which shall be billed first.

51.520.8 Value-Driven Health Care Report

The health plan shall submit *Value-Driven Health Care Report* that includes information on the health plan's value-driven program.

51.530 Covered Benefits and Services Reports

51.530.1 CMS 416 Report – EPSDT

The health plan shall submit *CMS 416 Report* that measure and document screening and participation rates in the EPSDT program. In addition to the requirements in the CMS 416 Report, the health plan shall report on any additional data that the DHS

has determined is necessary for monitoring and compliance purposes.

The health plan's medical director shall review this report prior to submission to the DHS.

51.530.2 Long-Term Services and Supports (LTSS) Report

The health plan shall submit to the DHS a *Long-Term Services and Supports report*. Reports shall be for members that are receiving LTSS as defined in Section 40.730. Reports shall include information on services provided, assessments performed, service plan updates, addition or reduction of services, authorization of services (i.e., environmental adaptations) and any other quality measures that the DHS deems necessary.

51.530.3 Going Home Plus Reports

On a quarterly basis, the health plan shall submit information to DHS to include, but not limited to:

- Referrals;
- Ineligibles;
- Admissions;
- Reinstitutionalizations;
- Discharges (completion of 365 days);
- Emergency Department visits;
- Hospitalizations;
- Voluntary and Involuntary Disenrollments;
- Deaths;
- Type of Housing;

- Changes in Living Arrangements;
- Changes in Case Management;
- Self Direction; and
- Expenditures related to provision of services.

The health plan shall use format(s) provided by the DHS.

On an ongoing basis, the health plans shall submit to DHS other GHP member paperwork to include, but not limited to, referral request forms, informed consent forms, service authorizations, adverse event reports, and Quality of Life Surveys as specified by the Money Follows the Person (MFP) grant.

51.540 Member Services Reports

51.540.1 Call Center Report

The health plan shall submit a report on the utilization rate of the call center for members, providers, and 24-hour nurse call line during the previous quarter that shall include, at a minimum, the following:

- Number of calls (actual number and number reported per 100 members/providers);
- Call abandonment rate;
- Average speed of answer;
- Average hold time;
- Blocked call rate;
- Longest wait in queue;

- Average talk time; and
- Type of call.

51.540.2 Interpretation Services Report

The health plan shall submit the *Interpretation Services Report* that include the following information on activities during the previous quarter:

- The name and Medicaid ID number for each individual to whom interpretation services was provided;
- The primary language spoken by each LEP individual;
- Sign language service provided;
- TTY/TDD services provided;
- The date of the request;
- The date provided;
- The type of interpreter service provided; and
- The name of the interpreter (and agency, if applicable).

51.540.3 Requests for Documents in Alternate Languages Report

The health plan shall submit *Requests for Documents in Alternative Languages Reports* that include the following information on activities during the previous quarter:

- The name and Medicaid ID number for each member requesting documents in an alternative language;
- The language requested;
- The date of the request; and
- The date the documents were mailed or provided.

51.540.4 Member Grievance and Appeals Report

The health plan shall submit *Member Grievance and Appeals Reports*. These reports shall be submitted in the format provided by the DHS. At a minimum, the reports shall include:

- The number of grievances and appeals by type;
- Type of assistance provided;
- Administrative disposition of the case;
- Overturn rates;
- Percentage of grievances and appeals that did not meet timeliness requirements;
- Ratio of grievances and appeals per one hundred (100) members; and
- Listing of unresolved appeals originally filed in previous quarters.

51.540.5 CAHPS® Consumer Survey

The health plan shall report the results of any *CAHPS® Consumer Survey* conducted by the health plan on Medicaid members, if applicable. The health plan shall provide a copy of the overall report of survey results to the DHS. This report is separate from any CAHPS® Consumer Survey that is conducted by the DHS.

51.540.6 Special Health Care Needs (SHCN) Report

The health plan shall submit to the DHS a *Special Health Care Needs (SHCN) Report*. Reports shall include a list of all new members (both children and adults) who are identified as having

a SHCN as defined in Section 40.910. In addition, the health plan shall provide information on the SHCN identified, service coordination, service plan, date identified as having a SHCN and date service plan was completed over the past quarter. In addition, the health plan shall provide information on members who were previously identified as having SHCN as well as those whose SHCNs have been resolved. The health plan shall also provide information regarding dual-eligible members who have opted out of service coordination.

51.540.7 1179- Summary of Change of Member Demographics

The health plan shall submit a summary of changes to member demographics in a format provided by the DHS.

51.540.8 ADRC Report

The health plan shall submit to the DHS an *Aid to Disabled Review Committee (ADRC) report.* Reports shall include information on number of ADRC referrals, number approved, number transitioned to LTSS, and number transitioned to SHOTT.

51.550 Quality Assessment and Performance Improvement (QAPI) Program Reports

51.550.1 Accreditation Update

The health plan shall submit *Accreditation Updates* in which it provides updates on its progress in achieving accreditation as

required in Section 50.710. These updates shall detail activities undertaken and provide a synopsis of any issues that have arisen that may impede the accreditation process.

51.550.2 QAPI Program Description

The health plan shall provide an annual *QAPI Program Report*. The health plan's medical director shall review these reports prior to submittal to the DHS. The *QAPI Program Report* shall include the following:

- Any changes to the QAPI Program;
- A detailed set of QAPI Program goals and objectives that are developed annually and includes timetables for implementation and accomplishments;
- A copy of the health plan's organizational chart including vacancies of required staff, changes in scope of responsibilities, changes in delegated activities and additions or deletions of positions;
- A current list of the required staff as detailed in Section 51.410 including name, title, location, phone number and fax number;
- An executive summary outlining the changes from the prior QAPI;
- A copy of the current approved QAPI Program description, the QAPI Program work plan and, if issued as a separate document, the health plan's current utilization management program description with signatures and dates;

- A copy of the previous year's QAPI Program, if applicable, and utilization management program evaluation reports; and
- Written notification of any delegation of QAPI Program activities to contractors.

51.550.3 Performance Improvement Projects (PIP) Report

Annually, the health plan shall submit two (2) *Performance Improvement Projects Report*s to the DHS and its EQRO. The report shall document a clearly defined study question, and well-defined indicators (both of which may be selected by the DHS). The reports shall also address the following elements: a correctly identified study population, valid sampling techniques, accurate/complete data collection, appropriate improvements strategies, data analysis and interpretation, reported improvements, if any, and sustained improvement over time, if any. The reports shall be independently validated by the EQRO, on an annual basis, to ensure compliance with CMS protocols, and DHS policy, including timeline requirements. Status reports on performance improvement projects may be requested more frequently by the DHS.

51.550.4 Healthcare Effectiveness Data and Information Set (HEDIS) Report

The health plan shall submit Healthcare Effectiveness Data and Information Set (HEDIS) Reports in the format required by the DHS. These reports shall cover the period from January 1 to December 31 and shall be reviewed by the health plan's Medical Director prior to submittal to the DHS.

The EQRO shall annually perform a HEDIS Report Validation to at least six (6) of the State-selected HEDIS measures to ensure health plan compliance with HEDIS methodology.

51.560 Utilization Management Reports

51.560.1 Prior Authorization Requests Denied/Deferred

The health plan shall submit *Prior Authorization Requests that have been Denied or Deferred Report*. The specific reporting period, types of services and due dates shall be designated by the DHS. The report shall include the following data:

- Date of the request;
- Name of the requesting provider;
- Member's name and ID number;
- Date of birth;
- Diagnoses and service/medication being requested;
- Justification given by the provider for the member's need for the service/medication;
- Justification of the health plan's denial or the reason(s) for deferral of the request; and
- The date and method of notification of the provider and the member of the health plan's determination.

51.560.2 Report of Over-Utilization and Under-Utilization of Drugs

The health plan shall submit *Reports of Over-Utilization and Under-Utilization of Drugs* that include:

- Listing of the top fifty (50) high cost formulary drugs and the top fifty (50) highly utilized formulary drugs, the criteria that is used/developed to evaluate their appropriate, safe and effective use, and the outcomes/results of the evaluations;

- Listing of the top fifty (50) highest utilized non-formulary drugs paid for by the plan including the charges and allowances for each drug as well as the criteria used/developed to evaluate the appropriate, safe and effective use of these medications and the outcomes/results of the evaluations;
- Listing of members who are high users of controlled substances but have no medical condition (e.g., malignancies, acute injuries, etc.) which would justify the high usage. Additionally, the health plan shall submit: (1) its procedures for referring for monitoring members identified and controlling their over-utilization; and (2) the results of the SC services provided; and
- Results of pharmacy audits, including who performed the audits, what areas were audited, and if problems were found, the action(s) taken to address the issue(s), and the outcome of the corrective action(s).

51.560.3 Report of Over-Utilization and Under-Utilization of Services

The health plan shall submit *Reports of Over-Utilization and Under-Utilization of Services*. The reports shall include information on the following measures.

- PCP Utilization: The number and percent of members that did not have access to a PCP who have a chronic disease or have over-utilization of narcotics or other pharmaceuticals;
- Hospital Utilization: The average length of stay (LOS) in hospitals by member type and the number and percentage of members by location and diagnosis who had a readmission within thirty (30) days) of a discharge;
- Emergency Department Utilization: The number and percent of members with ED use that were not admitted to a hospital by location and diagnosis;
- Adults and children whose utilization causes the members to be in the top two percent (2%) of all health plan members by utilization frequency and/or expenditures and increasing by one percent (1%) per year until reaching five percent (5%), expenditures over certain periods, and provided service coordination activities to the identified members;
- Provider Preventable Conditions (PPC): Provide information on PPC in a format specified by DHS; and
- Other criteria as determined by the DHS.

51.570 Administration and Financial Reports

51.570.1 Fraud, Waste and Abuse ~~Summary~~ Reports

The health plan shall submit *Fraud, Waste and Abuse Report*s that include, at a minimum, the following information on all alleged fraud and abuse cases:

- A summary of all fraud, waste and abuse referrals made to the State during the quarter, including the total number, the

administrative disposition of the case, any disciplinary action imposed both before the filing of the referral and after, the approximate dollars involved for each incident and the total approximate dollars involved for the quarter;

- A summary of the fraud, waste and abuse detection and investigative activities undertaken during the quarter, including but not limited to the training provided, provider monitoring and profiling activities, review of providers' provision of services (under-utilization and over-utilization of services), verification with members that services were delivered, and suspected fraud, waste and abuse cases that were ultimately not necessarily (or definitively) fraud or abuse and steps taken to remedy the situation;
- A summary of the results of the VOS performed with members as described in Section 50.455; and
- Trending and analysis as it applies to: utilization management, claims management, post-processing review of claims, and provider profiling.

The health plan and its subcontractors shall retain all Fraud, Waste and Abuse data for a period of no less than ten (10) years in accordance with 42 CFR 438.3 (u).

51.570.2 Provider Education and Training Report

The Health Plans shall submit all provider education and training relating to correct/incorrect coding, proper/improper claims submission. The education/training can be to prevent fraud, waste and abuse or initiated by the Health Plan as a result of pre-payment or post-payment claims reviews. This report shall

identify training/education at an individual provider level or as a group session.

51.570.3 Employee Suspension and Termination Report

The Health Plans shall report if a subcontractor or employee resigns, is suspended, terminated or voluntarily withdraws from participation as a result of suspected or confirmed fraud and abuse.

51.570.4 QUEST Integration Financial Reporting Guide

The health plan shall submit financial information on a regular basis in accordance with the QUEST Integration Financial Reporting Guide provided by the DHS.

The financial information shall be analyzed and compared to industry standards and standards established by the DHS to ensure the financial solvency of the health plan. The DHS may also monitor the financial performance of the health plan with on-site inspections and audits.

The health plan shall, in accordance with generally accepted accounting practices, prepare audited financial reports that adequately reflect all direct and indirect expenditures and management and fiscal practices related to the health plan's performance of services under this contract.

51.570.5 Third Party Liability (TPL) Cost Avoidance Report

The health plan shall submit *Third Party Liability (TPL) Cost Avoidance Reports* that identify all cost-avoided claims for members with third party coverage from private insurance carriers and other responsible third parties. These reports shall include any member that has a TPL that is not identified on the 834 file received by the health plan. In addition, on a quarterly basis, the health plan shall notify DHS of all of its QUEST Integration members who have commercial insurance with the same or another health plan.

51.570.6 Disclosure of Information on Annual Business Transaction Report

The health plan shall submit *Disclosure of Information on Annual Business Transactions Reports* that disclose information on the following types of transactions:

- Any sale, exchange, or lease of any property between the health plan and a party in interest;
- Any lending of money or other extension of credit between the health plan and a party in interest; and
- Any furnishing for consideration of goods, services (including management services) or facilities between the health plan and the party in interest. This does not include salaries paid to employees for services provided in the normal course of their employment.

The health plan shall include the following information regarding the transactions listed above:

- The name of the party in interest for each transaction;
- A description of each transaction and the quantity or units involved;
- The accrued dollar value of each transaction during the fiscal year; and
- Justification of the reasonableness of each transaction.

For the purposes of this section, a party in interest, as defined in Section 1318(b) of the Public Health Service Act, is:

- Any director, officer, partner, or employee responsible for management or administration of an HMO; any person who is directly or indirectly the beneficial owner of more than five percent (5%) of the equity of the HMO; any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than five percent (5%) of the HMO; or, in the case of an HMO organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law;
- Any organization in which a person described above is director, officer or partner; has directly or indirectly a beneficial interest of more than five percent (5%) of the equity of the HMO; or has a mortgage, deed of trust, note, or other interest valuing more than five percent (5%) of the assets of the HMO;

- Any person directly or indirectly controlling, controlled by, or under common control with a HMO; or
- Any spouse, child, or parent of an individual described in the foregoing bullets.

In addition, annually and within thirty (30) days after any change in ownership of the health plan, the health plan shall update the DHS on the following information:

- (1)(i) The name and address of any person (individual or corporation) with an ownership or controlling interest in the disclosing entity, fiscal agent, or managed care entity. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address (es).
- (ii) Date of birth and Social Security Number (in the case of an individual).
- (iii) Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) or in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a five (5) percent or more interest.
- (2) Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control

interest in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a five (5) percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

- (3) The name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the disclosing entity (or fiscal agent or managed care entity) has an ownership or control interest.
- (4) The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity (or fiscal agent or managed care entity).

51.570.7 Encounter Data/Financial Summary Reconciliation Report

The health plan shall submit *Encounter Data/Financial Summary Reconciliation Reports* using the instructions and format provided by the DHS.

51.570.8 Medicaid Contracting Report

The health plan shall submit an annual Medicaid contracting report to DHS, the State of Hawaii Department of Commerce and Consumer Affairs Insurance Division, and the Hawaii State Legislature, no later than one-hundred eighty (180) days following the end of the State Fiscal Year (SFY). The content of the Medicaid contracting report shall include the information required from the Section 103F-107, HRS.

51.570.9 QUEST Integration Dashboard

The health plan shall submit monthly a summary identified as the QUEST Integration dashboard of the health plan's performance utilizing a format provided by the DHS. Information included on the QUEST Integration Dashboard includes but is not limited to:

- Member demographics;
- Provider demographics;
- Call Center statistics;
- Claims processing;
- Complaints from both members and providers; and
- Utilization data.

The QUEST Integration Dashboard shall be posted by the DHS on the MQD website on a monthly basis and may be posted on other State websites. The data elements included on the dashboard may be changed to improve transparency in public reporting.

51.570.10 Medical Loss Ratio Report

The health plan shall submit an annual Medical Loss Ratio (MLR) Report in compliance with 42 CFR 4.38.8 as specified in Section 51.510. Any retroactive changes to capitation rates after the contract year end will need to be incorporated into the MLR calculation. If the retroactive capitation rate adjustment occurs after the MLR report has been submitted to DHS, a new report

incorporating the change will be required to be submitted within 30 days of the capitation rate adjustment payment by DHS.

The MLR standards are to ensure the health plan is directing a sufficient portion of the capitation payments received from DHS to services and activities that improve health in alignment with DHS's mission.

The health plan shall calculate and report the MLR in accordance to the following:

- The MLR experienced for the health plan in a reporting year is the ratio of the numerator, as defined in accordance with 42 CFR 438.8(e) to the denominator, as defined in accordance with 42 CFR 438.8(f);
- Each expense must be included under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses;
- Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on pro rata basis;
- Expense allocation must be based on a generally accepted accounting method that is expected to yield the most accurate results;
- Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense;

- Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by reporting entity and are not to be apportioned to the other entities;
- The health plan may add a credibility adjustment to a calculated MLR if the MLR reporting year experience is partially credible;
- The credibility adjustment is added to the reported MLR calculation before calculating any remittances, if applicable;
- The health plan may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible;
- If the health plan's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards;
- The health plan will aggregate data for all Medicaid eligibility groups covered under the contract;
- The health plan shall provide a remittance for a MLR reporting year if the MLR for that reporting year does not meet the minimum MLR standard of eighty five (85) percent or higher;
- The health plan must require any third party vender providing claims adjudication activities to provide all underlying data associated with MLR reporting to the health plan within one hundred eighty (180) days of the end of the MLR reporting year or within thirty (30) days of being requested by the health plan, whichever comes

sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting;

- In instances where the state makes a retroactive change to the capitation payments for a MLR reporting year where the report has already been submitted to the state;
    - The health plan must re-calculate the MLR for all reporting years affected by the change;
    - The health plan must submit a new MLR report meeting the applicable requirements;

The health plan shall submit a Medical Loss Ratio (MLR) report to the Department of Human Services that includes at least the following information for each MLR reporting year:

- Total incurred claims;
- Expenditures on quality improving activities;
- Expenditures related to activities compliant with 42 CFR 438.608(a)(1) through (5), (7), (8), and (b);
- Non-claims costs;
- Premium revenue as defined in 42 CFR 438.8;
- Taxes, licensing and regulatory fees;
- Methodology(ies) for allocation applied;
- Any credibility adjustment applied;
- The calculated MLR;
- Any remittance owed to the State, at minimum, must be equal to or higher than eighty five (85) percent, if applicable;

- A comparison of the information reported in this section with the audited financial report required under 42 CFR 438.3(m);
- A description of the aggregation method used to calculate total incurred claims; and
- The number of member months.

