

## **SECTION 50 HEALTH PLAN ADMINISTRATIVE REQUIREMENTS**

### **50.100 Health Plan Enrollment Responsibilities**

The health plan shall accept individuals enrolled into their plan by the DHS without restriction, unless otherwise authorized by the DHS. The health plan shall not, on the basis of health status or need for health care services, religion, race, color, gender, or national origin discriminate against individuals enrolled. The health plan shall not use any policy or practice that has the effect of discriminating on the basis of race, religion, color, gender, national origin, or health care status.

The health plan shall accept daily and monthly transaction files from the DHS as the official enrollment record. Upon receipt of enrollment information from the DHS, the health plan shall issue a new member enrollment packet within ten (10) days of enrollment by DHS. This packet shall include the following:

- A confirmation of enrollment;
- A health plan member number, which does not have to be the same as the Medicaid ID number which has been assigned by the DHS;
- An explanation of the role of the PCP and the procedures to be followed to obtain needed services;
- Information explaining that the health plan will provide assistance in selecting a PCP and how the member can receive this assistance;

- Information explaining that the health plan will auto-assign a member to a PCP if the member does not select a PCP within ten (10) days;
- A Member Handbook as described in Section 50.330;
- An explanation of the member's rights, including those related to the complaint and grievance 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, etc.;
- A copy of the written policies and procedures related to advance directives to members at the time of enrollment in accordance with 42 CFR 438.6(i); and
- Membership card(s) to the enrolled members with information as described in Section 50.360.

This information shall be provided to all new members within ten (10) days of enrollment.

50.110 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 meals and lodging for an attendant, if applicable, for all members who are enrolled in its plan on the date of admission to an acute care hospital. In the event a member changes health plans or is disenrolled during an acute hospital stay, the health plan shall remain responsible for these same

services through discharge regardless of the level of care, which is defined as the member having moved from an acute to a nursing facility level of care, as determined by the DHS or its contractor.

The health plan is not responsible for providing services to members who are hospitalized at the time of enrollment under Medicaid fee-for-service or another health plan. In this situation the other entity, either MQD, or the old health plan, shall be responsible for providing all acute care services, meals and lodging for an attendant, if applicable, through discharge of the member regardless of the lowering of the level of care. This includes providing transportation of the member (and attendant if applicable) to the member's island of residence if hospitalized in an off-island or out-of-state facility.

The new health plan shall be responsible for professional fees and outpatient prescription drugs from the date of enrollment into the health plan.

#### 50.120 PCP Selection

The health plan shall provide the DHS with provider information as outlined in Section 50.350 to assist MQD in compiling a Provider Directory, and information on how to obtain care during the time there is no PCP assignment and no health plan card. The health plan shall provide assistance in selecting a PCP and shall provide the member ten (10) calendar days to select a PCP. This ten (10) day period shall not include mail time. If a PCP is not selected within ten (10) days, the health plan shall assign a

PCP to the member based on the geographic area in which the member resides.

50.130 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 1179 form for changes in member status and submit the information by fax, courier services or mail to the appropriate MQD eligibility office. In addition, the health plan shall notify the member that it is also his or her responsibility to provide the information to the DHS.

The following are examples of changes in the member's status, which may affect the eligibility of the member.

- Death of the member or family member (spouse or dependent);
- Birth;
- Marriage;
- Divorce;
- Adoption;
- Transfer to long term care;
- Change in health status (e.g., pregnancy or permanent disability);
- Change of address;
- Institutionalization (e.g., state mental health hospital or prison); or
- TPL coverage, including employer sponsored or Medicare.

50.140 Enrollment for Newborns

The health plan shall notify the DHS within twenty-four (24) hours of receiving notification of the birth of a newborn to one of its members.

50.150 Enforcement of Documentation Requirements

The health plan shall assist the DHS in meeting all citizen documentation requirements prescribed in Section 6037 of the DRA.

50.160 Informational Brochure

The health plan shall provide information to the DHS for inclusion in the informational brochure distributed by the DHS to potential and current members at the time of health plan selection.

**50.200 Disenrollment**

50.210 Appropriate 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 which 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. Appropriate reasons for the health plan to request disenrollment include, but are not limited to, the following:

- Member no longer qualifies based on the eligibility criteria or voluntarily leaves the program;
- Member is deceased;
- Member is incarcerated;
- Member enters the State Hospital;
- Member is waitlisted at an acute hospital for a long-term care bed (after sixty (60) days and has been determined disabled by the DHS);
- Member's PCP is not in the health plan's network;
- Member is a blind or disabled child under the age of twenty-one (21);
- Member is in foster care and has moved out-of-state;
- Member becomes eligible for Medicare Special Savings Program;
- Member enters a home and community based waiver program and meet the requirements for eligibility in the Medicaid fee-for-service program; or
- Member provides false information with the intent of participating in the programs under false pretenses.

50.220 Members Waitlisted for a Long-Term Care Bed or Placement into a Long-Term Care Facility

If the health plan identifies a member it believes may qualify for nursing facility level of care services, the health plan shall initiate the referral process by completing a Form DHS 1147. The health plan shall complete the forms, which requires a review by the health plan's Medical Director, a statement of need for long term care, and the inclusion of additional documentation—especially related to the social supports

available to the member. These forms shall be provided to the DHS or its designated agent.

If the DHS determines that the member meets nursing facility level of care, the health plan or facility shall also refer the member for an ADRC determination. If determined disabled, the DHS or its agent will notify the eligibility worker to disenroll the member and to transfer the person to the Medicaid fee-for-service program. The member's disenrollment will become effective no later than the first day of the second month from the month in which the ADRC's determination was made. The health plan shall coordinate and pay for the member's care until the member is disenrolled from the health plan, or if in a facility, up to sixty (60) days of waitlist care, whichever is earlier. As long as the health plan has the member enrolled, the health plan shall make all medical necessity decisions on the placement of the member. The health plan may decide to place the member in a waitlist bed, nursing home bed or maintain the member at home with home care and other support.

The State will assume financial responsibility for the member when the member is disenrolled from the health plan and transferred to the Medicaid fee-for-service program or on the sixty-first (61<sup>st</sup>) day if the member is waitlisted for a long-term care bed and disenrollment has not been accomplished. The health plan shall notify the facility that the State has assumed financial responsibility for the waitlisted recipient. The disenrollment will be retroactively applied to become effective on the sixty-first (61<sup>st</sup>) day of waitlisted care. If a member is not

approved for nursing facility level of care or approved for nursing facility care but not determined permanently disabled through the ADRC process, the member shall remain in the health plan. If the health plan transfers the member to a nursing facility or places the member on a waitlist and the DHS's agent does not agree with the placement, the member shall remain in the health plan and the health plan shall remain responsible for the cost of the long-term care or waitlisted bed. The health plan may appeal the DHS's agent's decision to the Medical Standards Branch.

