

STATE OF HAWAII

**DEPARTMENT OF HUMAN SERVICES
MED-QUEST DIVISION
KAPOLEI, HAWAII**

**Legal Ad Date: June 14, 2006
REQUEST FOR PROPOSALS**

No. RFP-MQD-2007-002

Competitive Sealed Proposals:

**QUEST Managed Care Plans to Cover Medicaid and Other
Eligible Individuals Who Are Not Aged, Blind, or Disabled**

**will be received up to 4:30 p.m. Hawaii Standard Time (H.S.T.)
on August 11, 2006
in the Department of Human Services
Med-QUEST Division (MQD)
1001 Kamokila Boulevard, Room 317
Kapolei, Hawaii 96707**

Note: If this RFP was downloaded from the State Procurement Office RFP Website each applicant must provide contact information to the RFP contact person for this RFP to be notified of any changes. For your convenience, an [RFP Interest form](#) may be downloaded to your computer, completed and e-mailed or mailed to the RFP contact person. The State shall not be responsible for any missing addenda, attachments or other information regarding the RFP if a proposal is submitted from an incomplete RFP.

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SECTION 10 ADMINISTRATIVE OVERVIEW

10.100 Purpose of the Request for Proposal

This Request for Proposal (RFP) solicits participation by qualified and properly licensed health plans to provide required medical and behavioral health services to eligible QUEST, QUEST-Net, and QUEST-ACE (Adult Coverage Expansion) recipients. The services shall be provided in a managed care environment with reimbursement to qualifying health plans based on fully capitated rates for each island. The Department of Human Services (DHS) reserves the right to add new eligible groups and to negotiate different or new rates to include coverage of these new groups. Services to health plan members under the contracts awarded shall commence on February 1, 2007.

Separate RFPs shall be issued by the DHS to solicit participation of qualified plans for the provision of the required behavioral health services for the above recipients identified in Sections 30.760 and 30.770 of this RFP. A separate managed care program has also been developed to provide certain transplants for children and adults, as described in Section 30.710.

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

The DHS reserves the right to modify, amend, change, add or delete any requirements in this RFP and the documentation library to serve the best interest of the State. If significant

amendments are made to the RFP, the offerors will be provided additional time to submit their proposals.

10.200 Authority for Issuance of RFP

This RFP is issued under the authority of Title XIX of the Social Security Act, 42 USC Section 1396, et. seq. as amended, the implementing regulations issued under the authority thereof, Hawaii Revised Statutes (HRS) chapter 346-14, and the provisions of the HRS Title 9, Chapter 103F. All offerors are charged with presumptive knowledge of all requirements cited by these authorities, and submission of a valid executed proposal by any offeror shall constitute admission of such knowledge on the part of such offeror. Failure to comply with any requirement may result in the rejection of the proposal. DHS reserves the right to reject any or all proposals received or to cancel this RFP, according to the best interest of the State.

10.300 Issuing Officer

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

Mr. Brian Pang

Department of Human Services/Med-QUEST Division

601 Kamokila Boulevard, Suite 518

Kapolei, HI 96707

Telephone: (808) 692-8050

10.400 Use of Subcontractors

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

10.500 Organization of the RFP

This RFP is composed of 10 sections plus appendices:

- Section 10 – Administrative Overview – Provides general information on the purpose of the RFP, the authorities relating to the issuance of the RFP, the use of subcontractors and the organization of the RFP.
- Section 20 – RFP Schedule and Requirements - Provides information on the rules and schedules for procurement.
- Section 30 – Background and DHS Responsibilities – Describes the current Medicaid programs including Medicaid fee-for-service, QUEST, QUEST-Net, and QUEST-ACE and the role of the DHS.

- Section 40 – Provisions of Services – Health Plan Responsibilities – Provides information on the medical and behavioral health services to be provided and provider network requirements under the contract.
- Section 50 – Health Plan Administrative Requirements – Provides information on the enrollment and disenrollment of members, member services, marketing and advertising, quality management, utilization management requirements, information systems, health plan personnel, and reporting requirements.
- Section 60 – Financial Responsibilities – Provides information on health plan reimbursement, provider reimbursement, incentives, third party liability and catastrophic care.
- Section 70 – Terms and Conditions – Describes the terms and conditions under which the work will be performed.
- Section 80 – Technical Proposal – Defines the required format of the technical proposal and the minimum information to be provided in the proposal.
- Section 90 – Business Proposal – Defines the required format of the business proposal and the minimum information to be provided in the proposal.
- Section 100 – Evaluation and Selection – Defines the evaluation criteria and explains the evaluation process.

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

SECTION 20 RFP SCHEDULE AND REQUIREMENTS

20.100 RFP Timeline

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

Issue RFP	June 14, 2006
Orientation	June 21, 2006
Submission of Written Questions on Technical Proposal	June 29, 2006
Notice of Intent to Propose	June 30, 2006
Issue Section 90 Business Proposal of the RFP and Data Book	July 5, 2006
Submission of Written Questions on Business Proposal	July 17, 2006
Written Responses to Technical Proposal Questions	July 24, 2006
Written Responses to Business Proposal Questions	July 24, 2006
Proposal Due Date	August 11, 2006
Contract Award	September 5, 2006
Contract Effective Date	September 12, 2006
Commencement of Services to Members	February 1, 2007

20.200 Orientation

An orientation for offerors in reference to this RFP will be held on June 21, 2006 at 1:30 p.m. (H.S.T.) Room 577B in the Kakuhihewa Building, 601 Kamokila Boulevard, Kapolei, Hawaii.