The health plan and its subcontractors shall retain all MLR data for a period of no less than ten (10) years in accordance with 42 CFR 438.3 (u). The health plan shall attest to the accuracy of the calculation of the MLR in accordance with the MLR standards when submitting required MLR reports.

51.570.11 Mental Health and Substance Use Disorder Parity Report

The health plan shall provide an annual Mental Health and Substance Use Disorder Parity Report. This report shall be submitted in the format provided by the DHS.

This report ensures that behavioral health or mental health (MH)/substance use disorder (SUD) services are comparable or not any more stringent than medical/surgical (M/S) services provided as per the Medicaid Parity Final Rule and MHPAEA of 2008.

At a minimum this report shall include:

- Aggregate lifetime and annual dollar limits.
- Financial requirements and treatment limitations:
    - Copayments, coinsurance, deductibles, and out-of-pocket maximums;

- Quantitative treatment limits (QTLs) or limits on the scope or duration of a benefit, numerically (day or visit limits; and
- Non-Quantitative Treatment Limits (NQTLs) or limits on the scope or duration of benefits, such as prior authorization or network admission standards. These are "soft limits" that allows exceeding of numerical limits for medical/surgical or mental health/SUD benefits based on medical necessity.

- Supporting documents requested by DHS.

Analysis and comparison of the information between DHS services (MH/SUD) and other health plans providing M/S services shall be done by the DHS.

51.570.12 Overpayments Report

The health plan is required to recover and report all overpayments. "Overpayment" as used in this section is defined in 42 CFR 438.2. All overpayments identified by the health plan shall be reported to DHS. The overpayment shall be reported in the reporting period in which the overpayment is identified. It is understood the health plan may not be able to complete recovery of overpayment until after the reporting period. The health plan must report to DHS the full overpayment identified. The health plan may negotiate and retain a lesser repayment amount with the provider, however, the full overpayment amount will be used when setting capitation

rates for the health plan. The health plan shall also maintain documentation of the education and training provided in addition to reporting the recovered amounts.

This report is an annual report which will document all overpayments, and all recovered and pending recovery amounts. Additionally, this report will specify/distinguish those overpayments which were identified as fraud, waste, and abuse, from all the rest of the overpayments included in the report. The health plan will check the reporting of overpayment recoveries for accuracy and will provide an accuracy report to the DHS upon request. The health plan will certify that the report contains all overpayments and those overpayments are reflected in either the claims data submitted in the report, or listed as an itemized recovery."

51.580 Encounter Data Reporting

The health plan shall submit encounter data to MQD at least once per month in accordance with the requirements and specifications defined by the State and included in the Health Plan Manual. Encounters shall be certified and submitted by the health plan as required in 42 CFR Section 438.606 and as specified in Section 51.620. The health plan may be required to submit encounter data to an all-payer claims database (APCD).

The state will complete the encounter data validation for the populations to be served by the health plan to the actuary

developing the capitation rates for at least the three most recent and complete years prior to the rating period.

The health plan and its subcontractors shall retain all encounter data for a period of no less than ten (10) years in accordance with 42 CFR 438.3(u).

51.580.1 Accuracy, Completeness and Timeliness of Encounter Data Submissions

The following encounter data submission requirements apply. The data and information provided to the DHS shall be accurate and complete. Data and reports shall be mathematically correct and present accurate information. An accurate and complete encounter is one that reports a complete and accurate description of the service provided, and that passes the full edits/audits of the encounter processing cycle. DHS will provide each health plan an Encounter Timeliness and Accuracy Report at least monthly, in addition to the error reports the plan receives from the SFTP server after each encounter submission.

Accuracy and Completeness – DHS will measure accuracy with the following measures:

- Pended Rate for the latest month and the cumulative average for the past three (3) and six (6) months that is calculated based on new system pends for each encounter submission divided by the total encounter lines in that submission.
- Twelve (12) months new pends that is calculated based upon the last twelve month pended errors divided by total

encounter lines (including resubmitted adjusted, void and denied encounters).

- Total Pended Rate that is calculated based on cumulative total pended errors divided by the sum of the total encounter lines in the past twelve (12) months' submissions.

The following accuracy targets apply:

- Current Pended Rate of less than five percent (5%);
- Current Pended Rate of less than five percent (5%) for cumulative averages for the past three (3) and six (6) months; and
- Cumulative twelve month pended rate less than ten percent (10%); and
- Cumulative Total Pended Rate of twenty-five percent (25%).

- Timeliness – Sixty percent (60%) of the encounter data shall be received by the DHS no more than one- hundred twenty (120) days from the date that services were rendered. Health plans shall have the goal of submitting one-hundred percent (100%) and shall submit no less than ninety-nine percent (99%) of encounter data within fifteen (15) months from the date of services. Adjustments and resubmitted encounters shall not be subject to the one-hundred twenty (120) day submission requirement. In addition, TPL related encounters shall not be subject to the one-hundred twenty (120) day submission deadline.

The health plan shall be notified by the DHS within thirty (30) days from the receipt date of the initial encounter submission that the

health plan has failed the accuracy and completeness edits and/or timeliness targets. The health plan shall be granted a thirty (30) day error resolution period from the date of notification. If, at the end of the thirty (30) day error resolution period:

- In the most recent month on the latest Encounter Timeliness and Accuracy Report a penalty amounting up to five percent (5%) of the monthly (initial month's submission) capitation payment may be assessed against the health plan for failing to submit accurate encounter data if:
  - Current Pended Rate is still greater than five percent (5%);
  - Cumulative averages for the past three (3) and six (6) months are still greater than five percent (5%);
  - The average of the cumulative latest twelve months is greater than ten percent (10%); and
  - Total Pended Rate is still greater than twenty-five percent (25%).

  The most recent month on the latest Encounter Timeliness and Accuracy Report sixty percent (60%) of the encounter data was not received by the DHS within one- hundred twenty (120) days from the date that services were rendered OR ninety-nine percent (99%) of encounter data was not received by the DHS within fifteen (15) months from the date that services were rendered, a penalty amounting up to five percent (5%) of the monthly (initial month's submission) capitation payment may be assessed against the health plan for failing to submit timely encounter data.

51.600 Report Submission

51.610 Financial Penalties and Sanctions

The State may impose financial penalties or sanctions on the health plan for inaccurate, incomplete and late submissions of required data, information and reports. All requested data and information shall be accurate and complete with no material omissions. Encounter data is not accurate and complete if the data has missing or incomplete field information, or if the data does NOT pass the full edits/audits of the encounter processing cycle. The State may impose financial penalties on the health plan for failure to submit accurate or complete encounter data on a timely basis. Any financial penalty imposed on the health plan shall be deducted from the subsequent month's capitation payment to the health plan. The amount of the total financial penalty for the month shall not exceed ten percent (10%) of the monthly capitation payment.

The health plan may file a written challenge to the financial penalty with the DHS not more than thirty (30) days after the health plan receives written notice of the financial penalty. Challenges shall be considered and decisions made by the DHS no more than sixty (60) days after the challenge is submitted.

Financial penalties are not refundable unless challenged and decided in favor of the health plan.

The health plan shall continue reporting encounter data once per month beyond the term of the contract as processing and

reporting of the data is likely to continue due to lags in time in filing source documents by subcontractors and providers.

51.620 Health Plan Certification

The health plan shall certify the accuracy, completeness, and truthfulness of any data, including but not limited to, encounter data, data upon which payment is based, and other information required by the State, that may be submitted to determine the basis for payment from the State agency. The health plan shall certify that it is in substantial compliance with the contract and provide a letter of certification attesting to the accuracy, completeness, and truthfulness of the data submitted based on best knowledge, information, and belief. The health plan shall submit the letter of certification to the MQD concurrent with the certified data and document submission. In the case of two (2) submissions in one month, the health plan shall submit two (2) letters of certification. The certifications are to be based on best knowledge, information, and belief of the following health plan personnel.

The data shall be certified by:

- The health plan's Chief Executive Officer (CEO);
- The health plan's Chief Financial Officer (CFO); or
- An individual who has delegated authority to sign for, and who reports directly to, the health plan's CEO or CFO.

The health plan shall require claim certification from each provider submitting data to the health plan. Source, content, and timing of

certification shall comply with the requirements set forth in 42 CFR Section 438.606.

51.630 Follow-Up by Health Plans/Corrective Action Plans/Policies and Procedures

The DHS shall provide a report of findings to the health plan after completion of each review, monitoring activity, etc.

Unless otherwise stated, the health plan shall have thirty (30) days from the date of receipt of a DHS report to respond to the MQD's request for follow-up, actions, information, etc. The health plan's response shall be in writing and address how the health plan resolved the issue(s). If the issues(s) has/have not been resolved, the health plan shall submit a corrective action plan including the timetable(s) for the correction of problems or issues to MQD. In certain circumstances (i.e., concerns or issues that remain unresolved or repeated from previous reviews or urgent quality issues), MQD may request a ten (10) day plan of correction as opposed to the thirty (30) day response time.

For all medical record reviews, the health plan shall submit information prior to the scheduled review and arrange for MQD and/or the EQRO to access medical records through on-site review and provision of a copy of the requested records. The health plan shall submit this information within sixty (60) days of notification or sooner should circumstances dictate an expedited submission of records.

The health plan shall submit the most current copy of any policies and procedures requested. In the event the health plan has

previously submitted a copy of a specific policy or procedure and there have been no changes, the health plan shall state so in writing and include information as to when and to whom the policy and procedure was submitted. If there are no formal policies or procedures for a specific area, the health plan may submit other written documentation such as workflow charts or other documents that accurately document the course of actions the health plan has adopted or shall take.

51.700 Readiness Review

51.710 Required Review Documents

The health plan shall comply with all readiness review activities required by the DHS. This includes, but is not limited to, submitting all required review documents identified in the table below by the required due date, participating in any on-site review activities conducted by the DHS, and submitting updates on implementation activities. The DHS reserves the right to request additional documents for review and approval during readiness review.

Document	RFP Reference Section	Due Date
Selection and retention of providers policies and procedures	40.210 General Provisions	30 days after contract effective date
Availability of providers policies and procedures	40.230 Availability of Providers	30 days after contract effective date
PCP policies and procedures	40.250 PCPs	30 days after contract effective date

Document	RFP Reference Section	Due Date
Credentialing, recredentialing and other certification policies and procedures	40.400 Provider Credentialing, Recredentialing and Other Certifications	60 days after contract effective date
Model for each type of provider contract	40.500 Provider Contracts	10 days after contract effective date
The signature page of all finalized and executed contracts that have not been previously submitted	40.500 Provider Contracts	The last day of every month from contract effective date to 60-days prior to commencement of services
Provider education materials	40.610 Provider Education	At least 60 days prior to use of materials
Provider grievance and appeals system policies and procedures	40.620 Provider Grievance and Appeals Process	75 days after contract effective date
Provider manual	40.630 Provider Manual	30 days after contract effective date
Provider call center policies and procedures	40.640 Provider Call Center/PA Line	60 days after contract effective date
Provider web-site screen shots	40.650 Web-site for Providers	60 days after contract effective date
Access to provider web-site	40.650 Web-site for Providers	60 days after contract effective date
Web-site (member and provider portals) update policies and procedures	40.650 Web-site for Providers	60 days after contract effective date
Description of any additional services	40.700 Covered Benefits and Services – General Overview	30 days after contract effective date
Self-Direction policies and procedures	40.800 Self-Direction	60 days after contract effective date

Document	RFP Reference Section	Due Date
Service Coordination System policies and procedures	40.910 Service Coordination System	60 days after contract effective date
Assessment process	40.920.1. General Information, Assessments	60 days after contract effective date
Service Plan Development policies and procedures to include standards	40.930 Service Plan	60 days after contract effective date
EPSDT plan	41.100 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services for Children	60 days after contract effective date
Cultural competency plan	41.310 Cultural Competency Plan	60 days after contract effective date
Disease management policies and procedures	41.320 Disease Management	90 days after contract effective date
Transition of care policies and procedures	41.730 Transition of Care Policies and Procedures	60 days after contract effective date
Member Outreach	50.100 Health Plan Eligibility Responsibilities	60 days after contract effective date
Member Survey	50.240 Member Status Changes	30 days after contract effective date
Member Services policies and procedures	50.410 Member Services, General Requirements	30 days after contract effective date
Member education materials, including the training plans and curricula	50.420 Member Education	90 days after contract effective date
Translation Certification	50.430 Requirements for Written Materials	Within 60 days of DHS approval of English versions of documents
Oral Interpretation and Translation of Materials policies and procedures	50.435 Interpretation Services	60 days after contract effective date

Document	RFP Reference Section	Due Date
Member handbook	50.440 Member Handbook Requirements	30 days after contract effective date
Sample member ID card	50.470 Member ID Card	30 days after contract effective date
Member Call Center policies and procedures	50.480 Member Call Center	60 days after contract effective date
Member web-site screen shots	50.490 Internet Presence/Web-site	60 days after contract effective date
Access to member web-site	50.490 Internet Presence/Web-site	60 days after contract effective date
Value-Based Purchasing Plan	50.500 Value-Based Purchasing	120 days after contract effective date
Marketing materials other than those for initial enrollment and APC (including all printed materials, advertisements, video presentations, and other information prepared by the health plan that pertain to or reference the programs or the health plan's program business)	50.630 State Approval of Materials	60 days after contract effective date
QAPI Program	50.730 QAPI Program	60 days after contract effective date
Request for delegation of QAPI Program functions or activities (if applicable)	50.730 QAPI Program	90 days after contract effective date
Medical records standards	50.740 Medical Records Standards	60 days after contract effective date
Performance improvement projects	50.750 PIPs	60 days after contract effective date

Document	RFP Reference Section	Due Date
Practice guidelines policies and procedures, list of all current practice guidelines and practice guidelines adopted for two (2) medical conditions and two (2) behavioral health conditions	50.760 Practice guidelines	60 days after contract effective date
UMP description, corresponding workplan, and UMP policies and procedures	50.800 Utilization Management Program	60 days after contract effective date
Prior authorization/pre-certification policies and procedures	50.900 Authorization Services	60 days after contract effective date
Grievance system policies and procedures	51.100 Member Grievance System	60 days after contract effective date
Documentation describing its disaster planning and recovery operations	51.270 Disaster Planning and Recovery Operations	90 days after contract effective date
Compliance plan	51.330 Compliance Plan	60 days after contract effective date
Staffing and training plan (plus resumes, where applicable)	51.410 General Requirements	30 days after contract effective date
A GeoAccess (or comparable program) report	51.720 Updated GeoAccess Reports	30 days after contract effective date and every day thereafter until sixty (60) days prior to commencement of services
Subcontractor agreements	70.400 Subcontractor Agreements	30 days after contract effective date
Contract termination procedures	71.640 Procedure for Termination	120 days after contract effective date
Proof of License	80.230 Attachment, Other Documentation	Prior to contract signature

51.720 Updated GeoAccess Reports

The health plan shall submit updated GeoAccess reports (or reports generated by a similar program) that include all providers who have signed a provider agreement by the due dates identified in Section 51.700, Readiness Review.

51.730 Health Plan Provider Network

The health plans must meet provider network requirements outlined in Section 40.220 no later than sixty (60) days prior to date of Commencement of Services to Members as described in Section 20.100. Failure to meet all provider network requirements described in this section may result in termination of contract in accordance with Section 71.600.

51.800 Timeframes during RFP Implementation

The health plans and the DHS have timelines for implementation of processes prior to and after commencement of services to members. This section is a central location that compiles these processes for ease of implementation.