50.230 Aid to Disabled Review Committee (ADRC)

If the health plan identifies a member it believes would meet the disability criteria, it shall refer the member for an evaluation by the ADRC as outlined in QUEST Memo ENR9702. Specifically, the health plan shall submit to the ADRC Coordinator in the MQD Division, the following forms and documentation:

- An "ADRC Referral and Determination" Form DHS 1180;
- A medical evaluation report, providing diagnosis and prognosis of the member which has been completed by a licensed physician or authorized evaluator within ninety (90) days of the referral. This form shall be a DHS 1156 – "Physical Examination Report", DHS 1271 – "Report of Evaluation", or a DHS 1150 – "Patient Assessment for ICF-MR Services Prior Authorization", the 1147 Long Term Care Evaluation is sent to the DHS's agent for nursing facility level of care requests;

- Supporting medical evidence of physical or mental disability, if available;
- A completed DHS 1127, "Medical History and Disability Statement"; and
- A completed DHS 1128 "Disability Report"

The health plan shall provide all necessary medical services to the member until the disenrollment effective date for a member who has been determined to be disabled unless the member has been waitlisted for sixty-one (61) days and the disenrollment has not been accomplished by MQD as outlined in Section 50.220. If the ADRC does not determine that a member meets the disability criteria, the health plan shall continue to provide all services to the member.

Children who are enrolled in the programs and who later become blind or disabled and newborns that are blind or disabled shall be identified by the health plan. The health plan shall follow the ADRC process to have the child determined blind or disabled. If the health plan has supporting documentation that the child is SSI eligible, (copy of SSA letter or payment stub), said documentation shall be sent to the eligibility worker so that appropriate action can be taken. The health plan shall remain responsible for the child until the health plan receives a disenrollment from the State.

#### 50.240 State of Hawaii Organ and Tissue Transplant Program (SHOTT)

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

For all other non-experimental, non-investigational covered transplants, the health plan shall refer the member to the ADRC for a disability determination and submit a 1144 form to the MQD for authorization for an evaluation by SHOTT. Based on the information provided, the ADRC will 1) make a disability determination, and 2) The MQD and the SHOTT contractor will evaluate the member as a potential transplant candidate.

If the member is determined to meet the eligibility criteria for the SHOTT transplant program, then the member will be disenrolled from the health plan and placed in the SHOTT program.

If the member does not meet the criteria for a transplant, the member shall remain in the health plan.

If the recipient is determined to meet the criteria for a transplant by SHOTT, but the transplantation facility does not accept the recipient as a patient, and the recipient is not disabled, the recipient shall be re-enrolled into the same health plan they were enrolled in prior to the transplant evaluation effective the 1<sup>st</sup> day of the following month. If the member's condition changes to make him/her a better candidate for a transplant, the health plan may resubmit the member for re-consideration for the transplant program. If the member is determined permanently disabled, the member is transferred to the Medicaid fee-for-service program.

50.250 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 (except where the member's continued enrollment in the health plan seriously impairs the health plan's ability to furnish services to either the member or other members).

**50.300 Member Services**

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, and how to report suspected fraud and abuse. The health plan shall convey this information via written materials and other methods that may include telephone, internet, or face-to-face communications which allow the members to submit questions and receive responses from the health plan.

When directed by the State, 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.

50.310 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 for cancer, high blood pressure and diabetes; the importance of early prenatal care; and, the importance of 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 CC/CM services and how to access these services, the grievance and appeal process, 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.

The DHS will review and approve materials prior to the health plan distributing them or otherwise using them in educational programs.

50.320 Requirements for Written Materials

The health plan shall use easily understood language and formats for all 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 how to access those formats.

The health plan shall make all written information available in English, Ilocano, Tagalog, Chinese and Korean. 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 3 of this section.

The health plan shall certify that the transcription of the information into the different languages has been reviewed by a qualified individual for accuracy.

All written materials shall be worded such that the materials are understandable to a member who reads at the 6<sup>th</sup> (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.

## 50.330 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 mail to all enrolled members a Member Handbook at least annually thereafter.

Pursuant to the requirements set forth in 42 CFR 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;
- Information about reporting changes in family status and family composition;
- Appointment procedures;
- Information on benefits and services;
- 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;
- Benefits provided by the health plan not covered under the contract;
- The health plan's responsibility to coordinate care;

- 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 will 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 50.340;
- Information on advance directives;
- 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, and post-stabilization services;
  - 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 50.800. 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 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 438.6(h).

The Member Handbook shall be submitted to the DHS for review and approval within fourteen (14) days of contract award.

#### 50.340 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 438.100(a)(1)(2) and Sections 50.320 and 50.390 of this RFP;
- 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 160 and 164, subparts A and E, and request to amend or correct the record as specified in 45 CFR 164.524 and 164.526;
- Be furnished health care services in accordance with 42 CFR 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 will not adversely affect the way the member is treated;
- Not be held liable for the health plan's debts in the event of insolvency; not be held liable for the covered services provided to the member by the health plan for which the DHS does not pay the health plan; not be held liable for covered services provided to the member for which the DHS or the health plan does not pay the health care provider that furnishes the services; and not be held liable for 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 447.50 through 42 CFR 447.60.

50.350 Provider Directory

The health plan shall produce a provider directory for the DHS to provide assistance to members selecting a health plan. The health plan shall include in the provider directory information on providers by island, including the names, locations, office hours, telephone numbers and non-English languages spoken by current contracted providers (including specialists, PCPs, pharmacists, FQHCs and RHCs, mental health and substance abuse providers, and hospitals) as well as whether or not board certification has been attained and which providers are accepting new patients.

The health plan shall produce the number of copies requested by the State, in the format prescribed by the State, and in the timeframe prescribed by the State.

Annually, at the time prescribed by the State, the health plan shall produce and supply to the State up-dated provider directories in the format prescribed by the State. The health plan shall supply the number of provider directories as requested by the State. Quarterly, the health plan shall submit to the DHS provider directory up-dates which list any changes to the provider network. These up-dates shall be submitted in the format prescribed by the State.

## 50.360 Member Identification (ID) Card

The health plan shall mail a member ID card to all new 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;
- Benefit or other limits (if applicable—for example, QUEST, QUEST-Net, medical only benefits if behavioral health is provided by “carve-out”, etc);
- Third Party Liability (TPL) information; and
- EPSDT eligibility indicator.

The membership card does not have to include all of the listed information if the health plan demonstrates that it has other processes or procedures in place to enable providers to access this information in a timely manner and the processes have been approved by the DHS.

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, or for any other reason that results in a change to the information on the member ID card.

The health plan shall submit a front and back sample member ID card to the DHS for review and approval within thirty (30)days of contract award.

50.370 Toll-Free Telephone Hotline

The health plan shall operate a toll-free telephone hotline to respond to member questions, comments and inquiries. The hotline services shall be available and accessible to members from all islands which the health plan serves.

The health plan shall develop telephone hotline policies and procedures, that address staffing, personnel, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards.

The health plan shall submit these telephone hotline policies and procedures, to the DHS for review and approval within thirty (30)days of contract award.

The telephone hotline 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 call center systems shall have the capability to track call management metrics identified by the DHS.

The telephone hotline shall be fully staffed between the hours of 7:45 a.m. and 4:30 p.m., Monday through Friday, excluding

State holidays. The telephone hotline staff shall be trained to respond to member questions in all areas, including, but not limited to, covered services, the provider network, and non-emergency transportation (NET).

The health plan shall develop performance standards and monitor telephone hotline performance by recording calls and employing other monitoring activities. While not required to meet the following standards, the DHS is providing the following as general guidelines for developing hotline standards: 99% of calls are answered by the fourth ring, the call abandonment rate is 5% or less, the average hold time is two (2) minutes or less, and the blocked call rate does not exceed 1%.

The health plan shall have an automated answering system available between the hours of 4:30 p.m. and 7:45 a.m., Monday through Friday and during all hours on weekends and holidays. This automated system or answering service shall provide callers with operating instructions on what to do in case of an emergency and shall include, at a minimum, a voice mailbox for members to leave messages. The health plan shall ensure that the voice mailbox has adequate capacity to receive all messages. A health plan representative shall return messages within thirty (30) minutes of the time the message is left, whether the message is left on the automated system or by the answering service.

50.380 Internet Presence/Web Site

If the health plan chooses to have a web site, the section of the web site relating to programs under this contract shall comply with the marketing policies and procedures and with requirements for written materials described in this contract and must be in compliance with applicable state and federal laws.

DHS reserves the right to review and prior approve the web site's content information relating to the health plan's information covered under this contract.

50.390 Translation Services

The health plan shall provide oral translation services of information to any member who requests the service regardless of whether a member speaks a language that meets the threshold of a prevalent non-English language. The health plan shall notify its members of the availability of oral interpretation services and to inform them of how to access oral interpretation services. There shall be no charge to the member for translation services.

**50.400 Marketing and Advertising**

50.410 Prohibited Activities

The health plan is prohibited from engaging in the following activities:

- Directly or indirectly engaging in door-to-door, telephone, 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 \$5.00 cash;
- 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 recipient must enroll in a specific health plan to obtain benefits or to not lose 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, 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; and
- Attending educational sessions or presentations without the approval of the DHS.

The State may impose financial sanctions, as described in Section 71.300, up to the federal limit, on the health plan for any violations of the marketing and advertising policies.

50.420 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);
- Making telephone calls, mailings and home visits only to members currently enrolled in its health plan, for the sole purpose of educating them about services offered by or available through the health plan;
- 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 which have been prior approved by the DHS.

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 be in compliance with the information requirements in 42 CFR 438.10 and detailed in Section 50.320 of this RFP.

50.430 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 prior 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 that relate to the programs that have not been prior approved by the DHS. All materials shall be submitted to the DHS within thirty (30)days of contract award for review and approval.

The health plan shall not change any approved materials without the consent and approval of the DHS.

**50.500 Quality Improvement**

50.510 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 41.110;
- 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 seek input from, and work with, members, providers, MQD staff and its agents and community resources and agencies to actively improve the quality of care provided to members.

50.520 Quality Assessment and Performance Improvement Program (QAPI)

The health plan shall have an ongoing QAPI Program for all services it provides to its enrollees. The Hawaii Medicaid, MCO, Quality Assessment and Performance Improvement Program consists 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 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 within thirty (30)days of contract award, annually thereafter on a date designated by the DHS, and upon request by the DHS.

The health plan shall comply with the following requirements set forth in 42 CFR 438.240.

1. Conducting performance improvement projects (PIPs) described in 42 CFR 438.240(d);
2. Submitting performance measurement data (HEDIS measures) described in 42 CFR 438.240(c);
3. Mechanisms for detecting both under utilization and over utilization of services; and
4. Mechanisms for assessing the quality and appropriateness of care furnished to enrollees with SHCNs.

The health plan shall comply with the QAPI Program standards established by the DHS, which are based on applicable provisions of federal law and NCQA Standards/Guidelines for Accreditation of Managed Care Organizations. These standards are:

Standard I. QAPI Program Structure & Operations-Written Description

- A. QAPI Program Goals and Objectives
  - B. QAPI Program Scope
  - C. QAPI Program Range of Care
  - D. Governing Body Accountability
  - E. QAPI Program Supervision
  - F. QI Committee and Subcommittees
  - G. Annual Work Plan
  - H. QAPI Program Annual Assessment and Written Evaluation
  - I. Coordination of Quality Management Activity With Other Management Activity
- Standard II. Adequate Resources
- Standard III. Systematic Process of Monitoring Quality of Care/Services
- Standard IV. Member Rights and Responsibilities
- Standard V. Member Grievance System
- Standard VI. Provider Contract Standards, including
- A. Provider Services
  - B. Provider Grievance System
- Standard VII. Availability and Accessibility of Services
- Standard VIII. Continuity of Care, including
- A. Care Coordination/Case Management Services
  - B. Standards Relating to Recipients with Special Health Care Needs
- Standard IX. Medical Records, Record Retention, and Confidentiality Standards
- Standard X. Utilization Management Program
- Standard XI. Delegation of QAPI Program Activities

Standard XII. Credentialing and Re-credentialing of Providers  
Standard XIII. Program Integrity

The Standards and their respective elements are in Appendix K.

The DHS reserves the right to revise these standards and their respective elements to ensure compliance with changes to federal or state statutes, rules, and regulations as well as for clarification 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. 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 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; and

evaluate the content and frequency of reports from the delegated organization.

50.530 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.

The health plan's standards shall be consistent with the minimum standards established by the DHS for the content of the medical records, and shall require that the medical record is maintained by the PCP as described in Appendix K.