Document/Requirement	RFP Reference Section	Due Date	Respons-ible Party
Prior to commencement of services to members			
Standardized HFA	40.920.1.	180-days	DHS
"At risk" criteria	40.920.2.	180-days	DHS
Service plan format	40.930	180-days	DHS
Grievance system templates	51.105	180-days	DHS
QI memoranda	31.200	90-days	DHS
"At risk" limits	40.920.2	90-days	DHS
Expedited appeal procedures	51.140	60-days	DHS
Appeal procedures for sanctions	72.220	60-days	DHS
Submission of marketing materials	50.640 and 30.540.1.	45-days prior to Initial Enrollment	Health Plan
Enrollment limit for auto-assignment	30.560	30-days	Health Plan
Enrollment cap for auto-assignment	30.560	30-days	DHS
DHS remotely monitor member call center	50.480	30-days	DHS/ Health plan
After commencement of services to members- one time			
Quality-based component of auto-assignment	30.530	1/1/2016	DHS
After commencement of services to members- annually			
Update certificate of insurance	71.310	Within 30 days of contract execution	Health Plan
Enrollment limit for auto-assignment	30.560	90-days prior to APC	Health Plan
Enrollment cap for auto-assignment	30.560	90-days prior to APC	DHS
Submission of marketing materials	50.640	45-days prior to APC	Health Plan
Update performance bond	71.120	60 days after start of new benefit period	Health Plan

SECTION 60 FINANCIAL RESPONSIBILITIES

60.100 The DHS Responsibilities

60.110 Daily Rosters/Health Plan Reimbursement

The DHS shall enroll and disenroll members through daily files. All payments and recoveries shall be detailed on the daily file. The daily membership rosters identify the capitated fee amounts associated with mid-month enrollment and disenrollment transactions as well as prior period coverage transactions. The health plan agrees to accept daily and monthly transaction files from the DHS as the official enrollment record.

The DHS shall make capitation payments, with each payment being for a month's services, to the health plan for each enrolled member in the health plan beginning on the date of the Commencement of Services to Members identified in Section 20.100. Capitation payments shall be in the amounts listed in the health plan's contract with the DHS.

The DHS shall pay the established capitation rates to the health plan for members enrolled for the entire month. Capitation payment shall be paid on rate codes that reflect the risk factor adjustments. Capitation payments for members enrolled/disenrolled on dates other than the first or last day of the month shall be prorated on a daily basis based on the number of days in a month.

The DHS shall make a monthly capitation payment to the health plan for a member aged 21-64 receiving inpatient treatment in an Institution for Mental Diseases (IMD), as defined in 42 CFR 435.1010, so long as the facility is a hospital providing psychiatric or substance use disorder crisis residential services, and length of stay in the IMD is for a short term stay of no more than fifteen (15) calendar days during the period of the monthly capitation payment.

The DHS shall make additional capitation payments or recover capitation payments from the health plan as a result of retroactive enrollments, retroactive disenrollments and prior period coverage.

The DHS shall provide to the health plan a Monthly Payment Summary Report that summarizes capitation payments and recoveries made to the health plan.

The health plan shall not change any of the information provided by the DHS on the daily or monthly transaction files. Any inconsistencies between the health plan and the DHS information shall be reported to the DHS for investigation and resolution. All payments and recoveries shall be detailed on the daily file and summarized on the Monthly Payment Summary Report.

The DHS shall notify the health plan prior to making changes in the capitation amount/rate code.

60.120 Capitation Payments for Changes in Rate Codes

There are several situations in which a member may change eligibility categories, and therefore rate codes, that shall result in a different capitation payment amount or a disenrollment from the health plan.

Changes in the capitation payment amount/rate code paid shall become effective the next day after the enrollment change is processed.

60.130 Collection of Premium and Cost Shares for Members

The health plan shall be responsible for billing and collecting a members' premium share, for members with a required premium share, as stated in the HAR.

The health plan shall collect all cost sharing amounts from members who have cost sharing requirements. The health plan may delegate cost sharing collections to the providers, but shall be ultimately responsible for their collection.

60.140 Risk Share Program

The DHS shall implement and manage a risk share arrangement and shall share in any significant aggregate health plan losses or individual health plan savings. Additional information about the risk share program is available in Appendix E.

60.200 Incentives for Health Plan Performance

The health plan shall be eligible for financial performance incentives or Pay for Performance (P4P) as long as the health plan is fully compliant with all terms of the contract. All incentives shall be in compliance with the Federal managed care incentive arrangement requirements set forth in 42 CFR Section 438.6 and the State Health Plan Manual.

To qualify for receipt of a financial incentive that uses performance measurements as a performance indicator demonstrating improvement, a NCQA-licensed audit organization must have audited the reported rates for the measurements. This is to ensure that performance measures follow the CMS protocol for validation. The validation of performance measures shall be performed by the DHS through its EQRO. The total of all payments paid to the health plan under this contract shall be pursuant to 42 CFR Section 438.6. Funding for the incentive payments would come from a per member per month (PMPM) withhold amount taken from the administrative allowance in the capitation rates related to all members starting on the date of the Commencement of Services to Members identified in Section 20.100. For the CY 2015 and CY 2016 periods, this PMPM withhold amount would be $2.00 PMPM for non-ABD members and $1.00 PMPM for ABD members. Beginning in CY 2017 period, this PMPM withhold amount would be $2.00 PMPM for all members. The health plans' rates are actuarially sound with or without the refund of the PMPM P4P withhold. The P4P performance incentive program is comprised of multiple performance measures that the DHS feels are in alignment with the current Quality Strategy. The DHS shall assign weights to each of the performance measures as described

in Sections 60.205 to 60.245. The list of performance measures and the specific percentages for each performance measure may vary year over year, but it is the intent of the DHS to keep these performance measures as consistent as possible over time. Each performance measure will be calculated independently of other performance measures, to determine if any performance incentive was earned for that performance measure.

The evaluation for any particular performance measure will involve three rate data points:

- The current period actual rate,
- The prior period actual rate, and
- The current period target rate

The Actual Rate, Target Rate, and Rate Gap are defined in 30.200. A health plan will have closed 100% of the 'rate gap' if the current period actual rate moved at or above the current period target rate. Any increment short of that can be calculated as a linear fraction of the 100% 'rate gap'.

There are three ways that a health plan may achieve the specific percentage of the total available performance incentive attached to any particular measure:

- If the current period actual rate for that measure is at or above the current period target rate, the health plan will have achieved 100% of the performance incentive,
- If the current period actual rate has closed the 'rate gap' by <100.00% and >=25.00%, the health plan will have achieved 70% of the performance incentive, and

- If the current period actual rate has closed the 'rate gap' by <25.00% and >=10.00%, the health plan will have achieved 35% of the performance incentive

As an example, if measure A represented 12.50% of the total available performance incentive, and if for measure A the health plan's current period actual rate has closed the 'rate gap' by 35%, then the health plan would have achieved 12.50% times 70% or 8.75% of the total available performance incentive. This calculation would occur for each of the performance measures in the P4P performance incentive program described in Sections 60.205 to 60.245.

The sum of these individual percentages will result in the total achieved percentage for that year. This figure is then multiplied by the $ PMPM withhold taken, to come up with the total achieved $ PMPM. The payout will occur through the normal capitation payment system. The total achieved $ PMPM will be input into the system, and then run through the capitation cycle to adjudicate the payment based on the enrollment for the affected 12 month period. If the attempt to validate a measure results in a low response rate and inadequate sample, the performance measure shall not be considered successfully met.

The performance measures to be used for the calendar year are described in Sections 60.210 to 60.245. The MQD intends to retroactively start this new P4P performance incentive program, beginning with the 12 month period January 1, 2015 – December 31, 2015. Achieved incentives shall be paid within one-hundred and eighty (180) days after the validated results are available. The minimum threshold of achievement is listed below for each of

the performance measures; these performance measures and related targets are subject to change in subsequent years. DHS shall inform the health plan of the specifications of each performance measure for incentive payment no less than fourteen (14) days prior to the beginning of the time period from which the data is being measured.

For HEDIS measures, the target rates used shall be the HEDIS percentiles identified in the NCQA HEDIS Audit Means and Percentiles for Medicaid HMOs for the measurement year that NCQA publishes yearly in the spring, except for the Plan All-Cause Readmissions measure, which shall use the Medicare HMO percentiles instead. For other performance measures, where possible, the DHS shall use national standard percentile thresholds applicable to the Medicaid population, and when not possible the DHS shall develop another applicable threshold.

The performance measures to be used are the following HEDIS measures:

- Comprehensive Diabetes Care (CDC) - HBA1C Control
- Comprehensive Diabetes Care (CDC) - Eye Exam (Retinal) Performed
- Follow-Up After Hospitalization for Mental Illness (FUH) - Follow-Up Within 7 Days of Discharge
- Plan All-Cause Readmissions (PCR)
- Childhood Immunization Status (CIS) - Combination 3
- Well-Child Visits in the First 15 Months of Life (W15) - 6 or More Visits
- Well-Child Visits in the 3rd, 4th, 5th & 6th Years of Life (W34)

- Prenatal and Postpartum Care (PPC) - Timeliness of Prenatal Care
- Prenatal and Postpartum Care (PPC) - Postpartum Care

60.205 Comprehensive Diabetes Care (CDC) - HBA1C Control (<8%)

The weight assigned to this measure depends on the percentage of the total population that is ABD at the beginning of the current period. The percentage of ABD population shall be taken from the MQD published monthly enrollment. The weight assigned shall be as follows:

- 12.50% if the health plan has < 40.0% ABD,
- 17.50% if the health plan has >= 40.0% ABD.

This is a HEDIS measure. A health plan shall be eligible for a performance incentive payment if the current period actual rate:

- Meets or exceeds the target HEDIS 75th percentile rate,
- Closes the 'rate gap' by <100.00% and >=25.00%, or
- Closes the 'rate gap' by <25.00% and >=10.00%.

60.210 Comprehensive Diabetes Care (CDC) - Eye Exam (Retinal) Performed

The weight assigned to this measure depends on the percentage of the total population that is ABD at the beginning of the current period. The percentage of ABD population shall be taken from the MQD published monthly enrollment. The weight assigned shall be as follows:

- 12.50% if the health plan has < 40.0% ABD,
- 17.50% if the health plan has >= 40.0% ABD.

This is a HEDIS measure. A health plan shall be eligible for a performance incentive payment if the current period actual rate:

- Meets or exceeds the target HEDIS 75th percentile rate,
- Closes the 'rate gap' by <100.00% and >=25.00%, or
- Closes the 'rate gap' by <25.00% and >=10.00%.

60.215 Follow-Up After Hospitalization for Mental Illness (FUH) - Follow-Up Within 7 Days of Discharge

The weight assigned to this measure depends on the percentage of the total population that is ABD at the beginning of the current period. The percentage of ABD population shall be taken from the MQD published monthly enrollment. The weight assigned shall be as follows:

- 12.50% if the health plan has < 40.0% ABD,
- 17.50% if the health plan has >= 40.0% ABD.

This is a HEDIS measure. A health plan shall be eligible for a performance incentive payment if the current period actual rate:

- Meets or exceeds the target HEDIS 75th percentile rate,
- Closes the 'rate gap' by <100.00% and >=25.00%, or
- Closes the 'rate gap' by <25.00% and >=10.00%.

60.220 Plan All-Cause Readmissions (PCR)

The weight assigned to this measure depends on the percentage of the total population that is ABD at the beginning of the current period. The percentage of ABD population shall be taken from the MQD published monthly enrollment. The weight assigned shall be as follows:

- 12.50% if the health plan has < 40.0% ABD,
- 17.50% if the health plan has >= 40.0% ABD.

This is a HEDIS measure. A health plan shall be eligible for a performance incentive payment if the current period actual rate:

- Meets or exceeds the target HEDIS 75th percentile rate,
- Closes the 'rate gap' by <100.00% and >=25.00%, or
- Closes the 'rate gap' by <25.00% and >=10.00%.

60.225 Childhood Immunization Status (CIS) - Combination 3

The weight assigned to this measure depends on the percentage of the total population that is ABD at the beginning of the current period. The percentage of ABD population shall be taken from the MQD published monthly enrollment. The weight assigned shall be as follows:

- 12.50% if the health plan has < 40.0% ABD,
- 7.50% if the health plan has >= 40.0% ABD.

This is a HEDIS measure. A health plan shall be eligible for a performance incentive payment if the current period actual rate:

- Meets or exceeds the target HEDIS 75th percentile rate,
- Closes the 'rate gap' by <100.00% and >=25.00%, or
- Closes the 'rate gap' by <25.00% and >=10.00%.

60.230 Well-Child Visits in the First 15 Months of Life (W15) - 6 or More Visits

The weight assigned to this measure depends on the percentage of the total population that is ABD at the beginning of the current

period. The percentage of ABD population shall be taken from the MQD published monthly enrollment. The weight assigned shall be as follows:

- 12.50% if the health plan has < 40.0% ABD,
- 7.50% if the health plan has >= 40.0% ABD.

This is a HEDIS measure. A health plan shall be eligible for a performance incentive payment if the current period actual rate:

- Meets or exceeds the target HEDIS 75th percentile rate,
- Closes the 'rate gap' by <100.00% and >=25.00%, or
- Closes the 'rate gap' by <25.00% and >=10.00%.

60.235 Well-Child Visits in the 3rd, 4th, 5th & 6th Years of Life (W34)

The weight assigned to this measure depends on the percentage of the total population that is ABD at the beginning of the current period. The percentage of ABD population shall be taken from the MQD published monthly enrollment. The weight assigned shall be as follows:

- 12.50% if the health plan has < 40.0% ABD,
- 7.50% if the health plan has >= 40.0% ABD.

This is a HEDIS measure. A health plan shall be eligible for a performance incentive payment if the current period actual rate:

- Meets or exceeds the target HEDIS 75th percentile rate,
- Closes the 'rate gap' by <100.00% and >=25.00%, or
- Closes the 'rate gap' by <25.00% and >=10.00%.

60.240 Prenatal and Postpartum Care (PPC) - Timeliness of Prenatal Care

The weight assigned to this measure depends on the percentage of the total population that is ABD at the beginning of the current period. The percentage of ABD population shall be taken from the MQD published monthly enrollment. The weight assigned shall be as follows:

- 6.250% if the health plan has < 40.0% ABD,
- 3.750% if the health plan has >= 40.0% ABD

This is a HEDIS measure. A health plan shall be eligible for a performance incentive payment if the current period actual rate:

- Meets or exceeds the target HEDIS 75th percentile rate,
- Closes the 'rate gap' by <100.00% and >=25.00%, or
- Closes the 'rate gap' by <25.00% and >=10.00%.

60.245 Prenatal and Postpartum Care (PPC) - Postpartum Care

The weight assigned to this measure depends on the percentage of the total population that is ABD at the beginning of the current period. The percentage of ABD population shall be taken from the MQD published monthly enrollment. The weight assigned shall be as follows:

- 6.250% if the health plan has < 40.0% ABD,
- 3.750% if the health plan has >= 40.0% ABD

This is a HEDIS measure. A health plan shall be eligible for a performance incentive payment if the current period actual rate:

- Meets or exceeds the target HEDIS 75th percentile

rate,

- Closes the 'rate gap' by <100.00% and >=25.00%, or
- Closes the 'rate gap' by <25.00% and >=10.00%."

60.300 Health Plan Responsibilities

60.310 Provider and Subcontractor Reimbursement

With the exception of eligible services provided by hospice providers, FQHCs, RHCs, hospitals, critical access hospitals (CAHs), PCPs, and nursing facilities, the health plan may reimburse its providers and subcontractors in any manner, subject to Federal rules. However, this does not preclude additional payments such as for a health home or financial incentives for performance. Regardless of the payment methodology, the health plan shall require that all providers submit detailed encounter data, if necessary. Health plans shall incentivize electronic claims submission.

The health plan shall reimburse non-contracted FQHCs and RHCs at rates no less than the Medicaid fee schedule if those providers are necessary for network adequacy. The health plan shall not be required to cover services at an FQHC or RHC if that provider is not contracted and not required for network adequacy. The health plan shall reimburse contracted FQHCs or RHCs for PPS eligible services at the PPS rate provided annually by the DHS. Any other payment methodology to these providers requires prior approval by DHS.

The DHS shall calculate and reimburse FQHC/RHC's for any retroactive settlements involving a change in scope of services that result in an increased PPS rate that is not incorporated into the capitation rates. The health plans shall reimburse the FQHC/RHC the annual PPS increase when provided by DHS. This annual increase will be incorporated into the capitation rates. The DHS shall perform reconciliation and make any necessary supplemental payments to FQHCs and RHCs.

The health plan shall report the number of unduplicated visits provided to its members by FQHCs and RHCs and the payments made by the health plan to FQHCs and RHCs. The health plan shall report this information to the DHS quarterly and annually in the format required by the DHS as described in Section 51.520.5.

The health plans shall reimburse hospitals for inpatient services through a diagnostic related group (DRG) where acuity adjusted diagnosis-based reimbursement methodologies have been well developed. Health plans may reimburse on a per diem basis for services for which such methodologies are not well developed and for specific situations such as wait-listed patients.

The health plans shall reimburse Ke Ola Mamo (the facility that has a grant for the American Indian and Alaska Native Healthcare in Hawaii Project) for services provided to members who are qualified to receive services from an Indian Health Service Facility as set forth in Title 42, United States Code Section, 1396u-2(h)(2); Title V of the American Recovery and Reinvestment Act of 2009, Section 5006. The health plans shall pay Ke Ola Mamo

for covered services at a negotiated rate or in the absence of a negotiated rate, at a rate not less than the level and amount of payment the health plan would make for the services provided by non-participating providers.

The health plan shall pay hospice providers Medicare hospice rates as calculated by the DHS and CMS. The health plan shall implement these rates on October 1 of each year.