The health plan shall require of its providers that all medical records be maintained in a detailed and comprehensive manner that conforms to good professional medical practice, permits effective professional medical review and medical audit processes and facilitates an adequate system for follow-up treatment. Medical records shall be legible, signed and dated.

The health plan shall ensure that, as long as access to the records, including behavioral health and substance abuse records, is needed to perform the duties of this contract and to administer the program, approval or member consent is not needed for access by authorized DHS personnel or personnel contracted by the DHS. (See 42 CFR 431.300 et seq.).

50.540 Performance Improvement Projects (PIPs)

As part of its QAPI Program, the health plan shall conduct PIPs complying with 42 CFR 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 enrollee satisfaction. The PIPs shall include the following:

- The use of objective, measurable, and clearly defined quality indicators to measure performance;
- The implementation of system interventions to achieve improvement in quality;
- An evaluation of the effectiveness of the intervention; and
- A plan and activities that will increase or sustain improvement.

The health plan shall comply with the DHS's PIP Policy, (Appendix W) and shall complete each PIP in a time period determined by the DHS, to allow information on the progress of PIPs to produce new information on quality of care every year.

PIPs may be specified by the DHS and/or by CMS. In these cases, the health plan shall meet the goals and objectives specified by the DHS and/or 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.

50.550 Practice Guidelines

The health plan shall include, as part of its QAPI Program, practice guidelines that meet the following requirements. 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;
- Disseminated to all affected providers, and upon request, to members and potential members; and
- Consistent with 42 CFR 438.6(h) and 422.208, regarding Physician Incentive Programs.

Additionally, in compliance with 42 CFR 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 health plan shall submit with its proposal, policies and procedures addressing the stated requirements, a list of all current practice guidelines as well as the practice guidelines adopted specifically for asthma, diabetes, and pregnancy/high risk pregnancy.

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 will 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;
- Describe how the health plan will ensure that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines; and
- Be consistent with CFR 438.6(h) regarding Physician Incentive Programs.

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.

#### 50.560 Performance Incentives

The health plan may be eligible for performance incentives as described in Section 60.300.

#### **50.600 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 aimed at objectively and systematically monitoring and evaluating the necessity, appropriateness, efficiency, timeliness and cost-effectiveness of care and services provided to members in order to continuously promote quality clinical care and services as well as maximize appropriate use of resources.

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 employing objective evidenced-based criteria to ensure that utilization decisions regarding medical necessity and appropriateness of medical and behavioral health care/services are made in a fair, impartial and consistent manner by qualified licensed health care professionals.

The health plan shall review and update, on an annual basis, 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;
- Case management; and
- Pharmacy Management.

There shall be 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- 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 not develop a compensation structure that creates incentives for the individuals or entities conducting UMP 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 within thirty (30) days of contract award.

## **50.700 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. 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.

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 clinical expertise in treating the member's condition or disease.

The health plan shall not require prior authorization of emergency services, post-stabilization services, or urgent care services.

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 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 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 appeal 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 three (3) business days after receipt of the request for service. The health plan may extend the three (3) business day timeframe by up to 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 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 appeal 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 the health plan fails to make a determination on service authorization requests by the date the timeframes expire, the determination shall be considered an approval.

## **50.800 Member Grievance System**

50.805 General Requirements

The health plan shall have a formal grievance system that is consistent with the QUEST MEMO ADMN 0311 Attachment A-2, State of Hawaii Grievance System, and 42 CFR 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 access to the State's administrative hearing system. The health plan shall require that members exhaust its internal grievance system prior to accessing the State's administrative hearing system. The health plan shall develop policies and procedures for its grievance system and submit these to the DHS for review and approval within thirty (30) days of contract award. The health plan shall submit an updated copy of these policies and procedures within thirty (30) days of any modification for review and approval.

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 not arbitrarily deny or reduce the required scope of services 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 the services furnished can reasonably be expected to achieve their purpose.

The health plan shall give members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, 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)<sup>1</sup> 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.

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 made by a health care professional that has appropriate medical knowledge and clinical expertise in treating the member's condition or disease.

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 and are health care

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<sup>1</sup> 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.

professionals who have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease if deciding any of the following:

- 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.

50.810 Recordkeeping

The health plan shall maintain records of its members' grievances and appeals in accordance with recordkeeping and confidentiality provisions.

50.815 Inquiry Process

An inquiry is when a member contacts the health plan about any aspect of the health plan's, subcontractor's or providers' operations, activities, behavior, or a request for disenrollment that does not express dissatisfaction. 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, or provider acting on behalf of the member, their grievance and appeal rights.

50.820 Grievance Process

A member or a member's representative (on behalf or a member with written consent) may file a grievance orally or in writing. A

grievance may be filed about any matter other than an adverse action, as defined in Section 30.200, and when the expression of dissatisfaction is regarding some aspect of the health plan's or provider's operations, activities, behavior or denial of an expedited appeal request. 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.

In addition to meeting all requirements detailed in Section 50.805, 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 within thirty (30) calendar days of the initial expression of dissatisfaction; and
- Include information on 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.

#### 50.825 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) calendar days after the member receives the grievance disposition from the health plan. A State grievance review may be made by contacting the MQD office by calling the MQD Health Plan Liaison or mailing a request to:

Med-QUEST Division  
Health Coverage Management Branch  
PO Box 700190  
Kapolei, HI 96709-0190

- The MQD Health Plan Liaison will review the grievance and contact the member with a determination within thirty (30) calendar days from the day the request for a grievance review is received; and
- The grievance review determination made by MQD is final.

50.830 Appeals Process

An appeal may be filed when the health plan issues a notice of adverse action to a health plan member.

A member, provider, or authorized representative (on behalf of the member with the member's written consent) may file an appeal within thirty (30) calendar days of the notice of adverse action. An oral appeal may be submitted in order to establish the appeal submission date; however, this must be followed by a written request. The health plan shall assist the member, provider or authorized representative in this process.

In addition to meeting the general requirements detailed in Section 50.805, the health plan shall:

- Ensure that oral inquiries seeking to appeal an action are treated as appeals and confirmed in writing, unless the provider requests expedited resolutions;
- 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 a reasonable opportunity to present evidence, and evidence of allegations of fact or law, in person as well as in writing;
- Provide the member and his or her representative opportunity, before and during the appeals process, to examine the member's case file, including medical records, and any other documents and records considered during the appeal process; and
- Include as parties to the appeal, the member and his or her representative, or the legal representative 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 affected parties as expeditiously as the member's health condition requires, but no more than thirty (30) calendar days from the day the health plan receives the appeal.