The health plan shall reimburse critical access hospitals (CAHs) for hospital services and nursing home services at rates calculated prospectively by the DHS using Medicare reasonable cost principles in accordance with HRS § 346-59.

The health plan shall reimburse PCPs for evaluation and management services with an enhanced rate no less than the Medicare fee schedule. Refer to memorandum issued on PCP Managed Care Enhanced Reimbursement.

The health plan shall reimburse nursing facilities in accordance with HRS § 346E and § 346D-1.5 utilizing an acuity-based system at rates comparable to current Medicaid FFS.

The health plan shall pay Medicare co-payments to both contracted and non-contracted providers. The health plan shall utilize the current Medicaid reimbursement methodology and rate structure (if applicable) for Medicare co-payments. MQD reimburses all Medicare co-payments up to 100% of the Medicare rate for outpatient services only.

The health plan shall pay co-payments for services covered by a TPL to include co-payments for a three-month supply of maintenance medications or supplies.

The health plan shall pay out-of-network providers who deliver emergency services the same as they would have been paid if the emergency services had been provided to an individual in the Medicaid fee-for-service program. These providers shall not balance-bill the member.

The health plan shall pay its subcontractors and providers on a timely basis, consistent with the claims payment procedures described in Section 1902(a)(37)(A) of the Social Security Act. The health plans shall allow providers at least one year from date of service or discharge, whatever is the latter, to submit claims for reimbursement.

This section requires that ninety percent (90%) of all clean claims for payment (for which no further written information or substantiation is required in order to make payment) are paid within thirty (30) days of the date of receipt of such claims and that ninety-nine percent (99%) of all clean claims are paid within ninety (90) days of the date of receipt of such claims. The calculation of clean claim percentage paid is based on total claim count. The clean claims payment requirements apply in the aggregate but also individually for, hospital inpatient, hospital outpatient, skilled nursing facilities, Community Care Foster Family Homes (CCFFH), hospices, home health agencies, and

federally qualified health centers. Health plans shall also report to the DHS timeliness of payment regarding claims submitted in the aggregate and also separately for hospital inpatient, hospital outpatient, skilled nursing facilities, CCFFHs, hospices, home health agencies, and federally qualified health centers. The date of receipt is the date the health plan receives the claim, as indicated by its date stamp on the claim and the date of payment is the date of the check or other form of payment. The health plan and the provider may, however, agree to an alternative payment schedule provided this alternative payment schedule is reviewed and approved by the DHS.

Interest shall be allowed at a rate of fifteen percent (15%) a year for money owed by a health plan on payment of a clean claim exceeding the applicable time limitations under this section from the first calendar date after the thirty (30) day period.

The health plan shall require that providers use HIPAA standard 837I or 837P or NCDP transactions for electronic claims and the CMS 1500 or UB-04 forms for paper claims.

The health plan shall develop and maintain a claims payment system capable of processing, cost avoiding, and paying claims accurately in accordance with_reimbursement terms with the provider. The system must produce a remittance advice related to the health plan's payments to providers and must contain, at a minimum:

- An adequate description of all denials and adjustments using HIPAA standard Claim Adjustment Reason Codes (RARCs). Denial and adjustment codes assigned must provide sufficient information to fully explain a denial or adjustment without requiring additional inquiry from the payor, and shall use language that explains in adequate detail and in language that a lay person could reasonably understand. Any payor specific or customized reason codes shall also be fully explained in the same manner;
- The amount billed;
- The amount paid;
- Application of coordination of benefits (COB) and subrogation of claims (SOC); and
- Provider rights for claim disputes.

The related remittance advice must be sent with the payment, unless the payment is made by electronic funds transfer. For payments made by electronic funds transfer, payor must provide remittance advice via HIPAA standard electronic remittance advice transactions (835). Payor may opt to also provide a paper remittance advice. The remittance advice sent related to an electronic funds transfer must be mailed, or sent to the provider, not later than the date of the electronic funds transfer.

In no event shall the health plan's subcontractors and providers look directly to the State for payment.

The State and the health plan's members shall bear no liability for the health plan’s failure or refusal to pay valid claims of

subcontractors or providers. The health plan shall include in all subcontractor and provider contracts a statement that the State and plan members bear no liability for the health plan's failure or refusal to pay valid claims of subcontractors or providers for covered services. Further, the State and health plan members shall bear no liability for covered services provided to a member for which the State does not pay the health plan; or for which the plan or State does not pay the individual or health care provider that furnishes the services under a contractual, referral, or other arrangement; or for payment for covered services furnished under a contract, referral, or other arrangement, to the extent that these payments are in excess of the amount that the member would owe if the health plan provided the services directly.

The health plan shall indemnify and hold the State and the members harmless from any and all liability arising from such claims and shall bear all costs in defense of any action over such liability, including attorney's fees.

60.320 Non-Covered Services

The health plan may collect fees directly from members for non-covered services or for services from unauthorized non-health plan providers. If a member self-refers to a specialist or other provider within the health plan's network without following procedures (i.e., obtaining prior authorization), the health plan may deny payment to the service provider.

The health plan shall educate providers about the processes that must be followed for billing a member when non-covered or

unauthorized services are provided. This education shall include at a minimum the following:

- If a member self-refers to a specialist or other provider within the network without following health plan procedures (i.e., obtaining prior authorization) and the health plan does deny payment to the provider, the provider may bill the member if the provider provided the member with an Advance Beneficiary Notice of non-coverage;
- If a provider fails to follow health plan procedures which results in nonpayment, the provider may not bill the member; and
- If a provider bills the member for non-covered services or for self-referrals, he or she shall inform the member and obtain prior agreement from the member regarding the cost of the procedure and the payment terms at time of service.

In addition, the health plan shall inform the member of instances when they may be billed by a provider.

If the health plan later determines that a member has been billed and paid for health plan-covered services, the health plan shall refund the member directly.

60.330 Physician Incentives

The health plan may establish physician incentive plans pursuant to Federal and State regulations, including Section 1876(i)(8) of the Social Security Act and 42 CFR Sections 417.479, 422.208, 422.210, and 438.6.

The health plan shall disclose any and all such arrangements to the DHS for review and approval prior to implementing physician incentives, and upon request, to members. Such disclosure shall include:

- Whether services not furnished by the physician or group are covered by the incentive plan;
- The type of incentive arrangement including methodology;
- The percent of withhold or bonus amount; and
- The panel size and if patients are pooled, the method used.

Upon request, the health plan shall report adequate information specified by applicable regulations to the DHS so that the DHS can adequately monitor the health plan.

If the health plan's physician incentive plan includes services not furnished by the physician/group, the health plan shall: (1) ensure adequate stop loss protection to individual physicians, and must provide to the DHS proof of such stop loss coverage, including the amount and type of stop loss; and (2) conduct annual member surveys, with results disclosed to the DHS, and to members, upon request.

Such physician incentive plans may not provide for payment, directly or indirectly, either to a physician or to physician group as an inducement to reduce or limit medically necessary services furnished to an individual.

Aligning payment to incentivize high quality and high efficiency care is addressed in Section 50.500.

60.340 Payment for Provider Preventable Conditions (PPC)

The health plan shall not pay for health care-acquired conditions (HCAC) or other provider-preventable conditions (OPPC) identified by CMS and DHS. DHS shall update the health plans, as needed, of changes to the CMS and DHS required list. A current list of PPC is located in Appendix R.

60.350 Co-Payments

Health plans may be required to implement co-payments for members as determined by DHS. This process may include tracking and limiting aggregate amounts of co-payment for a household. Services for which co-payments may be imposed include but are not limited to prescription drugs, emergency room visits for non-emergent visits or non-emergency transportation. Co-payments are subject to Federal regulations.

60.400 Third Party Liability (TPL)

60.410 Background

TPL refers to any other health insurance plan or carrier (i.e., individual, group, employer-related, self-insured or self-funded, or commercial carrier, automobile insurance and worker's compensation) or program, that is, or may be, liable to pay all or part of the health care expenses of the member.

Pursuant to Section 1902(a)(25) of the Social Security Act, the DHS authorizes the health plan as its agent to identify legally liable third parties and treat verified TPL as a resource of the member.

Reimbursement from the third party shall be sought unless the health plan determines that recovery would not be cost effective. For example, the health plan may determine that the amount it reasonably expects to recover will be less than the cost of recovery. In such situations, the health plan shall document the situation and provide adequate documentation to the DHS.

Each quarter, the health plan shall report to DHS in a format specified by DHS all TPLs known for its members, including any of its QUEST Integration members that also have commercial insurance through the health plan. The health plan shall also comply with Act 95, SLH 2012.

60.420 Responsibilities of the DHS

The DHS shall:

- Be responsible for coordination and recovery of accident and workers' compensation subrogation benefits;
- Collect and provide member TPL information to the health plan. TPL information shall be provided to the health plan via the daily TPL roster; and
- Conduct TPL audits every six (6) months to ensure TPL responsibilities are being completed by the health plan.

60.430 Responsibilities of the Health Plan

The health plans shall enter into a Coordination of Benefits Agreement with Medicare and participate in the automated claims crossover process for individuals dually eligible for Medicaid and Medicare. The health plans shall be responsible for dually eligible individual's coordination of benefits.

The health plan shall coordinate health care benefits with other coverages, both public and private, which are or may be available to pay medical expenses on behalf of any member.

The health plan shall seek reimbursement from all other liable third parties to the limit of legal liability for the health services rendered. The health plan shall retain all health insurance benefits collected, including cost avoidance.

The health plan shall follow the mandatory pay and chase provisions described in 42 CFR Section 433.139(b)(3)(i)(ii).

In addition, the health plan shall:

- Continue cost avoidance of the health insurance plans accident and workers' compensation benefits;
- Report all accident cases incurring medical and medically related dental expenses in excess of five-hundred dollars ($500) to the DHS;
- Provide a list of medical and medically related dental expenses, in the format requested by the DHS, for recovery

purposes. "RUSH" requests shall be reported within three (3) business days of receipt and "ROUTINE" requests within seven (7) business days of receipt. Listings shall also include claims received but not processed for payments or rejected;

- Provide copies of claim forms with similar response time as the above;
- Provide listings of medical and medically related dental expenses (including adjustments, e.g., payment corrections, refunds, etc.) according to the payment period or "as of" date. Adjustments shall be recorded on the date of adjustment and not on the date of service;
- Inform the DHS of TPL information uncovered during the course of normal business operations;
- Provide the DHS with monthly reports of the total cost avoidance and amounts collected from TPLs within thirty (30) days of the end of the month;
- Develop procedures for determining when to pursue TPL recovery; and
- Provide health care services for members receiving motor vehicle insurance liability coverage at no cost through the Hawaii Joint Underwriting Plan (HJUP) in accordance with Section 431:10C-401 et. seq., HRS.

SECTION 70 SPECIAL TERMS AND CONDITIONS

70.100 Contract Documents

The following documents form an integral part of the written contract between the health plan and the DHS (hereafter collectively referred to as "the Contract"):

- Contract for Health and Human Services: Competitive Purchase of Service (AG Form 103F1 (10/08)) (see Appendix S), including General Conditions for Health & Human Services Contracts (AG Form 103F (10/08) (see Appendix S), any Special Conditions, attachments, and addenda;
- this RFP, appendices, attachments, and addenda, which shall be incorporated by reference; and
- the health plan's technical proposal submitted in response to this RFP form, which shall be incorporated by reference.

References to "General Conditions" in this Section 70 are to the General Conditions for Health & Human Services Contracts attached as Appendix S.

70.200 Conflict Between Contract Documents, Statutes and Rules

Replace General Condition 7.5, Conflict between General Conditions and Procurement Rules, with the following:

- Contract Documents: In the event of a conflict among the contract documents, the order of precedence shall be as follows: (1) Contract for Health and Human Services:

Competitive Purchase of Service (AG Form 103F1), including all general conditions, special conditions, attachments, and addenda; (2) the RFP, including all attachments and addenda, as amended; and (3) applicant's proposal. In the event of a conflict between the General Conditions and the Special Conditions, the Special Conditions shall control.

- Contract and Statutes: In the event of a conflict between the language of the contract, and applicable statutes, the latter shall prevail.
- Contract and Procurement Rules/Directives: In the event of a conflict between the Contract and the Procurement Rules or a Procurement Directive, the Procurement Rules or any Procurement Directive in effect on the date this Contract became effective shall control and are hereby incorporated by reference.
- The sections of the rules and regulations cited in this RFP may change as the rules and regulations are amended for MQD. No changes shall be made to this RFP due to changes in the section numbers. The documents in the documentation library shall be changed as needed. The availability and extent of the materials in the documentation library shall have no effect on the requirements stated in this RFP.

70.300 Licensing and Accreditation

General Condition 1.2.2, Licensing and Accreditation, is amended to read as follows:

At the time of submission of the applicant's proposal, the health plan shall be properly licensed as a health plan in the State of Hawaii as described in chapters 431, 432, or 432D, HRS, and any other licenses and accreditations required under applicable federal, state, and county laws, ordinances, codes, rules, and regulations to provide the services under the contract. The health plan shall comply with all applicable requirements set forth in the above mentioned statutes, and shall include with its proposal proof of licensure and a certificate of good standing from the DCCA Insurance Division dated within 30 days of the date of the proposal (see Section 80.230). In the event of any conflict between the requirements of the contract and the requirements of any these licensure statutes, the statute shall prevail and the health plan shall not be deemed to be in default of compliance with any mandatory statutory requirement.

70.400 Subcontractor Agreements

Replace General Condition 3.2, Subcontracts and Assignments, with the following:

The health plan may negotiate and enter into contracts or agreements with subcontractors to the benefit of the health plan and the State. All such agreements shall be in writing. No subcontract that the health plan enters into with respect to the performance under the contract shall in any way relieve the health

plan of any responsibility for any performance required of it by the contract.

The health plan shall submit to the DHS for review and prior approval, all subcontractor agreements related to the provision of covered benefits and services and member services activities to members (e.g., call center) and provider services activities and payments to providers. The health plan shall submit these subcontractor agreements as required in Section 51.700, Readiness Review. In addition, the DHS reserves the right to inspect all subcontractor agreements at any time during the contract period.

The health plan shall notify the DHS in writing at least ninety (90) days prior to adding or deleting subcontractor agreements or making any change to any subcontractor agreements which may materially affect the health plan's ability to fulfill the terms of the contract.

The health plan shall provide the DHS with immediate notice in writing by registered or certified mail of any action or suit filed against it by any subcontractor, and prompt notice of any claim made against the health plan by any subcontractor that, in the opinion of the health plan, may result in litigation related in any way to the contract with the State of Hawaii.

Additionally, no assignment by the health plan of the health plan's right to compensation under the contract shall be effective unless and until the assignment is approved by the Comptroller of the

State of Hawaii, as provided in Section 40-58, HRS, or its successor provision.

All subcontractor agreements must, at a minimum:

- Describe the activities, including reporting responsibilities, to be performed by the subcontractor and require that the subcontractor meet all established criteria prescribed and provide the services in a manner consistent with the minimum standards specified in the health plan's contract with the State;
- Require that the subcontractor fulfill the requirements of 42 CFR Section 438.6 that are appropriate to the service delegated under the subcontract;
- Provide information regarding member rights and processes regarding the Member Grievance System found in Section 51.100, if applicable;
- Include a provision that allows the health plan to:
    - Evaluate the subcontractor's ability to perform the activities to be delegated;
    - Monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule (the frequency shall be stated in the agreement) established by the DHS and consistent with industry standards or State laws and regulations;
    - Identify deficiencies or areas for improvement; and

    - Take corrective action or impose other sanctions including, but not limited to, revoking delegation, if the subcontractor's performance is inadequate.
- Require that the subcontractor submits to the health plan a tax clearance certificate from the Director of the DOTAX, State of Hawaii, showing that all delinquent taxes, if any, levied or accrued under State law against the subcontractor have been paid;
- Include a provision that the health plan shall designate itself as the sole point of recovery for any subcontractor;
- Include a provision that neither the State nor the health plan members shall bear any liability of the health plan's failure or refusal to pay valid claims of subcontractors;
- Require that the subcontractor track and report complaints against them to the health plan;
- Require that the subcontractor fully adhere to the privacy, confidentiality and other related requirements stated in the RFP and in applicable federal and state law;
- Require that the subcontractor follow all audit requirements as outlined in Section 71.800 inclusive. The actual requirements shall be detailed in the agreement;
- Require that the medical records be retained in compliance with Section 70.500. The actual requirements shall be detailed in the agreement;
- Require that the subcontractor comply with all requirements related to confidentiality of information as outlined in Section 71.700. The actual requirements found in this section shall be detailed in the agreement.

- Require that the subcontractor notify the health plan and the MQD of all breaches of confidential information relating to Medicaid applicants and recipients, as health plan members. The notice to the State shall be within two (2) business days of discovery of the breach and a written report of the investigation and resultant mitigation of the breach shall be provided to the State within thirty (30) calendar days of the discovery of the breach.
- Require that the subcontractor allow the state and federal government full access to inspect and audit any records or documents, and inspect the premises physical facilities, and equipment where Medicaid-related activities or work is conducted, to the extent allowed by law.