The health plan may extend the resolution timeframe by up to fourteen (14) calendar 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 is in the member's interest. For

any extension not requested by a member, the health plan shall give the member written notice of the reason for the delay.

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, and how to access this process;
  - The right to request an expedited State administrative hearing if applicable;
  - 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 shall notify the provider of the resolution but it need not be in writing.

#### 50.835 Expedited Appeal Process

The health plan shall establish and maintain an expedited review process for appeals. The member or provider may file an expedited appeal either orally or in writing. An expedited appeal is only appropriate when the health plan or the provider indicates that taking the time for a standard resolution could

seriously jeopardize the member's life, 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 three (3) business days from the time the health plan received the appeal. The health plan shall make reasonable efforts to provide oral notice to the member with the appeal determination.

The health plan may extend the expedited appeal resolution timeframe by up to fourteen (14) calendar days if the member requests the extension or the health plan needs additional information and demonstrates to the MQD that the extension of time is in the member's interest.

The health plan shall notify a MQD Health Plan Liaison, within twenty-four (24) hours, regarding expedited appeals if an expedited appeal has been granted by the health plan or if an expedited appeal timeframe has been requested by the member or the health plan. The health plan shall provide the reason it is requesting a fourteen (14) day extension. The health plan shall notify the MQD Health Plan Liaison within twenty-four (24) hours

(or sooner if possible) from the time, the expedited appeal is lost.

The health plan shall follow the procedures below when notifying the MQD Health Plan Liaison:

- Contact the designated Health Plan Liaison;
- If no Liaison is available, send a fax to MQD/HCMB, to the attention of the Supervising Contract Specialist, label the fax as "Urgent", and include all applicable information.

For any extension not requested by the member, the health plan shall give the member written notice of the reason for the delay. If the health plan denies a request for expedited resolution of an appeal, it shall:

- Transfer the appeal to the timeframe for standard resolution;
- Make reasonable efforts to give the member prompt oral notice of the denial, and follow-up within two (2) calendar days of written notice; and
- Inform the member that they may file a grievance for the denial of the expedited process.

The health plan shall provide the member a reasonable opportunity to present evidence and allegation of fact or law, in person as well as in writing and inform the member of limited time available to present this information.

The health plan shall inform the member of the limited time available for this process in the case of expedited resolutions.

50.840 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 within thirty (30) calendar days of the receipt of the notice of disposition (denial). At the time of the denied appeal determination, the health plan shall inform the member, the provider acting on behalf of the member, or the representative of a deceased member's estate that he or she may access the state administrative hearing process. The member, or his or her representative, may access the state administrative hearing process by either calling the member's eligibility worker or submitting a letter to the Administrative Appeals Office (AAO) within thirty (30) calendar 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

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.

50.845 Expedited State Administrative Hearings

The member may file for an expedited state administrative hearing only when the health plan has provided an expedited appeal and the action of the appeal was determined to be adverse to the member (Action Denied). In this situation, the health plan shall inform the member that he or she must contact a MQD Health Plan Liaison within three (3) days of the receipt of the denial from the health plan.

An expedited state administrative hearing must be heard and determined within three (3) business days 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 are in compliance 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 to deny the expedited appeal.

50.850 Continuation of Benefits During an Appeal or State Administrative Hearing

The health plan shall continue the member's benefits if:

- The member requests an extension of benefits;
- The appeal or request for state administrative hearing is filed in a timely manner, meaning on or before the later of the following:
  - Within ten (10) days of the health plan mailing the notice of adverse action; or
  - The intended effective date of the health plan's proposed adverse action.
- The appeal or request for state administrative hearing involves the termination, suspension, or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized provider; and
- The original period covered by the original authorization 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 following occurs:

- The member withdraws the appeal;
- The member does not request an administrative hearing within ten (10) days from when the health plan mails a notice of adverse action;
- A State administrative hearing decision adverse to the member is made; or
- The authorization expires or authorization service limits are met.

If the final resolution of the State administrative hearing is adverse to the member, that is, upholds the health plan's adverse action, the health plan may recover the cost of the services furnished to the member while the appeal is 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.

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.

#### 50.855 External Review Procedures

After exhausting all internal grievance and appeal procedures available with the health plan, the member, the member's provider or the member's authorized representative may file a request for an external review of a managed care plan's final internal determination with the State of Hawaii's Insurance Commissioner.

The health plan shall inform the member, the member's provider or the member's authorized representative of the process to request an external review by the Insurance Commissioner.

50.860 Notice of Adverse Action

The health plan shall give the member and the referring provider a written notice of any adverse action within the timeframes specified below. The notice to the member or provider shall include the following information:

- The adverse action the health plan has taken or intends to take;
- The reasons for the adverse action;
- 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;
- The circumstances under which an expedited resolution is available and how to request it; and
- The member's right to have benefits continue pending resolution of an appeal, how to request that the benefits be continued, and the circumstances under which a member may be required to pay the costs of these services.

The notice of adverse action to the member shall be written pursuant to the requirements in Section 50.320 of this RFP.

The health plan shall mail the notice within the following timeframes:

- For termination, suspension, or reduction of previously authorized Medicaid-covered services: at least ten (10) calendar days prior to the date the adverse action 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 recipient 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) calendar days following receipt of request for service, with a possible extension of up to fourteen (14) additional calendar days (total timeframe allowed with extension is twenty-eight (28) calendar days from the date of the request for services) if (1) the recipient or provider requests an extension and (2) the health plan justifies a need for additional information and how the extension is in the member's interest. If the health plan extends the timeframe it must (1) 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 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 three (3) business days after receipt of the request for service.

Service authorization decisions not reached within the timeframes specified above shall be considered a denial and therefore considered an adverse action.

## **50.900 Information Systems**

### 50.910 Health Plan Information System

The health plan shall have information management systems that enable it to meet the DHS requirements, state and federal reporting requirements, all other contract requirements and any other applicable state and federal laws, rules and regulations, including HIPAA.

Specifically, the DHS requires that the health plan install the DHS approved Virtual Private Network (VPN) software that is provided free of charge to the health plans. The VPN software allows the MQD and the health plan to securely transfer member, provider, and encounter data via the internet.

50.920 Compliance with the Health Insurance Portability and Accountability Act

The health plan shall implement the electronic transaction standards and other "Administrative Simplification" provisions, privacy and security provisions of the Health Insurance Portability and Accountability Act (HIPAA), Public Law 104-191, as specified by CMS.

50.930 Possible Audits of Health Plan Information System

The health plan shall institute processes to insure 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.