70.500 Retention of Medical Records

The following is added to the end of General Condition 2.3, Records Retention:

The health plan and its providers shall retain all medical records, in accordance with 42 CFR 438.3(h), for a minimum of ten (10) years from the last date of entry in the records. For minors, the health plan shall retain all medical records during the period of minority plus a minimum of ten (10) years after the age of majority.

The health plan shall include in its subcontracts and provider agreements record retention requirements that are at least equivalent to those stated in this section.

During the period that records are retained under this section, the health plan and any subcontractor or provider shall allow the state and federal government full access to inspect and audit any records or documents, and inspect the premises physical facilities, and equipment where Medicaid-related activities or work is conducted, to the extent allowed by law.

70.600 Responsibility For Taxes

In addition to the requirements of General Condition 3.4.4, PROVIDER's Responsibilities, subject to its corporate structure, licensure status, or other statutory exemptions, health plans may be liable for, or exempt from, other federal, state, and/or local taxes including, but not limited to, the insurance premium tax (chapter 431, Article 7, Part II, HRS). Each health plan is responsible for determining whether it is subject to, or exempt from, any such federal, state, or local taxes. The DHS makes no representations whatsoever as to the liability or exemption from liability of the health plan to any tax imposed by any governmental entity.

70.700 Full Disclosure

70.710 Business Relationships

The health plan warrants that it has fully disclosed all business relationships, joint ventures, subsidiaries, holding companies, or any other related entity in its proposal and that any new relationships shall be brought to the attention of the DHS as soon as such a relationship is consummated. The terms and conditions

of CMS require full disclosure on the part of all contracting health plans and providers.

The health plan shall not knowingly have a director, officer, partner, or person with more than five percent (5%) of the health plan's equity, or have an employment, consulting, or other agreement with such a person for the provision of items and services that are significant and material to the entity's contractual obligation with the State, who has been debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. The health plan shall not, without prior approval of the DHS, lend money or extend credit to any related party. The health plan shall fully disclose such proposed transactions and submit a formal written request for review and approval.

The health plan shall include the provisions of this section in any subcontract or provider agreement.

70.720 Litigation

The health plan shall disclose any pending litigation both in and out of Hawaii to which they are a party, including the disclosure of any outstanding judgment. If applicable, please explain.

70.800 Conflict of Interest

The following is added to the end of General Condition 1.7, Conflicts of Interest:

No official or employee of the State of Hawaii or the federal government who exercises any function or responsibilities in the review or approval of the undertaking or carrying out of the programs shall, prior to the completion of the project, voluntarily acquire any personal interest, direct or indirect, in the contract. All officials or employees of the State of Hawaii shall be bound by Chapter 84, HRS, Standards of Conduct.

The health plan shall not contract with the State of Hawaii unless the conflict of interest safeguards described in 42 CFR 438.58 and in section 27 of the Office of Federal Procurement Policy Act (41 U.S.C § 423) are in place and complies with the requirement described in section 1902 (a)(4)(c) of the Social Security Act applicable to contracting officers, employees, or independent contractors.

70.900 Employment of Department Personnel

The health plan shall not knowingly engage any persons who are or have been employed within the past twelve (12) months by the State of Hawaii to assist or represent the health plan for consideration in matters which he/she participated as an employee or on matters involving official action by the State agency or subdivision, thereof, where the employee had served.

71.100 Fiscal Integrity

71.110 Warranty of Fiscal Integrity

The health plan warrants that it is of sufficient financial solvency to assure the DHS of its ability to perform the requirements of the contract. The health plan shall comply with the solvency standards established by the State Insurance Commissioner for private health maintenance organizations or health plans licensed in the State of Hawaii, and shall, upon request by the DHS, provide financial data and information to prove its financial solvency.

71.120 Performance Bond

The health plan shall obtain a performance bond issued by a reputable surety company authorized to do business in the State of Hawaii in the amount of one-million dollars ($1,000,000) or more, conditioned upon the prompt, proper, and efficient performance of the contract, and shall submit the same to the DHS prior to or at the time of the execution of the contract. The performance bond shall be liable to forfeit by the health plan in the event the health plan is unable to properly, promptly and efficiently perform the contract terms and conditions or the contract is terminated by default or bankruptcy of the health plan.

The amount of the performance bond shall be adjusted at the time members begin enrolling in the plan. At that time, the amount of the performance bond shall approximate eighty percent (80%) of one month's capitation payments. The health plan shall update their performance bond annually. The health plans shall submit to DHS a revised performance bond no later than sixty (60) days

after the start of the benefit period. The revised capitation payment shall be based upon the last capitation payment for the previous benefit period.

The health plan may, in place of the performance bond, provide the following in the same amount as the performance bond:

- Certificate of deposit, share certificate, or cashier's, treasurer's, teller's or official check, or a certified check made payable to the Department of Human Services, State of Hawaii, issued by a bank, a savings institution, or credit union that is insured by the Federal Deposit Insurance Corporation (FDIC) or the National Credit Union Administration, and payable at sight or unconditionally assigned to the procurement officer advertising for offers. These instruments may be utilized only to a maximum of one-hundred thousand dollars ($100,000) each and must be issued by different financial institutions.
- Letter of credit with a bank insured by the FDIC with the Department of Human Services, State of Hawaii, designated as the sole payee.

Upon termination of the contract, for any reason, including expiration of the contract term, the health plan shall ensure that the performance bond is in place until such time that all of the terms of the contract have been satisfied. The performance bond shall be liable for, and the DHS shall have the authority to, retain funds for additional costs including, but not limited to:

- Any costs for a special plan change period necessitated by the termination of the contract;
- Any costs for services provided prior to the date of termination that are paid by MQD;
- Any additional costs incurred by the State due to the termination; and
- Any sanctions or penalties owed to the DHS.

71.200 Term of the Contract

This is a multi-term contract solicitation that has been deemed to be in the best interest of the State by the Director of the DHS in accordance with Section 3-149-302(c), HAR. The contract is for the initial term from the date of commencement of services to members as specified in Section 20.100 to December 31, 2017. Unless terminated, the contract may be extended without the necessity of re-bidding, for not more than four (4) additional twelve (12) month periods or parts thereof, only upon mutual agreement of the parties in writing. The health plan shall not contract with the State of Hawaii unless safeguards at least equal to Federal safeguards (41 USC 423, section 27) are in place.

The State of Hawaii operates on a fiscal year basis, which runs from July 1 to June 30 of each year. Funds are available for only the first fiscal period of the contract ending June 30 in the first year of the initial term. The contractual obligation of both parties in each fiscal period succeeding the first fiscal period is subject to the appropriation and availability of funds to DHS.

The contract will be terminated only if funds are not appropriated or otherwise made available to support continuation of performance in any fiscal period succeeding the initial fiscal period of the contract; however this does not affect either the State's rights or the health plan's rights under any termination clause of the contract. The State shall notify the health plan, in writing, at least sixty (60) days prior to the expiration of the contract whether funds are available or not available for the continuation of the contract for each succeeding contract extension period. In the event of termination, as provided in this paragraph, the health plan shall be reimbursed for the unamortized, reasonably incurred, nonrecurring costs.

The health plan acknowledges that other unanticipated uncertainties may arise that may require an increase or decrease in the original scope of services to be performed, in which event the health plan agrees to enter into a supplemental agreement upon request by the State. The supplemental agreement may also include an extension of the period of performance and a respective modification of the compensation.

71.300 Insurance

71.310 Liability Insurance Requirements

The health plan shall maintain insurance acceptable to the DHS in full force and effect throughout the term of this contract, until the DHS certifies that the health plan's work has been completed satisfactorily.

Prior to or upon execution of the contract and any supplemental contracts, the health plan shall provide to the DHS certificate(s) of insurance, including any referenced endorsements, dated within thirty (30) days of the effective date of the contract necessary to satisfy the DHS that the insurance provisions of this contract have been complied with. Upon request by the DHS, health plan shall furnish a copy of the policy(ies) and/or updated Certificate of Liability Insurance including referenced endorsement(s) necessary for DHS to verify the coverages required by this section.

The policy or policies of insurance maintained by the health plan shall be written by insurance companies licensed to do business in the State of Hawaii or meet the requirements of Section 431:8-301, et seq., HRS, if utilizing an insurance company not licensed by the State of Hawaii.

The policy(ies) shall provide at least the following limit(s) and coverage:

Coverage		**Limits**
Commercial General Liability		Per occurrence, not claims made • $1 million per occurrence • $2 million in the aggregate
Automobile		May be combined single limit: • Bodily Injury: $1 million per person, $1 million per accident • Property Damage: $1 million per accident
Workers Compensation / Employers Liability (E.L.)		• Workers Comp: Statutory Limits • E.L. each accident: $1,000,000 • E.L. disease: $1,000,000 per employee, $1,000,000 policy limit

		• E.L. $1 million aggregate
Professional Liability, if applicable		May be claims made: • $1 million per claim • $2 million annual aggregate

Each insurance policy required by this contract shall contain the following clauses, which shall also be reflected on the certificate of insurance:

1. "The State of Hawaii is an additional insured with respect to operations performed for the State of Hawaii."
2. "Any insurance maintained by the State of Hawaii shall apply in excess of, and not contribute with, insurance provided by this policy."

Automobile liability insurance shall include excess coverage for the health plan's employees who use their own vehicles in the course of their employment.

The health plan shall immediately provide written notice to the DHS should any of the insurance policies required under the Contract be cancelled, limited in scope, or not be renewed upon expiration.

Failure of the health plan to provide and keep in force the insurance required under this section shall be regarded as a material default under this contract, entitling the DHS to exercise any or all of the remedies provided in this contract for a default of the health plan.

The procuring of such required policy or policies of insurance shall not be construed to limit health plan's liability hereunder nor to fulfill the indemnification provisions and requirements of this contract. Notwithstanding said policy or policies of insurance, health plan shall be liable for the full and total amount of any damage, injury, or loss caused by health plan in connection with this contract.

If the health plan is authorized by the DHS to subcontract, subcontractors are not excused from the indemnification and/or insurance provisions of this contract. In order to indemnify the State of Hawaii, the health plan agrees to require its subcontractors to obtain insurance in accordance with this section.

71.320 Reinsurance

Given the relatively low enrollment for some plans and potential high costs for the aged, blind and disabled population, the state is offering a State sponsored catastrophic reinsurance program for the ABD population. DHS will offer this option to MCOs for a limited time prior to the completion of the annual rating process. Once this decision is made to either to opt in to choose or our out of reinsurance, the option selected is binding for the entire rating period. The initial reinsurance period will be from July 1, 2016 through December 31, 2016, and subsequent reinsurance periods will be on a calendar year basis beginning January 1, 2017. For MCOs that accept this option, the value of this benefit is removed from the capitation rate for this MCO. For MCOs that decline the State sponsored reinsurance, they will receive a capitation rate reflecting the full costs for these members.

The reinsurance benefit is equal to 85% of the annual costs for an individual over $300,000 and 100% of costs over $1,000,000, excluding long-term care services and, starting in 2017, Hepatitis C drug costs. The reinsurance would only apply to members while enrolled in the ABD program and would not apply to services for this same member while enrolled in the Non-ABD program. Costs for a member will be adjusted to be consistent with any pricing adjustments included in the rate development. Specifically, if there are unit cost issues with a plan such that repricing was required for the rate development material, that same repricing would be applied to the claims before application of the reinsurance benefit. Historically, claims have been repriced prior to application of the reinsurance parameters. It is the state's intention to reprice inpatient claims as these are the primary driver in triggering the application of the reinsurance. The state fee schedule is not consistent with current contracting between the health plan and the provider, so inpatient claims will be repriced at the state fee schedule with a multiplier applied to be consistent with the average load of FFS levels based on contributing MCOs to the capitation rate. This is consistent with the development of the value of the benefit which is netted out of the rates for those who opt for this provision.

Claims are considered to be incurred during the reinsurance period based on the same criteria for assigning financial responsibility related to transition of care as detailed in memorandum number FFS M14-16 QI-1432 dated December 31, 2014 from the Med-QUEST Division. Specifically, if an admission begins during the reinsurance period, then facility costs continue to be associated with the admission date until a transition of care

occurs, based on the transition of care rules as included in the above listed memorandum. This is consistent with how costs are transferred from one MCO to another when a member in a facility changes health plans. Professional fees and enabling services (e.g. meals, transportation, and lodging) are to be considered with the incurred date of service, not the admit date.

There will be an interim settlement two months after the end of the period. A final settlement will take place once the retroactive risk corridor settlements have been finalized, and in addition, starting in 2017, once the hepatitis C risk corridor settlement has been finalized.

71.400 Modification of Contract

The following is added as General Condition 4.1.4:

All modifications of the contract may be negotiated and accompanying capitated rates established. Such modifications shall result in a supplemental agreement document produced by the DHS and delivered to the health plan. If the parties are in agreement, the supplemental agreement document shall be signed by the Director of the DHS and an authorized representative of the health plan. If the parties are unable to reach an agreement within thirty (30) calendar days of the health plan's receipt of the supplemental agreement document, the provisions of such contract change will be deemed to have been accepted on the thirty-first (31st) calendar day after the health plan received the supplemental agreement document, even if the contract change has not been signed by the health plan, unless

within the thirty (30) calendar days after the health plan received the supplemental agreement document, the health plan notifies the DHS in writing that it refuses to sign the amendment. If the health plan provides such notification, the DHS will initiate termination proceedings.

71.500 Conformance with Federal Regulations

Any provision of the contract which is in conflict with Federal Medicaid statutes, regulations, or CMS policy guidance is hereby amended to conform to the provisions of those laws, regulations, and federal policy. Such amendment of the contract shall be effective on the effective date of the statutes or regulations necessitating it, and shall be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

71.600 Termination of the Contract

The contract may terminate or may be terminated by DHS for any or all of the following reasons in addition to the General Conditions in Appendix S:

- Termination for Default;
- Termination for Expiration of the Programs by CMS; or
- Termination for Bankruptcy or Insolvency

71.610 Termination for Default

The failure of the health plan to comply with any term, condition, or provision of the contract or applicable requirements in Sections

1932, 1903(m) and 1905(t) of the Social Security Act shall constitute default by the health plan. In the event of default, the DHS shall notify the health plan by certified or registered mail, with return receipt requested, of the specific act or omission of the health plan, which constitutes default. The health plan shall have fifteen (15) days from the date of receipt of such notification to cure such default. In the event of default, and during the above-specified grace period, performance under the contract shall continue as though the default had never occurred. In the event the default is not cured within fifteen (15) days, the DHS may, at its sole option, terminate the contract for default. Such termination shall be accomplished by written notice of termination forwarded to the health plan by certified or registered mail and shall be effective as of the date specified in the notice. If it is determined, after notice of termination for default, that the health plan's failure was due to causes beyond the control of and without error or negligence of the health plan, the termination shall be deemed a termination for convenience under General Condition 4.3 in Appendix S.

The DHS' decision not to declare default shall not be deemed a waiver of such default for the purpose of any other remedy the health plan may have.

71.620 Termination for Expiration or Modification of the Programs by CMS

The DHS may terminate performance of work under the contract in whole or in part whenever, for any reason, CMS terminates or modifies the programs. In the event that CMS elects to terminate its agreement with the DHS, the DHS shall so notify the health

plan by certified or registered mail, return receipt requested. The termination shall be effective as of the date specified in the notice.

71.630 Termination for Bankruptcy or Insolvency

In the event that the health plan shall cease conducting business in the normal course, become insolvent, make a general assignment for the benefit of creditors, suffer or permit the appointment of a receiver for its business or its assets or shall avail itself of, or become subject to, any proceeding under the Federal Bankruptcy Act or any other statute of any State relating to insolvency or the protection of the rights or creditors, the DHS may, at its option, terminate the contract. In the event the DHS elects to terminate the contract under this provision it shall do so by sending notice of termination to the health plan by registered or certified mail, return receipt requested. The termination shall be effective as of the date specified in the notice.

In the event of insolvency of the health plan, the health plan shall cover continuation of services to members for the duration of period for which payment has been made, as well as for inpatient admissions up until discharge. Members shall not be liable for the debts of the health plan. In addition, in the event of insolvency of the health plan, members may not be held liable for the covered services provided to the member, for which the State does not pay the health plan.

71.640 Procedure for Termination

In the event the State decides to terminate the contract, it shall provide the health plan with a pre-termination hearing. The State shall:

- Give the health plan written notice of its intent to terminate, the reason(s) for termination, and the time and place of the pre-termination hearing; and
- Give the health plan's members written notice of the intent to terminate the contract, notify members of the hearing, and allow them to disenroll immediately without cause.

Following the termination hearing, the State shall provide written notice to the health plan of the termination decision affirming or reversing the proposed termination. If the State decides to terminate the contract, the notice shall include the effective date of termination. In addition, if the contract is to be terminated, the State shall notify the health plan's members in writing of their options for receiving Medicaid services following the effective date of termination.