50.940 Health Plan Information System Changes

The health plan shall notify the DHS and obtain prior approval for any proposed changes to its information system which could impact any process or program under this contract.

50.950 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 within thirty (30)days of contract award.

## **51.100 Fraud & Abuse**

The health plan shall comply with Program Integrity Requirements, as outlined in 42 CFR Part 438, Subpart H. The health plan shall have a written compliance program which 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.

The health plan shall have a monitoring program and identify providers or members who may be committing fraud or abuse. The health plan's fraud and abuse monitoring program shall include the following activities, but not be limited to:

- A. Monitoring the billings of its providers to ensure members receive services for which the health plan is billed;
- B. Investigating all reports of suspected fraud and over billings (upcoding, unbundling, billing for services furnished by others and other overfilling practices);
- C. Reviewing providers for over or underutilization;
- D. Verifying with members the delivery of services as claimed; and
- E. Reviewing and trending consumer complaints on providers.

The health plan shall have administrative and management fraud and abuse policies and procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse. The health plan shall submit these procedures to MQD for review and approval within thirty (30) days of contract award. The health plan's fraud and abuse policies and procedures shall include the following:

- A. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable federal and state standards;
- B. The designation of a compliance officer and a compliance committee that are accountable to senior management;
- C. Effective training and education for the compliance officer and the organization's employees;
- D. Education about fraud and abuse identification and reporting in provider and member material;
- E. Effective lines of communication between the compliance officer and the organization's employees;
- F. Enforcement of standards through well-publicized guidelines; and
- G. 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.

Within thirty (30) days of discovering instances of suspected fraud or abuse, the health plan shall submit a report it to the Med-QUEST Division, Medical Standards Branch and the Medicaid

Fraud Control Unit of the Attorney General's Office. The health plan shall use the report form in Appendix X to report or refer suspected cases of Medicaid fraud or abuse that includes, at a minimum:

- Name
- ID Number
- Source of complaint
- Type of provider
- Nature of complaint
- Approximate dollars involved
- Legal and administrative disposition of the case

The health plan shall provide any evidence it has on the member's services or providers' billing practices (unusual billing patterns, services not rendered as billed and same services billed differently or separately).

The health plan and all subcontractors shall cooperate fully with federal and state agencies in investigations and subsequent legal actions.

If the provider is not billing appropriately, but the health plan has found no evidence of fraud (defined as intention to defraud) or abuse, the health plan shall provide education and training to the provider in question.

The DHS may impose sanctions on the health plan for fraud and abuse. Refer to Section 71.300 for more information on sanctions.

51.110 Child Abuse Reporting Requirements

The health plan shall report all cases of suspected child abuse to the Child Protective 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.

**51.200 Health Plan Personnel**

51.210 Medical Director

The health plan shall have on staff a locally based Medical Director licensed to practice medicine in the State of Hawaii, to oversee the quality of care furnished by the plan and to 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 quarterly DHS Medical Director meetings, Provider Advisory Board meetings and any committee meetings relating to the programs when requested by the DHS.

51.220 Support Staff and Systems

The health plan shall have in place adequate organizational and administrative systems that are capable of implementing

contractual obligations. The staff and associated functions shall include, but not be limited to:

- QUEST Coordinator to serve as the health plan's key contact for the contract;
- Behavioral health practitioner involved in behavioral health care aspects of the QAPI Program;
- Care Coordination/Case Management staff to ensure timely access to medically necessary services and to assist the member in understanding and following his/her treatment plan;
- Pharmacist either on staff with the health plan or on contract who is physically located in the State of Hawaii to address pharmacy needs of members;
- Quality Improvement Program Director and staff capable of undertaking all Quality Improvement activities;
- Utilization Management Coordinator and sufficient staff to handle all UM activities;
- EPSDT Coordinator (must be an R.N. and minimum 0.5 FTE);
- Member Services Director and representatives located in the State of Hawaii to address member needs or coordinate services;
- Provider Services Director and representatives located in the State of Hawaii to confirm eligibility, interpret/explain plan policies and guidelines and resolve provider complaints;
- Grievance Coordinator to investigate member and provider complaints;

- Catastrophic Claims Coordinator;
- Fraud and Abuse Compliance Officer;
- Administrator to oversee the business processes;
- Designated Financial Officer to oversee the budget and accounting system and to ensure timely and accurate submission of financial reports;
- Information Systems Director and staff capable of processing rosters, and ensuring the timely and accurate submission of encounter data and other required information and reports;
- Support Services staff to ensure the timely and accurate processing of other reports; and
- Clerical staff to conduct daily business.

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 on-going training of all staff to ensure they have the education, knowledge and experience to fulfill the requirements of this contract. A specific number of staff or FTEs are not required; only that adequate staff is available and assigned to appropriate areas to fulfill the required functions specified in this contract. The health plan shall submit a staffing plan to DHS for review and approval within thirty (30) days of contract award.

## **51.300 Reporting Requirements**

### 51.310 Purpose for Collection of Data

The health plan shall submit all requested data to the DHS or its designee (i.e. EQRO) so that periodic reviews, including validation studies, can be performed. The State is required to have in its contracts with the health plan, the requirement for the provision of the data and is authorized to impose financial penalties if the data is not provided timely and accurately.

The health plan shall comply with all additional requests from the DHS, or its designee, for additional data, information and reports.

## **51.400 Provider Network Reports**

### 51.410 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 and specialty services 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 program 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; and
- Verification that provider or affiliated provider is not on the federal or state exclusions list.

These reports shall be submitted to the DHS at the following times:

- Prior to implementation of the contract (the DHS reserves the right to delay implementation of the contract or cap enrollment due to an inadequate provider network);
- Monthly;
- Upon the DHS request;
- Upon enrollment of a new population in the health plan;
- Upon changes in services, benefits, geographic service area or payments; and

- Any time there has been a significant change in the health plan's operations that would impact adequate capacity and services. A significant change is defined as any of the following:
  - A decrease in the total number of PCPs by more than 5% per island;
  - A loss of providers in a specific specialty where another provider in that specialty is not available on the island; or
  - A loss of a hospital.

51.420 PCP Report

The health plan shall submit a monthly *PCP Assignment Report* which lists each member's name and the name of the PCP to which they are assigned. This report shall be provided in the format to be prescribed by the DHS.