In the event of any termination, the health plan shall:

- Stop work under the contract on the date and to the extent specified in the notice of termination;
- Complete the performance of such part of the work as shall not have been terminated by the notice of the termination;
- Notify the members of the termination and arrange for the orderly transition to the new health plan(s), including timely provision of any and all records to the DHS that are

necessary to transition the health plan's members to another health plan;

- Promptly supply all information necessary for the reimbursement of any outstanding claims;
- Place no further orders or enter into subcontracts for materials, services, or facilities, except as may be necessary for completion of the work under the portion of the contract that is not terminated;
- Terminate all orders and subcontracts to the extent that they relate to the performance of work terminated by the notice of termination;
- Assign to the DHS in the manner and to the extent directed by the MQD Administrator of the right, title, and interest of the health plan under the orders or subcontracts so terminated, in which case the DHS shall have the right, in its discretion, to settle or pay any or all claims arising out of the termination of such orders and subcontracts;
- With the approval of the MQD Administrator, settle all outstanding liabilities and all claims arising out of such termination of orders and subcontracts, the cost of which would be reimbursable, in whole or in part, in accordance with the provisions of the contract;
- Take such action as may be necessary, or as the MQD Administrator may direct, for the protection and preservation of any and all property or information related to the contract which is in the possession of the health plan and in which the DHS has or may acquire an interest; and
- Within thirty (30) business days from the effective date of the termination, deliver to the DHS copies of all current data

files, program documentation, and other documentation and procedures used in the performance of the contract at no cost to the DHS. The health plan agrees that the DHS or its designee shall have a non-exclusive, royalty-free right to the use of any such documentation.

The health plan shall create written procedures for the orderly termination of services to any members receiving the required services under the contract, and for the transition to services supplied by another health plan upon termination of the contract, regardless of the circumstances of such termination. These procedures shall include, at the minimum, timely notice to the health plan's members of the termination of the contract, and appropriate counseling. The health plan shall submit these procedures to the DHS for review and approval by the due date identified in Section 51.700, Readiness Review.

71.650 Termination Claims

After receipt of a notice of termination, the health plan shall submit to the MQD Administrator any termination claim in the form and with the certification prescribed by the MQD Administrator. Such claim shall be submitted promptly but no later than six (6) months from the effective date of termination. Upon failure of the health plan to submit its termination claims within the time allowed, the MQD Administrator may, subject to any review required by the State procedures in effect as of the date of execution of the contract, determine, on the basis of information available to him/her, the amount, if any, due to the

health plan by reason of the termination and shall thereupon cause to be paid to the health plan the amount to be determined.

Upon receipt of notice of termination, the health plan shall have no entitlement to receive any amount for lost revenues or anticipated profits or for expenditures associated with this or any other contract. The health plan shall be paid only the following upon termination:

- At the contract price(s) for the number of members enrolled in the health plan at the time of termination; and
- At a price mutually agreed to by the health plan and the DHS.

In the event the health plan and the DHS fail to agree, in whole or in part, on the amount of costs to be paid to the health plan in connection with the total or partial termination of work pursuant to this section, the MQD Administrator shall determine, on the basis of information available to the DHS, the amount, if any, due to the health plan by reason of the termination and shall pay to the health plan the amount so determined.

The health plan shall have the right to appeal any such determination made by the MQD Administrator as stated in Section 72.100, Disputes.

71.660 Departing Health Plan

In the event that the health plan is not awarded a new QI contract at the termination of this current contract, including a health plan

that continues with a future contract on Oahu but not the Neighbor Islands, the departing health plan shall continue to meet the provisions in this RFP.

The health plans shall cover continuation of services to members for the duration of the period for which capitation payments have been made, as well as for inpatient admissions up until discharge or level of care change.

The Transition Plan addressing RFP/contract compliance during the run out period shall be submitted by the departing health plan to MQD, which at a minimum should describe how the health plan will:

- Ensure continuous care delivery to members that are in an institution on June 30, 2019
- Ensure continuity of customer and provider services call centers
- Ensure the member service authorization process continues as necessary
- Ensure the adjudication of self-direct service provider claims/timesheets
- Ensure continuity of existing provider claim processing/payment/resubmission process for both electronic and paper modalities
- Ensure continuous delivery of timely and accurate encounter data to MQD
- Ensure continuous delivery of scheduled management reports to MQD
- Adequately staff for the run out period, including contingencies around unexpected staff departures

- Secure IT hardware/software, telephony, and business space to conduct run out operations
- Communicate regularly with MQD during the run out period

71.700 Confidentiality of Information

In addition to the requirements of General Condition 8, the health plan understands that the use and disclosure of information concerning applicants, beneficiaries or members is restricted to purposes directly connected with the administration of the Hawaii Medicaid program, and agrees to guard the confidentiality of an applicant's, beneficiary's or member's information as required by law. The health plan shall not disclose confidential information to any individual or entity except in compliance with the following:

- 42 CFR Part 431, Subpart F;
- The Administrative Simplification provisions of HIPAA and the regulations promulgated thereunder, including but not limited to the Security and Privacy requirements set forth in 45 CFR Parts 160 and 164;Section 346-10, HRS; and
- All other applicable federal and State statutes and administrative rules, including but not limited to:
    - Section 325-101, HRS, relating to persons with HIV/AIDS;
    - Section 334-5, HRS, relating to persons receiving mental health services;
    - Chapter 577A, HRS relating to emergency and family planning services for minor females;
    - 42 CFR Part 2 relating to persons receiving substance abuse services;

- Chapter 487J, HRS, relating to social security numbers; and
- Chapter 487N, HRS, relating to personal information.

Access to member identifying information shall be limited by the health plan to persons or agencies that require the information in order to perform their duties in accordance with this contract, including the U.S. Department of Health and Human Services (HHS), the Secretary, the DHS and other individuals or entities as may be required by the DHS. (See 42 CFR Section 431.300, et seq. and 45 CFR Parts 160 and 164.)

Any other party shall be granted access to confidential information only after complying with the requirements of state and federal laws, including but not limited to HIPAA, and regulations pertaining to such access. The health plan is responsible for knowing and understanding the confidentiality laws listed above as well as any other applicable laws. The health plan, if it reports services to its members, shall comply with all applicable confidentiality laws. Nothing herein shall prohibit the disclosure of information in summary, statistical or other form that does not identify particular individuals, provided that de-identification of protected health information is performed in compliance with the HIPAA Privacy Rule.

Federal and State Medicaid rules, and some other Federal and State statutes and rules, including but not limited to those listed above, are often more stringent than the HIPAA regulations. Moreover, for purposes of this contract, the health plan agrees

that the confidentiality provisions contained in Chapter 17-1702, HAR, shall apply to the health plan to the same extent as they apply to MQD.

The health plan shall implement a secure electronic mail (email) encryption solution to ensure confidentiality, integrity, and authenticity of email communications that contain information relating to members.

Health plans are business associates of the DHS as defined in 45 CFR §160.103, and agree to the terms of the Business Associate Agreement (BAA) found in Appendix U.

71.800 Audit Requirements

The state and federal standards for audits of the DHS designees, contractors and programs conducted under contract are applicable to this subsection and are incorporated by reference into the contract. The DHS, the HHS, or the Secretary may, at any time, inspect and audit any records, inspect the premises, physical facilities, and equipment of the health plan and its subcontractors, subcontractor's contractors, or providers. There shall be no restrictions on the right of the State or Federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services and reasonableness of their costs. The right to audit shall exist for ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later.

71.810 Accounting Records Requirements

The health plan shall, in accordance with generally accepted accounting practices, maintain fiscal records and supporting documents and related files, papers and reports that adequately reflect all direct and indirect expenditures and management and fiscal practices related to the health plan's performance of services under the contract.

The health plan's accounting procedures and practices shall conform to generally accepted accounting principles and the costs properly applicable to the contract shall be readily ascertainable from the records.

71.820 Inclusion of Audit Requirements in Subcontracts

The provisions of Section 71.800 and its associated subsections shall be incorporated in every subcontract/provider agreement.

71.900 Ongoing Inspection of Work Performed

In addition to the ongoing monitoring described in Section 31.100, the DHS, the State Auditor of Hawaii, the Secretary, the U.S. Department of Health and Human Services (HHS), CMS, the General Accounting Office (GAO), the Comptroller General of the United States, the Office of the Inspector General (OIG), Medicaid Fraud Control Unit of the Department of the Attorney General, State of Hawaii, or their authorized representatives shall have the right to enter into the premises of the health plan, all subcontractors and providers, or such other places where duties under the contract are being performed, to inspect, monitor, or

otherwise evaluate the work being performed and have access to all records. All inspections and evaluations shall be performed in such a manner to not unduly delay work. This includes timely and reasonable access to the personnel for the purpose of interview and discussion related to the records. All records and files pertaining to the health plan shall be located in the State of Hawaii at the health plan's principal place of business or at a storage facility on Oahu that is accessible to the foregoing identified parties.

72.100 Disputes

The parties shall first attempt to resolve all disputes arising under this contract by informal resolution. Where informal resolution cannot be reached, the health plan shall submit a written request for dispute resolution (by certified mail, return receipt requested) to the Director of the DHS or the Director's duly authorized representative. The health plan shall be afforded the opportunity to be heard and to present evidence in support of its position in the dispute. The Director of the DHS or the Director's authorized representative shall issue a written decision within ninety (90) days of the health plan's written request. The decision of the Director of the DHS or the Director's authorized representative shall be final and binding and may only be set aside by a State court of competent jurisdiction where the decision was fraudulent, capricious, arbitrary, or grossly erroneous as to imply bad faith.

Pending any subsequent legal proceedings regarding the final decision, including all appeals, the health plan shall proceed diligently

in the performance of the contract in accordance with the Director's final decision.

Any legal proceedings against the State of Hawaii regarding this RFP or any resultant contract shall be brought in a State court of competent jurisdiction in the City and County of Honolulu, State of Hawaii.

This dispute resolution section does not apply to the appeals of sanctions imposed under Section 72.220.

72.200 Liquidated Damages, Sanctions and Financial Penalties

72.210 Liquidated Damages

In the event of any breach of the terms of the contract by the health plan, liquidated damages shall be assessed against the health plan in an amount equal to the costs of obtaining alternative medical benefits for its members. The damages shall include, without limitation, the difference in the capitated rates paid to the health plan and the rates paid to a replacement health plan.

Notwithstanding the above, the health plan shall not be relieved of liability to the State for any damages sustained by the State due to the health plan's breach of the contract.

The DHS may withhold amounts for liquidated damages from payments to the health plan until such damages are paid in full.

72.220 Sanctions

The DHS may impose sanctions for non-performance or violations of contract requirements. Sanctions shall be determined by the State and may include:

- Imposing civil monetary penalties (as described below);
- Suspending enrollment of new members with the health plan;
- Suspending payment;
- Notifying and allowing members to change plans without cause;
- Appointment of temporary management (as described in Section 72.230); or
- Terminating the contract (as described in Section 71.200).

The State shall give the health plan timely written notice that explains the basis and nature of the sanction as outlined in 42 CFR Part 438, Subpart I. The health plan may follow DHS appeal procedures to contest the penalties or sanctions. The DHS shall provide these appeal procedures to the health plan by the date identified in Section 51.800.

The civil or administrative monetary penalties imposed by the DHS on the health plan shall not exceed the maximum amount established by federal statutes and regulations.

The civil monetary penalties that may be imposed on the health plan by the State are as follows:

Number	Activity	Penalty
1	Misrepresentation of actions or falsification of information furnished to the CMS or the State	A maximum of one hundred thousand dollars ($100,000) for each determination
2	Acts to discriminate among members on the basis of their health status or need for healthcare services	A maximum of one hundred thousand dollars ($100,000) for each determination
3	Failure to implement requirements stated in the health plan's proposal, the RFP or the contract, or other material failures in the health plan's duties, including but not limited to failing to meet readiness review or performance standards	A maximum of fifty thousand dollars ($50,000) for each determination
4	Substantial failure to provide medically necessary services that are required under law or under contract, to an enrolled member	A maximum of twenty-five thousand dollars ($25,000) for each determination
5	Imposition upon members' premiums and charges that are in excess of the premiums or charges permitted under the program	A maximum of twenty-five thousand dollars ($25,000) or double the amount of the excess charges (whichever is greater). The State shall deduct from the penalty the amount of overcharge and return it to the affected member(s)
6	Misrepresentation or false statements to	A maximum of twenty-five

Number	Activity	Penalty
	members, potential members or providers	thousand dollars ($25,000) for each determination
7	Violation of any of the other applicable requirements of Sections 1903(m), 1905(t)(3) or 1932 of the Social Security Act and any implementing regulations	A maximum of twenty-five thousand dollars ($25,000) for each determination
8	Failure to comply with the requirements for physician incentive plans, as set forth in 42 CFR Sections 422.208 and 422.210	A maximum of twenty-five thousand dollars ($25,000) for each determination
9	Distribution, directly or indirectly through any agent or independent contractor, of marketing materials that have not been approved by the State in form in which distributed or that contain false or materially misleading information	A maximum of twenty-five thousand dollars ($25,000) for each determination
10	Failure to use DHS approved materials for marketing during Initial Enrollment or APC	Loss of all auto-assignment for contract year for that Initial Enrollment or APC
11	Not enrolling a member because of a discriminatory practice	A maximum of fifteen thousand dollars ($15,000) for each member the State determines was not enrolled because of a discriminatory practice

Number	Activity	Penalty
12	Failure to resolve member appeals and grievances within the time frames specified in Section 51.100	A maximum of ten thousand dollars ($10,000) for each determination of failure
13	Failure to comply with the claims processing standard required in Section 60.310	A maximum of five thousand dollars ($5,000) for each determination of failure
14	Failure to meet minimum compliance of provision of periodic screens to EPSDT eligible members as described in Section 41.100	A maximum of five thousand dollars ($5,000) for each determination of failure
15	Failure to conduct an assessment or develop a service plan within the timeframe required in Sections 40.920 and 40.930	A maximum of five thousand dollars ($5,000) for each determination of failure
16	Failure to comply with staffing requirements as outlined in Section 51.410	A maximum of five thousand dollars ($5,000) for each determination of failure
17	Failure to provide accurate information, data, reports and medical records, including behavioral health and substance abuse records to the DHS by the specified deadlines provided in Section 51.510	Two hundred dollars ($200) per day until all required information, data, reports and medical records are received
18	Failure to report confidentiality breaches relating to Medicaid applicants and recipients to the DHS by the	One hundred dollars ($100) per day per applicant/recipient. A maximum of twenty-five

Number	Activity	Penalty
	specific deadlines provided in Section 71.700	thousand dollars ($25,000) until the reports are received

Payments provided for under the contract shall be denied for new members when, and for so long as, payment for those members is denied by CMS in accordance with the requirements in 42 CFR section 438.730.

72.230 Special Rules for Temporary Management

The sanction of temporary management may be imposed by the State, as allowed or required by 42 CFR 438.706, if it finds that:

- There is continued egregious behavior by the health plan, including, but not limited to, behavior that is described in 42 CFR Section 438.700, or that is contrary to any requirements of Sections 1903(m) and 1932 of the Social Security Act;
- There is substantial risk to the member's health; or
- The sanction is necessary to ensure the health of the health plan's members while improvements are made to remedy violations under 42 CFR Section 438.700 or until there is an orderly termination or reorganization of the health plan.

The State shall impose temporary management if it finds that the health plan has repeatedly failed to meet the substantive requirements in Sections 1903(m) and 1932 of the Social Security Act. The State shall not provide the health plan with a pre-

termination hearing before the appointment of temporary management.

The State may not terminate temporary management until it determines that the health plan can ensure that the sanctioned behavior will not recur.

In the event the State imposes the sanction of temporary management, members shall be allowed to disenroll from the health plan without cause.

72.300 Compliance with Laws

In addition to the requirements of General Condition 1.3, Compliance with Laws, the health plan shall comply with the following:

72.310 Wages, Hours and Working Conditions of Employees Providing Services

Pursuant to Section 103-55, HRS, services to be performed by the health plan and its subcontractors or providers shall be performed by employees paid at wages or salaries not less than the wages paid to public officers and employees for similar work. Additionally, the health plan shall comply with all applicable Federal and State laws relative to workers compensation, unemployment compensation, payment of wages, prepaid healthcare, and safety standards. Failure to comply with these requirements during the contract period shall result in cancellation of the contract unless such noncompliance is corrected within a reasonable period as determined by the DHS. Final payment

under the contract shall not be made unless the DHS has determined that the noncompliance has been corrected. The health plan shall complete and submit the Wage Certification provided in Appendix D.

72.320 Compliance with other Federal and State Laws

The health plan shall agree to conform to the following federal and state laws as affect the delivery of services under the Contract including, but not limited to:

- Titles VI, VII, XIX, and XXI of the Social Security Act;
- Title VI of the Civil Rights Act of 1964;
- Title IX of the Education Amendments of 1972 (regarding education programs and activities);
- The Age Discrimination Act of 1975;
- The Rehabilitation Act of 1973;
- The Americans with Disability Act of 1990 as amended;
- The Patient Protection and Affordable Care Act of 2010, including section 1557;
- Chapter 489, HRS (Discrimination in Public Accommodations);
- Education Amendments of 1972 (regarding education programs and activities);
- Copeland Anti-Kickback Act;
- Davis-Bacon Act;
- Debarment and Suspension;
- All applicable standards, orders or regulations issued under section 306 of the Clean Air Act (42 USC 1857 (h)), section 508 of the Clean Water Act (33 USC 1368), Executive Order 11738, and Environmental Protection Agency regulations (40 CFR part

15) and the Federal Water Pollution Control Act, as amended (33 U.S.C. Section 1251, et seq.);

- The Byrd Anti-Lobbying Amendment (31 U.S.C. Section 1352); and
- E.O. 11246, "Equal Employment Opportunity," as amended by E.O. 11375 "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulations at 41 C.F.R. part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor".

The health plan shall recognize mandatory standards and policies relating to energy efficiency that are contained in any State energy conservation plan developed by the State in accordance with the Energy Policy and Conservation Act (Pub. L. 94-163, Title III, Part A).

The health plan shall include notice of grantor agency requirements and regulations pertaining to reporting and patient rights under any contracts involving research, developmental, experimental or demonstration work with respect to any discovery or invention which arises or is developed in the course of or under such contract, and of grantor agency requirements and regulations pertaining to copyrights and rights in data.

72.400 Miscellaneous Special Conditions

72.410 Use of Funds

The health plan shall not use any public funds for purposes of entertainment or perquisites and shall comply with any and all

conditions applicable to the public funds to be paid under the contract, including those provisions of appropriate acts of the Hawaii State Legislature or by administrative rules adopted pursuant to law.

72.420 Prohibition of Gratuities

Neither the health plan nor any person, firm or corporation employed by the health plan in the performance of the contract shall offer or give, directly or indirectly, to any employee or designee of the State of Hawaii, any gift, money or anything of value, or any promise, obligation, or contract for future reward or compensation at any time during the term of the contract.

72.430 Publicity

General Condition 6.1 is amended to read as follows: Acknowledgment of State Support. The health plan shall not use the State's, DHS's, MQD's name, logo or other identifying marks on any materials produced or issued without the prior written consent of the DHS. The health plan also agrees not to represent that it was supported by or affiliated with the State of Hawaii without the prior written consent of the DHS.

72.440 Force Majeure

If the health plan is prevented from performing any of its obligations hereunder in whole or in part as a result of major epidemic, act of God, war, civil disturbance, court order or any other cause beyond its control, the health plan shall make a good faith effort to perform such obligations through its then-existing

facilities and personnel; and such non-performance shall not be grounds for termination for default.

Neither party to the contract shall be responsible for delays or failures in performance resulting from acts beyond the control of such party.

Nothing in this section shall be construed to prevent the DHS from terminating the contract for reasons other than default during the period of events set forth above, or for default if such default occurred prior to such event.

72.450 Attorney's Fees

In addition to costs of litigation provided for under General Condition 5.2, in the event that the DHS shall prevail in any legal action arising out of the performance or non-performance of the contract, or in any legal action challenging a final decision under Section 72.100, the health plan shall pay, in addition to any damages, all of the DHS' expenses of such action including reasonable attorney's fees and costs. The term "legal action" shall be deemed to include administrative proceedings of all kinds, as well as all actions at law or in equity.

72.460 Time is of the Essence

Time is of the essence in the contract. As such, any reference to "days" shall be deemed calendar days unless otherwise specifically stated.

72.470 Health plan request for waiver of contract requirements

Health plans may request a waiver of operational contract requirements from DHS that are described in the RFP. Health plans may submit this request in a format provided by the DHS. DHS shall only approve a health plan's request for waiver of a contract requirement that does not adversely affect the outcome of services that its members receive. DHS reserves the right to revoke these waivers at any time upon written notice to the affected health plans. Whenever possible, DHS shall provide reasonable advance notice of any such revocation to allow the affected health plan(s) to make any necessary operational changes.

SECTION 80 MANDATORY AND TECHNICAL PROPOSAL

80.100 Introduction

The applicant shall comply with all content and format requirements for the technical proposal. The proposal shall be on standard 8 ½" by 11" paper, one and a half (1 ½) spaced, singled sided and with text no smaller than 11-point font. The pages must have at least one-inch margins. All proposal pages must be numbered and identified with the applicant's name.

Applicants shall answer all questions as part of the narrative in the order that they appear in each sub-section. The question shall be restated above the response. The maximum page numbers includes restating the question. The question may be stated single spaced with text no smaller than 11-point font. The questions related to any attachment do not need to be restated as long as it is clear from the heading of the referenced attachment. Attachments may be placed, in the order in which they are requested, behind the narrative responses for that sub-section. Attachments do not count toward the maximum page limits.

Narratives in excess of the maximum page limits and any documentation not specifically requested shall not be reviewed. Likewise, providing actual policies and procedures in lieu of a narrative may result in the applicant receiving a non-responsive score for that question.

80.200 Mandatory Requirements

80.210 Attachment: Transmittal Letter

The transmittal letter shall be on official business letterhead and shall be signed by an individual authorized to legally bind the applicant. It shall include:

A. A statement indicating that the applicant is a corporation or other legal entity and is a properly licensed health plan in the State of Hawaii at the time of proposal submission. All subcontractors shall be identified and a statement included indicating the percentage of work to be performed by the prime applicant and each subcontractor, as measured by percentage of total contract price;

B. A statement that the applicant has an established provider network to serve Medicaid beneficiaries in the State of Hawaii;

C. A statement that the applicant is registered to do business in Hawaii and has a State of Hawaii General Excise Tax License, if applicable, and that this will be submitted to the DHS with the signed contracts (following the Contract Award date and prior to the Contract Effective Date identified in Section 20.100);

D. The applicant's Hawaii excise tax number (if applicable);

E. A statement identifying all amendments and addenda to this RFP issued by the issuing office. If no amendments or addenda have been issued, a statement to that effect shall be included;

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

G. A statement that no attempt has been made or will be made by the applicant to induce any other party to submit or refrain from submitting a proposal;

H. A statement that the applicant has read, understands and agrees to all provisions of this RFP;

I. A statement that it is understood that if awarded the contract, the applicant's organization shall deliver the goods and services meeting or exceeding the specifications in the RFP and amendments;

J. A statement that the person signing this proposal certifies that he/she is the person in the applicant's organization responsible for, or authorized to make, decisions as to this offer, that the offer is firm and binding, and that he/she has not participated and shall not participate in any action contrary to the above conditions; and

K. A statement on whether the applicant is applying for Oahu and one other island, or Statewide. If less than two selected health plans applied to operate Statewide, the Department shall allow the other health plans to change to operate Statewide. If no plan chooses to change, then the Department may require a completely new procurement.

80.220 Company Background Narrative

The applicant shall provide a description of its company that includes:

A. The legal name and any names under which the applicant has done business;
B. Address, telephone number and e-mail address of the applicant's headquarter office;
C. Date company was established;
D. Date company began operations;
E. Complete organization chart of applicant;
F. Organization chart of parent company and all subcontractors;
G. Names and addresses of officers and directors;
H. The size and resources, including the gross revenues and total number of employees and current number of employees in Hawaii; and
I. A description of any services it objects to based on moral or religious grounds as described in Section 40.300 including a description of the grounds for the objection and information on how it will provide the required services. If there are no services to which it objects, the applicant shall state that.

The information required above shall be supplied for each affiliated company that serves Medicaid members and any subcontractors the applicant intends to use.

80.230 Attachment: Other Documentation

The applicant shall attach, in the following order, completed forms provided in Appendix D:

A. The Proposal Application Identification form (Form SPO-H-200);
B. The State of Hawaii DHS Proposal Letter*;*
C. The Certification for Contracts, Grants, Loans and Cooperative Agreements form;
D. The Disclosure Statement (CMS required) form;
E. Disclosure Statement;
F. The Disclosure Statement (Ownership) form;
G. The Organization Structure and Financial Planning form;
H. The Financial Planning form;
I. The Controlling Interest form;
J. The Background Check Information form;
K. The Operational Certification Submission form;
L. The Grievance System form;
M. Applicant's Proof of Insurance;
N. The Wage Certification form;
O. The Standards of Conduct Declaration form;
P. The State and Federal Tax Clearance certificates from the prime applicant and, upon request from subcontractors, as assurance that all federal and state tax liabilities have been paid and that there are no significant outstanding balances owed (a statement shall be included if certificates are not available at time of submission of proposal that the certificates will be submitted in compliance with Section 20.600);
Q. Proof of its current license to serve as a health plan in the State of Hawaii. A letter from the Insurance Division

notifying the health plan of its license shall be acceptable "proof" for DHS; and

R. Certificate of Compliance from the State of Hawaii, Department of Commerce and Consumer Affairs, Insurance Division that validates financial solvency.

80.240 Attachment: Risk Based Capital

The applicant shall provide the most recent completed risk based capital (RBC) amount. Where applicable, the applicant shall submit separate RBC amounts for all affiliated companies and companies with the same parent company as the applicant.

80.300 Technical Proposal

80.310 Experience and References (15 pages maximum not including attachments B, C, E, F, and G below)

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;

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;

F. EPSDT measures for the last twelve (12) month period submitted to the State of Hawaii on February 28, 2013 on a CMS 416. Applicant shall include both pages of the CMS 416 in their submission. 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

G. The health plan's most recent HEDIS® 2013 Compliance Audit™ that includes validated HEDIS measures (hereby called HEDIS validation evaluation) issued from the State of Hawaii on September 19, 2013 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.

80.315 Provider Network and Services (32 pages maximum not including attachments)

80.315.1 Provider Network Narrative (included in page maximum)

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.

80.315.2 Attachment: Required acute, primary care, and behavioral health Providers (not included in page maximum)

The applicant shall provide a separate listing of its acute, primary care and behavioral health providers for each island for which it is bidding. Use the format listed below for these listings.

Applicants shall include in this listing only providers who have signed a contract for provision of the QUEST Integration line of business. DHS will request from the applicant a sampling of provider contract signature pages for contract verification.

Examples of completed rows are provided as examples.

Provider Type	**Island/County (for Oahu include the city)**	**Provider Name (Last name, First name, Middle Initial)**	**Accepting new QUEST Integration members (Y/N)?**
PCP – Family practitioners, General Practitioners and General Internists	Honolulu, Oahu	Last Name, First Name, MI	
PCP – OB/GYN	Kapolei, Oahu	Last Name, First Name, MI	
Specialist – Cardiologist	Maui County	Last Name, First Name, MI	
Hospital	Kauai	Hospital Name	
Home Health Agency	Hawaii- East	Agency Name	

The applicant shall separate the providers by provider type and list alphabetically within the different provider type by last name as follows:

A. PCP providers (PCPs include pediatricians, family practitioners, general practitioners, internists, OB/GYN, geriatricians, and clinics);
B. Certified nurse midwives, pediatric nurse practitioners, and family nurse practitioners;
C. Specialists;
D. Hospitals (the DHS shall assume the hospital is on contract for acute services, outpatient and emergency department unless otherwise noted in the specialty column);
E. Urgent care providers;
F. Emergency transport (including ground and air ambulance) providers;
G. Pharmacies;
H. Laboratories;
I. Radiology providers;
J. Physical, occupational, audiology and speech and language therapy providers;
K. Behavioral health providers;
L. Home health agencies and hospices;
M. Durable medical equipment and medical suppliers;
N. Non-Emergency transportation providers; and
O. Interpretation/translation service providers.

The applicant shall list each provider once. For example, if an OB/GYN is serving both as a PCP and as a specialist, he or she shall be listed as either a PCP or a specialist, not both.

For provider types that may include a variety of providers, the provider listing shall be ordered by specialty. As an example, for

the PCP matrix, sort providers by pediatricians, physician assistants, family practitioners, general practitioners, internists, and OB/GYNs.

List nurse midwives, pediatric nurse practitioners, family nurse practitioners and behavioral health practitioners who are in independent practice separately. If the nurse midwife, pediatric nurse practitioner or family nurse practitioner practices in a physician's office or clinic, he/she shall be listed under the clinic or physician's office as described below.

For clinics serving in the capacity of a PCP, list the clinic and under the clinic name, identify each specific provider (e.g., physician, nurse practitioner, etc.). Clinics may be listed on different provider type network matrices, but the individual provider of the service is listed only once. As an example, the clinic may be listed as a PCP with the clinic's pediatrician. Other physicians serving as specialists shall be listed on the specialty care matrix with the clinic's name. If the clinic also provides interpretation, it shall be listed on the interpretation services matrix.

The specialists list shall include all physicians (e.g., cardiologists, neurologists, ophthalmologists, pulmonologists, etc.) and non-physician services (e.g., optometrists, opticians, podiatrists, etc.), that provide medical services, but are not in the behavioral health service providers.

All behavioral health providers shall be listed on the behavioral health service provider lists and not the specialists list. This

includes psychiatrists, psychologists, licensed social workers, case management agencies, residential treatment providers, etc.

In addition to a hard copy of the provider listings, the applicant shall include with its proposal an electronic file of providers in Excel 2010 or lower.

80.315.3 Attachment: Required LTSS Providers (not included in page maximum)

The applicant shall provide a separate listing of its LTSS for each island for which it is bidding. Use the format listed below for these listings. DHS will request from the applicant a sampling of provider contract signature pages for contract verification, if applicable.

For LTSS providers, health plans may submit letters of intent (LOI) for home and community based services (HCBS) providers instead of completing the process of having these individuals be a contracted provider. The applicant shall have a signed contract for provision of the QUEST Integration line of business with all other LTSS providers (i.e., nursing facilities). The applicant shall attach copies of each of the LOIs in the order listed on the table. The applicant shall use the format for the LOI provided in Appendix T. No substitutions will be accepted. DHS will request from the applicant a sampling of provider contract signature pages for contract verification.

A list of LTSS providers are:

Provider Type	Island/County (for Oahu include the city)	Provider Name	LOI or Contracted Provider?
Adult Day Care	Honolulu, Oahu	Adult Day Care Name	
Adult Day Health	Kapolei, Oahu	Adult Day Health Name	
Community Care Foster Family Home (CCFFH)	Maui County	CCFFH Name	
Community Case Management Agency (CCMA)	Kauai	CCMA Name	
Nursing Facility	Hawaii- East	Nursing Facility Name	
Personal Care Agency		Personal Care Agency Name	

The applicant shall separate the providers by provider type and listed alphabetically within the different provider type by agency or last name as follows:

- Adult day care facilities;
- Adult day health facilities;
- Assisted living facilities;
- Community care foster family homes (CCFFH);
- Community care management agencies (CCMA);
- Expanded adult residential care homes (E-ARCHs);
- Home delivered meal providers;
- Non-medical transportation providers;
- Nursing facilities;
- Personal care assistance providers;
- Personal emergency response systems providers;
- Private duty nursing providers;

- Respite care providers; and
- Specialized medical equipment and supply providers.

In addition to a hard copy of the provider listings, the applicant shall include with its proposal an electronic file of providers in Excel 2010 or lower.

80.315.4 Attachment: Maps of Providers (not included in page maximum)

The applicant shall include in its proposal the following maps of the State by island with the following criteria:

Provider Type	**# of maps for submission per island**	**Accepting new QUEST Integration members without any limitation**	**Contracted Provider**	**LOI Provider**
PCP	2	√	√	
Specialist	2	√	√	
Acute Care Hospital	1		√	
Pharmacy	1		√	
24-hour Pharmacy	1		√	
Behavioral Health Provider	2	√	√	
LTSS	2		√	√

The applicant shall submit a separate map of each of the provider-types listed above Statewide by island. Applicants shall submit maps for the following islands: Hawaii, Kauai, Lanai, Maui, Molokai, and Oahu. If an applicant is not bidding Statewide, then

the applicant shall submit maps only for the two islands that they are bidding on.

For PCPs, specialists, and behavioral health providers, the applicant shall submit two (2) maps for each island Statewide (or bidding on): one (1) for all contracted providers and one (1) for contracted providers who are accepting new QUEST Integration members without any limitations.

For acute care hospitals, pharmacies, and 24-hour pharmacies, the applicant shall submit one (1) map for each island Statewide (or bidding on) of all contracted providers.

For long-term services and support (LTSS) providers, the applicant shall submit (1) map for each island Statewide (or bidding on) of all contracted providers or providers that applicant has a signed LOI. If the applicant has both contracted and LOI providers, then the applicant shall submit one (1) map for each island Statewide (or bidding on) of contracted LTSS providers and one (1) map for each island Statewide (or bidding on) of providers that applicant has a signed LOI.

Finally, when a provider has multiple locations, the applicant may include them on all islands that they practice, but only once per island. For example, if a provider practices on Oahu and Maui, then the provider may be listed on both the Oahu map and the Maui map. In addition, if the provider practices in several locations on Oahu, they may only be listed in one location on Oahu.

80.315.5 Availability of Providers Narrative (included in page maximum)

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.

80.315.6 Provider Services Narrative – General Requirements (included in page maximum)

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.

80.320 Covered Benefits and Services (18 pages maximum)

80.320.1 Covered Benefits and Services Narrative

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.

80.320.2 Long-Term Services and Supports (LTSS)

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.

80.320.3 Hospital readmission within thirty (30) days

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.

80.320.4 Early and Periodic Screening Diagnostic, and Treatment (EPSDT) Services for Children Narrative

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.

80.320.5 Transition of Care Narrative

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.