51.430 Timely Access Report

The health plan shall submit a quarterly *Timely Access Report* that monitors the time lapsed between a member's initial request for an office appointment and the date of the appointment. The data for the Timely Access Reports may be collected using statistical sampling methods (including periodic member or provider surveys). The report shall include:

- Total number of appointment requests;
- Total number of requests that meet the waiting time standards (for each provider type/class);

- Total number of requests that exceed the waiting standards (for each provider type/class); and
- Average waiting time for those requests that exceed the waiting time standards (for each provider type/class).

The reports shall be submitted November 30 for the quarter July-September, February 28 for the quarter October-December, May 31 for the quarter January-March, and August 31 for the quarter April-June.

51.440 Annual Report of Services Rendered to Members by an FQHC or RHC

The health plan shall submit an *Annual Report of Services Rendered to Members by an FQHC or RHC* by June 30 of each year, for the prior calendar year (January through December). The report shall include the following information:

- 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.

51.450 Provider Suspensions and Termination Report

The health plan shall submit a *Provider Suspensions and Terminations Report* listing by name, all provider suspensions or terminations on a quarterly basis. 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 should be documented in the *Provider Suspensions and Terminations Report*. The health plan shall utilize the report format provided by the DHS.

The reports shall be submitted November 30 for the quarter July-September, February 28 for the quarter October-December, May 31 for the quarter January-March, and August 31 for the quarter April-June.

51.460 Provider Complaints Report

The health plan shall submit to DHS the following Provider Complaints Reports for each of the quarters identified in Section 51.740. Due dates are also the same as specified in Section 51.740. Reports shall be submitted using the matrix provided by the DHS on the same due dates specified in Section 51.740 in hard copy and in electronic file copy.

- A quarterly report which totals the number of complaints by category (benefits and limits; eligibility and enrollment;

member issues; health plan issues) which were resolved during the reporting quarter;

- A quarterly report which totals the number of complaints by category (benefits and limits; eligibility and enrollment; member issues; health plan issues) and by unresolved provider complaint reason code (complaint is expected to be resolved by the reporting date and complaint is unlikely to be resolved by the reporting date);
- A quarterly follow-up report consisting of data elements specified by DHS for provider complaints unresolved in previous quarter(s).
- A quarterly report of delays in claims payment, denials of claims payment, and claims not paid correctly which includes the following:
  - The number of calls from providers received for each month in the reporting quarter; percentage of calls abandoned for each month in the reporting quarter; and average wait time for each month in the reporting quarter;
  - 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 14, 30, 60, and 90 days) after date of service for each month of the reporting quarter;
  - The number of claims denied for each month in the reporting quarter;

- 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 should be billed first.

## **51.500 Covered Benefits and Services Reports**

### 51.510 CMS 416 Report

The health plan shall submit an annual, CMS 416 Report to the DHS no later than March 1 of every year to measure and document screening and participation rates in the EPSDT program so opportunities for improvement can be identified and addressed.

## **51.600 Quality Assessment and Performance Improvement (QAPI) Program Reports**

### 51.610 QAPI Program Report

The health plan shall provide an annual *QAPI Program Report*. This report shall be submitted by the date specified by MQD in the Annual Reporting and Monitoring Activities Memorandum that is issued to the health plans every year. The health plan's medical director shall review these reports prior to submittal to the DHS. The *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 51.200 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 and utilization management program evaluation reports; and
- Written notification of any delegation of QAPI Program activities to contractors.

51.620 Health Plan Employer Data and Information Set (HEDIS) Report

The health plan shall submit an annual *Health Plan Employer Data and Information Set (HEDIS) Report* in the format required by the DHS. This report shall cover the period from July 1 to June 30 and shall be reviewed by the health plan's Medical

Director prior to submittal to the DHS by December 31 of each year.

The EQRO shall annually perform a HEDIS Report Validation of three (3) of the State-selected HEDIS measures to ensure health plan compliance with HEDIS methodology.

51.630 Performance Improvement Projects Report

Annually, the health plan shall submit, on the DHS designated reporting form, two (2) *Performance Improvement Projects Reports* to the DHS and its EQRO. Each 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). These 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.

This report shall be submitted on the same date the QAPI Program Report required in Section 51.610 is submitted.

## **51.700 Member Grievance System Reports**

### 51.710 Member Grievance and Appeals Report

The health plan shall submit to the DHS a *Member Grievance and Appeals Report* on a quarterly basis. Reports shall be submitted November 30 for the quarter July-September, February 28 for the quarter October-December, May 31 for the quarter January-March, and August 31 for the quarter April-June. Reports shall meet the formatting and content requirements outlined in Section 50.805, and shall be submitted in the format provided by the DHS.

### 51.720 Report of Grievances a Provider Has Filed on Behalf of Members

The health plan shall submit a quarterly *Report of Grievances a Provider Has Filed on Behalf of Members* which shall:

- Be grouped by the following categories:
  - Provider quality;
  - Provider accessibility/availability;
  - Provider – delivery of service;
  - Plan quality;
  - Plan accessibility/availability;
  - Plan – delivery of service;
  - Delays/denials of authorization;
  - Delays/denials of payment and inadequate payment.
- Include grievance code, name, ID #, provider name, original date of receipt of grievance, date of resolution, description of grievance, plan of action and timetable, and

whether an appeal has been filed. The grievance code shall be:

- A – for those related to quality, availability, and/or delivery of service and elevated to grievance which was submitted in writing by the provider. This code should also be used to identify serious quality of care problems from provider who refuse to commit the issues to writing or
- B – for grievances initiated by the provider.

The health plan shall submit the report according to the quarter and due dates identified in Section 51.710.

51.730 Follow-up Report of Unresolved Appeals

The health plan shall submit a *Follow-up Report of Unresolved Appeals* originally filed in previous quarter(s) which consists of the following: name, ID#, Date Of Birth, provider name (if applicable), original date of receipt of appeal, date resolved, resolution, plan of action and timetable, and disposition of appeal (upheld or overturned).

The health plan shall submit the report according to the quarter and due dates identified in Section 51.710.

51.740 Quarterly Report of Grievances and Appeals

The health plan shall submit a *Quarterly Report of Grievances and Appeals*. These reports shall be submitted sixty (60) days following the end of each quarter based on the State fiscal year

of July 1 through July 30 (November 30, February 28, May 31 and August 31). The reports shall include the following:

- The number of complaints by type;
- Type of assistance provided;
- Administrative disposition of the case;
- Overturn rates;
- Percentage of grievances and appeals that did not meet timeliness requirements; and
- Ratio of grievances and appeals per 1,000 members.

Inquiries need not be reported by the health plan.

## **51.800 Utilization Management Reports**

### **51.810 Prior Authorization Requests Denied/Deferred**

The health plan shall submit on a semi-annual basis, a *Prior Authorization Requests that have been Denied or Deferred Report*. The specific reporting period, types of services and due dates will be designated by the DHS. The quality improvement objective of this report is to ensure that health plans are correctly interpreting the QUEST program benefits and appropriately applying the program's medical necessity criteria. 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.

51.820 Report of Over- and Under Utilization of Drugs

The health plan shall submit a Report of Over- and Under Utilization of Drugs which consists of the following four (4) reports two (2) times per year on a schedule designated by the DHS:

- A. Listings of the top fifty (50) high cost drugs and the top fifty (50) highly utilized drugs, the criteria that is used/developed to evaluate their appropriate, safe and effective use, and the outcomes/results of the evaluations
- B. Listings 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.
- C. Listing of members who are high users of controlled substances but have no medical condition (i.e. malignancies, acute injuries, etc.) which would justify the high usage. Additionally, the health plan shall submit: 1) its procedures for referring these members for care

coordination/case management (CC/CM) for monitoring and controlling their over-utilization, and 2) the results of the CC/CM services provided.

- D. 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).

These reports shall be submitted twice per year according to the schedule prescribed by the DHS.

51.830 Report of Over- and Under-Utilization of Services

The health plan shall submit a *Report of Over- and Under Utilization of Services*, consisting of the following six (6) reports, on September 30 and March 31:

- A. PCP Visit Rates: Listings of PCPs that are at the top three percent (3%) and bottom three percent (3%) in utilization compared to the health plan's specialty. The health plan shall include only those PCPs that have at least one hundred (100) members assigned to them.
- B. Approved Authorization/1000 Member Months: Listings of PCPs that are at the top three percent (3%) and bottom three percent (3%) in utilization compared to the health plan's specialty norm. The health plan shall include only those PCPs that have at least one hundred (100) members assigned to them.

- C. QI Investigations for Delay in Treatment: Listings of PCPs that have twenty percent (20%) or more of QI referrals experiencing delays in treatment.
- D. Inpatient Acute Bed Days per 1000 Member Months: Listings of hospitals and other providers delegated for concurrent review that have one hundred fifty percent (150%) or higher of services that exceed the health plan average and of those that have twenty-five percent (25%) or less than recommended services provided by clinical decision criteria adopted by the health plan e.g. Milliman or InterQual guidelines.
- E. Selected Specialty Visit Rates: Listings of the top and bottom three percent (3%) compared to the health plan's specialty norm of individual providers within the specialty of cardiology, general surgery and orthopedics that have fifty (50) or more approved prior authorizations in a six (6) month period.
- F. Selected Chronic Conditions: Listings of the follow-up utilization variance per clinical practice guidelines or disease management guidelines adopted by the health plan and follow-up utilization variance per clinical practice guidelines. For each measure, the health plan shall identify the threshold designated by the health plan's Medical Director that triggers further investigation for over and/or under utilization.

## **51.900 Fraud and Abuse Reports**

The health plan shall submit a Fraud and Abuse Report that shall include, at a minimum, the following:

- Source of complaint;
- Alleged persons or entities involved;
- Nature of complaint;
- Approximate dollars involved;
- Date of the complaint;
- Disciplinary action imposed;
- Administrative disposition of the case;
- Investigative activities, corrective actions, prevention efforts, and results; and
- Trending and analysis as it applies to: utilization management, claims management, post-processing review of claims, and provider profiling.

## **52.100 Financial Reports**

### **52.110 QUEST Financial Reporting Guide**

The health plan shall submit financial information on a regular basis in accordance with the QUEST Financial Reporting Guide in Appendix S. The health plan shall comply by submitting all quarterly and annual reports and data in the formats prescribed in the QUEST Financial Reporting Guide. The DHS reserves the right to increase the frequency of financial reporting by the health plan. 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 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.

52.120 Third Party Liability (TPL) Cost Avoidance Report

The health plan shall submit a monthly *Third Party Liability (TPL) Cost Avoidance Report*, using the format received by the DHS, which identifies all cost-avoided claims for members with third party coverage from private insurance carriers and other responsible third parties.

52.130 Disclosure of Information on Annual Business Transaction Report

The health plan shall submit to the DHS a *Disclosure of Information on Annual Business Transactions Report* that discloses 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 in 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.

#### 52.140 Encounter Data/Financial Summary Reconciliation Report

The health plan shall submit quarterly Encounter Data/Financial Summary Reconciliation Reports to MQD. These reports shall be submitted within ninety (90) calendar days of the last day of the quarter. The health plan shall submit these reports using the instructions and format provided in Appendix B. In addition, the health plan shall provide any additional summaries, data or explanations as to differences between the summary report, and encounter data and financial summaries (for example, this analysis could include a detailed discussion of reserves and any items included in the claim cost portion of the financial statements that are not included in the encounter data).

### **52.200 Encounter Data Reporting**

The health plan shall submit encounters to MQD 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 plans as required in 42 CFR 438.606 and as specified in Section 52.300.

52.210 Accuracy, Completeness and Timeliness of Encounter Data Submissions

The State will 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 complete with no material omissions. Encounter data is not complete if the data has missing or incomplete field information. The State shall impose financial penalties on the health plan for failure to submit accurate 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 following encounter data submission requirements apply:

- Timeliness –eighty percent (80%) 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 and one-hundred percent (100%) within fifteen (15) months from the date of services. Adjustments and resubmitted encounters will not be subject to the one-hundred twenty (120) day submission requirement. In addition, TPL related encounters will not be subject to the one-hundred twenty (120) day submission deadline.
- Accuracy and Completeness – 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 encounter is one that reports a complete and accurate description of the service provided.

The health plan will be notified by the DHS within thirty (30) days from the receipt date of the initial encounter submission of all encounters that have failed the accuracy and completeness edits. 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, fifteen percent (15%) of the initial encounter submission continues to fail the accuracy and completeness edits, a penalty amounting up to ten percent (10%) of the monthly (initial month's submission) capitation payment shall be assessed against the health plan for failing to submit accurate and timely encounter data.

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 will 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 twice a 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.

### **52.300 Financial Penalties for Failure to File Reports, Information and Data Requests**

All information, data, reports and medical records, including behavioral health and substance abuse records, shall be provided to the DHS or its designee by the specified deadlines. The health plan shall be assessed a penalty of \$200.00 per day until the required information, accurate data, reports or medical records are received by the DHS or its designee.

### **52.400 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. Health plan representation 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 its MQD plan liaison 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.

#### **52.500 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 issue(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 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 production 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 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 actions the health plan has or will take.