80.325 <u>Service Coordination System/Services Narrative (20 pages maximum)</u>

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:

A. The organizational structure of its service coordination system;
B. How the applicant identifies members who meet Special Health Care Needs (SHCN) as described in Sections 40.910.1 and 40.910.2;
C. How the applicant shall monitor that service coordinators are meeting their responsibilities as described in Section 40.910;
D. The applicant's processes to maintain a partnership between nurse and social worker service coordinators for members receiving LTSS;
E. The applicant's processes to monitor the differing levels of service coordination and maintenance of case load ratios;
F. 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);
G. How the service coordinator addresses coordination of behavioral health services with CCS;
H. The processes for monitoring emergency department utilization and informing members of options for urgent care, after-hours care, and twenty-four hour nurse line;

I. The processes for assuring that service coordinators are adequately trained to meet member and RFP requirements;
J. 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;
K. How the service plan is a person-centered document that analyzes the assessment and describes both the medical and social needs of the member;
L. The processes for meeting self-direction requirements to include nurse delegation; and
M. 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.

80.330 Member Services (20 pages maximum)

80.330.1 Member Services Narrative - General Member Services

The applicant shall describe:

A. How it will implement the member survey as described in Section 50.220;
B. How it will help their members retain their Medicaid eligibility;
C. 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;

D. How it will assure interpretation services are available to members that speak a language other than English as their primary language; and
E. How it will assure that members understand their role in verifying services that they received as required in Section 50.455.

80.330.2 Member Services Narrative - Toll-free Call Center and Twenty-Four Hour Nurse Line

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.

80.330.3 Member Grievance System Narrative

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.

80.335 Quality Assessment and Performance Improvement (QAPI) (30 pages maximum)

80.335.1 QAPI Narrative – QAPI Program

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:
        - The chairperson(s) – including title(s), and for physicians, provide specialty;
        - Physician membership - including the total number and types of specialties represented;
        - The physician designated to have substantial involvement in the QAPI Program;
        - The licensed behavioral health care practitioner designated to be involved in the behavioral health care aspects of the QAPI Program; and
        - 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.

80.335.2 QAPI Narrative – General Provisions

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.

80.335.3 QAPI Narrative – Value-Based Purchasing (VBP)

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.

80.335.4 QAPI Narrative - Performance Measures

The applicant shall:

A. Describe its policies and procedures relating to meeting HEDIS performance measures requirements; and

B. Provide all 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.

80.335.5 Disease Management (DM) Programs Narrative

The applicant shall provide:

A. 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

B. Quantitative data on health improvement/outcomes of members in two disease management programs the applicant is currently operating in Hawaii or another State.

80.340 Utilization Management Program and Authorization of Services (10 pages maximum)

80.340.1 Utilization Management Program (UMP) Narrative

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.

80.340.2 UMP and Authorization of Services – Prior Authorization (PA) including:

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.

80.345 Health Plan Administrative Requirements (20 pages maximum)

80.345.1 Health Plan Administrative Requirements Narrative - Fraud and Abuse

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.

80.345.2 Health Plan Administrative Requirements Attachment and Narrative - 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. Note: the organizational chart(s) do not count towards the page limit.

80.345.3 Health Plan Administrative Requirements Narrative - 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.

80.345.4 Health Plan Administrative Requirements Narrative - Reporting Requirements

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.

80.345.5 Health Plan Administrative Requirements Narrative – Encounter Data Reporting Requirements

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.

80.345.6 Health Plan Administrative Requirements Narrative- Information Technology

The applicant shall provide:

A. A description of its information systems environment including:

1. 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.

80.345.7 Financial Responsibilities Narrative - Third Party Liability

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.

SECTION 90 RATE STRUCTURE

90.100 Introduction

This section describes the rate structure and the guidelines for future rate setting.

90.200 Overview of the Rate Structure

For any member of a given QUEST Integration contracted health plan, the DHS shall pay a capitation rate which varies by aid category, island and age/gender band. Aid categories include the following:

1. Medicaid Expansion;
2. Aged/Blind/Disabled (ABD):
   - ABD – Medicare Eligible, and
   - ABD – Medicaid Only;
3. Other Populations:
   - CHIP,
   - Foster Care, and
   - Adults and Children.

The capitation rates shall assume an administrative load of no more than 10% for all rates except for aged, blind and disabled, and an administrative load of no more than 7% for aged, blind and disabled, both inclusive of administrative expenses and risk margin expenses but excluding general excise and insurance premium tax, if applicable.

90.300 Rate Development

The DHS shall provide all applicants with proposed capitation rates with supporting documentation by the date identified in Section 20.100. The DHS shall conduct an orientation of proposed capitation rates as described in Sections 20.100 and 20.200. During this orientation, DHS shall describe the process used to generate the proposed capitation rates and receive input from the applicants regarding the proposed capitation rates. In addition, DHS shall receive written questions and comments from the applicants regarding the proposed capitation rates by the date identified in Section 20.100.

DHS shall have a second meeting with applicants on the date specified in Section 20.100 via meeting in person, via teleconference, or by another method deemed appropriate by DHS after reviewing written questions and comments to discuss the final capitation rates and changes resulting from applicant comments, if any.

The DHS shall provide final actuarially sound capitation rates to all selected applicants as part of the contracted award on the date specified in Section 20.100. All selected applicants shall receive the same base capitation rates as described in Section 90.200. Due to the lag in rate development and application of rates, further adjustments may be required before implementation. If this is the case DHS will provide documentation of the rate change similar to that provided during a rate renewal. The allowed administrative expenditures shall be increased to an amount as

described in Section 90.200 for those that serve Statewide. Allowed administrative expenses shall be discounted for plans that serve only Oahu and one other island

The capitation rates shall have three components of risk adjustment to the base rates. Each of these adjustments shall be made after the initial enrollment period as described in Section 30.540.1.

The first part of the enhanced payment is based on FQHC and RHC use rates for enrolled members. The enhancement is intended to provide for the additional cost for services at these facilities due to the requirement that they be reimbursed at the PPS rate. Rates for health plans shall be increased to cover this additional cost based on historical use rates at these facilities for members enrolled in each plan. This enhancement shall vary by health plan, aid category, island and age/gender cohort.

The second adjustment will account for the distribution and acuity of the membership with long-term services and supports (LTSS) within the rate cells below.

Aged/Blind/Disabled (ABD)

- ABD – Medicare Eligible; and
- ABD – Medicaid Only.

We anticipate that this will involve stratifying members into those residing in a nursing facility, those meeting institutional level of care (LOC) and receiving home and community services, those at

risk of deteriorating to LOC and receiving home and community based services, and those without LTSS needs. We will further evaluate the risk within these populations.

In addition, in order to account for risk selection between health plans, DHS may perform a diagnosis and/or pharmacy based, or other risk adjustment. This adjustment shall be performed in a budget neutral manner for each applicable rate category. That is, the result of the application of risk factors for each rate category shall be expected to shift revenue between the health plans, with no impact on aggregate state funding. Risk adjustment factors shall be applied as early as possible at program startup, with the expectation of being no later than the second month of enrollment. If the risk adjustment is delayed beyond the initial month of enrollment, no retroactive adjustments shall be made. Each year, the risk adjustment process shall be refreshed with the target implementation for the next CY.

Health Plans shall submit proof of payment of the Health Insurance Provider Fees (HIPF). After the DHS actuary reviews the HIPF submissions, DHS will reimburse the health plans accordingly. This process will apply to both retrospective and prospective activities.

In addition, the capitation rates will comply with the following sections of Title 42 CFR:

§438.4(b)(7), §438.4(b)(8), §438.5(b), §438.5(c), §438.5(d), §438.5(e), §438.5(f), §438.6(b)(3), §438.6(c), §438.6(d), §438.7(b), §438.7(c)(1), §438.7(c)(2), §438.8, §438.74.

90.400 Future Rate Setting

Subject to limitations imposed by CMS, legislative direction or other outside influence for which the DHS shall comply, it is the intent of the DHS to publish revised rates each CY throughout the term of the contract. The DHS specifically does not commit to any particular methodology or formula, or to any particular benchmark or objective, for rate revisions.

SECTION 100 EVALUATION AND SELECTION

100.100 Introduction

The DHS shall conduct a comprehensive, fair and impartial evaluation of proposals received in response to this RFP. The DHS shall be the sole judge in the selection of the applicant(s). The evaluation of the proposals shall be conducted as follows:

- Review of the proposals to ensure that all mandatory requirements detailed in Section 80.200 are met;
- Review and evaluation of the technical proposals for proposals that meet all mandatory requirements to determine whether the applicant meets the minimum technical criteria and requirements detailed in Section 80.300; and
- Award of the contract to the selected applicants.

Failure of the applicant to comply with the instructions of this RFP or failure to submit a complete proposal shall be grounds for deeming the proposal non-responsive to the RFP. However, the DHS reserves the right to waive minor irregularities in proposals provided such action is in the best interest of the State. Where the DHS may waive minor irregularities, such waiver shall in no way modify the RFP requirements or excuse the applicant from full compliance with the RFP specifications and other contract requirements if the applicant is awarded the contract.

Proposals deemed by the evaluation committee(s) to be incomplete or not in accordance with the specified requirements shall be disqualified. Applicants may retrieve their proposal as described in Section 20.860.

100.200 Evaluation Process

The DHS shall establish an evaluation committee that shall evaluate designated sections of the proposal. The committee shall consist of members who are familiar with the programs and the minimum standards or criteria for the particular area. Additionally, the DHS may, at its discretion, designate additional representatives to assist in the evaluation process. The committee shall evaluate and discuss the proposal documenting consensus comments, where proposal met or did not meet the evaluation criteria, and rating score.

100.300 Mandatory Proposal Evaluation

Each proposal shall be evaluated to determine whether the requirements as specified in this RFP have been met. The proposal shall first be evaluated against the following criteria:

- Proposal was submitted within the closing date and time for proposals as required in Section 21.200;
- The proper number of separately bound copies are in sealed envelopes as required in Section 21.200;
- An electronic version of the proposal is submitted as required in Section 21.200;

- All information required in Section 80.100 and 80.200 has been submitted; and
- Proposal contains the necessary information in the proper order.

A proposal must meet all mandatory requirements prior to the technical evaluation. Any proposal that does not meet all mandatory requirements shall be rejected.

100.400 Technical Proposal Evaluation

The technical proposals that have met the minimum mandatory requirements shall be evaluated in order to identify those applicants that meet the minimum technical requirements detailed in this section.

Evaluation Categories Section/Title	**Available Points**	**Points Needed to Pass**
80.310 Experience and References	**150**	**112.5**
A. Narrative- experience in Hawaii	90*	
B. Contract for Medicaid program clients		
C. Letters of recommendation		
D. Information about termination, non-renewal, etc.		
E. EQRO evaluations	20	
F. EPSDT measures	20	
G. HEDIS validation evaluations	20	
80.315 Provider Network and Services	**150**	**112.5**
80.315.1 Provider Network Narrative	100*	
80.315.2 Attachment: Required acute, primary care, and behavioral health Providers		
80.315.3 Attachment: Required LTSS Providers		
80.315.4 Attachment: Maps of Providers		

Evaluation Categories Section/Title	**Available Points**	**Points Needed to Pass**
80.315.5 Availability of Providers Narrative	50*	
80.315.6 Provider Services Narrative		
*The subsections of these sections are combined together and only receive a single rating score.		
80.320 Covered Benefits and Services	**150**	**112.5**
80.320.1 Covered Benefits and Services Narrative	30	
80.320.2 Long-Term Services and Supports (LTSS)	30	
80.320.3 Hospital readmission within thirty (30) days	30	
80.320.4 EPSDT Narrative	30	
80.320.5 Transition of Care Narrative	30	
80.325 Service Coordination System/Services	**150**	**112.5**
80.330 Member Services	**100**	**75**
80.330.1 General Member Services	40	
80.330.2 Toll-free Call Center and Twenty-Four Hour Nurse Line	30	
80.330.3 Member Grievance System	30	
80.335 Quality Assessment and Performance Improvement (QAPI)/ Utilization Management	**150**	**112.5**
80.335.1 QAPI program	20	
80.335.2 General Provisions	20	
80.335.3 Value-Based Purchasing	30	
80.335.4 Performance Measures	20	
80.335.5 Disease Management	20	
80.340.1 Utilization Management Program (UMP) Narrative	20	
80.340.2 UMP and Authorization of Services	20	
80.345 Health Plan Administrative Requirements	**150**	**112.5**
80.345.1 Fraud and Abuse	30	
80.345.2 Narrative and Organization Charts	20	
80.345.3 Organization and Staffing Tables	20	
80.345.4 Reporting Requirements	20	
80.345.5 Encounter Data Reporting Requirements	20	
80.345.6 Information Technology	20	
80.345.7 Third Party Liability	20	

Evaluation Categories Section/Title	**Available Points**	**Points Needed to Pass**
Total	**1,000**	**750**

100.500 Evaluation Criteria

Each evaluated category shall be given a rating score using the following rating system:

Rating Score	Description
5	The response has no deficiencies and provides a detailed and comprehensive description that demonstrates the ability to more than minimally meet the contractual requirements.
4	The response has no deficiencies and describes how the requirements will be minimally met.
3	The response has no major deficiencies and only minor deficiencies that are easily correctible.
2	The response has one major deficiency and/or multiple minor deficiencies that do not appear to be easily correctable.
1	The response has multiple major deficiencies that do not appear to be correctable.
0	No response provided.

The applicant must receive a rating score of 3 for each Evaluation Category or the proposal will not be considered technically acceptable and shall be rejected. Those proposals that do not meet the minimum points to pass each of the required criteria shall be returned to the applicant with a letter of explanation.

The rating score (0-5) shall represent the corresponding conversion factor used to calculate the points awarded for each Evaluation Category listed in Section 100.500, as follows:

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

The total maximum number of points available for each Evaluation Category will be multiplied by the applicable conversion factor, based on the rating score given, to determine the number of points awarded for the Evaluation Category. The points awarded for each Evaluation Category shall by totaled to yield a final score. The DHS shall select all applicants/health plans that pass the technical proposal for provision of services.

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

The broad criteria for each Evaluation Category are listed below and include consideration of the specific elements identified in Section 80. MQD reserves the right to add, delete or modify any criteria in accordance with applicable procurement rules.

100.510 Experience and References (150 points possible)

80.310 A, B, C, and D

- 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.

80.310 E

- The EQRO compliance with standards evaluations shall be evaluated based upon its compliance with Federal regulations.

80.310 F

- EPSDT measures shall be evaluated based upon standards established by the State of Hawaii in Section 41.100.

80.310 G

- HEDIS validation measures shall be evaluated based upon 75th percentile for Medicaid nationally.

100.520 Provider Network and Services (150 points possible)

- Provision of the data required in Section 80.315; and
- Other factors identified in Section 80.315.

80.315.1 to 80.315.4

- 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.

80.315.5 to 80.315.6

- 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.

100.530 Covered Benefits and Services (150 points possible)

- Answer all of the questions from Section 80.320; and
- Other factors identified in Section 80.320.

80.320.1

- Description of experience of providing covered benefits and services for a similar population.

80.320.2

- 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.

80.330.3

- Processes to assure adequate discharge planning and decrease hospital readmissions within thirty (30) days.

80.340.4

- Plan for assuring Hawaii's EPSDT plan is implemented.

80.340.5

- Description of processes for transition of care for former and new members.

100.540 Service Coordination System/Services (150 points possible)

- 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.

100.550 Member Services (100 points possible)

- Answer all of the questions from Section 80.330; and
- Other factors identified in Section 80.330.

80.330.1

- 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.

80.330.2

- 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.

80.330.3

- Description of applicant's grievance system as described in Section 51.100; and
- Description of training for call center and grievance system staff.

100.560 Quality Assessment and Performance Improvement (QAPI)/Utilization Management (150 points possible)

- Answers all questions from Sections 80.335 and 80.340.
- Other factors identified in Sections 80.335 and 80.340.

80.335.1

- 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.

80.335.2

- 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.

80.335.3

- 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.

80.335.4

- 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.

80.335.5

- 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.

80.340.1

- 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.

80.340.2

- 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.

100.570 Health Plan Administrative Requirements (150 points possible)

- Answer all of the questions from Section 80.345; and
- Other factors identified in Section 80.345.

80.345.1

- 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.

80.345.2 and 80.345.3

- 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.

80.345.4

- 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.

80.345.5

- 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.

80.345.6

- 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.

80.345.7

- Description of a clear methodology for obtaining reimbursement from other liable third parties.

100.600 Selection of Applicants

Upon completion of the Technical Proposal evaluations, the DHS shall sum the scores from the evaluation to determine the applicants that shall be awarded contracts from the State. The DHS shall select all applicants/health plans that pass the technical proposal for provision of services.

100.700 Contract Award

Upon selection of the applicants that will be awarded contracts, the DHS shall initiate the contracting process. The applicant shall be notified in writing that the RFP proposal has been accepted and that the DHS intends to award a contract to the applicant. This letter shall serve as notification that the applicant should begin to develop its programs, materials, policies and procedures for the programs.

The contracts shall be awarded no later than the Contract Award date identified in Section 20.100. If an awarded applicant requests to withdraw its proposal, it must be requested in writing

to the MQD before the close of business (4:30 p.m. H.S.T.) on the Contract Award date identified in Section 20.100. After that date, the State expects to enter into a contract with the applicant.

This RFP and the applicant's technical proposal shall become part of the contract.