Offerors are encouraged to submit written questions prior to the orientation. Impromptu questions will be permitted at the orientation and spontaneous answers provided at the state purchasing agency's discretion. However, answers provided at the orientation are only intended as general direction and may not represent the state purchasing agency's position. Formal official responses will be provided in writing. To ensure a written response, any oral questions should be submitted in writing following the close of the orientation, but no later than the submittal deadline for written questions indicated in Section 20.300, Written Questions.

20.300 Submission of Written Questions

Offerors shall submit questions in writing, and/or on diskette in Word 2000 format, or lower to the following mailing address or e-mail address:

Dona Jean Watanabe
Med-QUEST Division-Finance Office
1001 Kamokila Boulevard, Suite 317
Kapolei, Hawaii 96707-2005
Fax: (808) 692-7989
Email Address: dwatanabe@medicaid.dhs.state.hi.us

The written questions shall reference the RFP section, page and paragraph number in the format provided in Appendix G. Offerors must submit written questions on the technical proposal by 4:30 p.m. (H.S.T.) on June 29, 2006 and on the business proposal by 4:30 p.m. (H.S.T.) on July 17, 2006. The DHS shall respond to the written questions no later than July 24, 2006. No verbal responses shall be considered as official.

20.400 Notice of Intent to Propose

Offerors shall submit a Notice of Intent to Propose to the Issuing Officer no later than 4:30 p.m. (H.S.T.) June 30, 2006. Submission of a Notice of Intent to Propose is not a prerequisite for the submission of a proposal, but it is necessary that the Issuing Officer receive the letter by this deadline to assure proper distribution of amendments, questions and answers and other communication regarding this RFP.

The Notice of Intent can be mailed or faxed to:

Dona Jean Watanabe
Med-QUEST Division-Finance Office
1001 Kamokila Boulevard, Suite 317
Kapolei, Hawaii 96707-2005
Fax Number: (808) 692-7989

20.500 Tax Clearance

A certified copy of a current valid tax clearance certificate issued by the State of Hawaii, Department of Taxation (DOTAX) and the Internal Revenue Service (IRS) will be required upon notice of award.

Tax clearance certificates are valid for a six (6)-month (not one hundred eighty (180) day) period beginning on the later dated DOTAX or IRS approval stamp.

The tax clearance certificate shall be obtained on the State of Hawaii, DOTAX Tax Clearance Application Form A-6 (rev. 2004) which is available at the DOTAX and IRS office in the State of Hawaii or the DOTAX website at www.hawaii.gov/tax/tax.html.

The offeror is also required to submit an original current tax clearance certificate for final payment on the contract.

20.600 Certificate of Good Standing

Upon award of a contract, the health plan will be required to obtain a Certificate of Good Standing from the Department of Commerce and Consumer Affairs (DCCA) Business Registration Division (BREG).

A business entity referred to as a "Hawaii business", is registered and incorporated or organized under the laws of the State of Hawaii. The health plan shall submit a "Certificate of Good Standing" issued by the DCCA, BREG.

A business entity referred to as a "compliant non-Hawaii business," is not incorporated or organized under the laws of the State of Hawaii but is registered to do business in the State. Contractor shall submit a "Certificate of Good Standing" and may be obtained from www.BusinessRegistrations.com. To register or to obtain a "Certificate of Good Standing" by phone, call (808) 586-2727 (M-F 7:45 to 4:30 HST). The "Certificate of Good Standing" is valid for six (6) months from date of issue and must be valid on the date it is received by the purchasing agency. There are costs associated with registering and obtaining a "Certificate of Good Standing" from the DCCA; these costs are the responsibility of the health plan.

20.700 Current and Prior Medicaid Experience

Offerors shall provide addresses, telephone numbers and e-mail addresses for the contact/contract manager for all current and prior Medicaid contracts as required in Section 80.300.

20.800 Documentation

Offerors may review information describing Hawaii's Medicaid program and the QUEST programs by contacting the Med-QUEST Division, Health Coverage Management Branch secretary by telephone at 692-8085 between 7:45 A.M. and 4:30 P.M. for an appointment. The documentation library contains material designed to provide additional program and supplemental information and shall have no effect on the requirements stated in this RFP.

- QUEST applications/renewals
- QUEST Program Documentation
- Organization charts and functional statements
- QUEST Health Plan Manual
- QUEST Policy Memorandum Manual
- EPSDT Manual
- Forms Manual
- HEDIS
- QUEST Financial Reporting Guide
- Information on the development of the capitated rate ranges
- Other pertinent data

Offerors that request copies of documentation after visiting the Documentation Library shall be provided the documents at cost. Packaging and shipping of documentation shall be the responsibility of the offerors.

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

20.900 Rules of Procurement

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

20.910 No Contingent Fees

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

20.920 Discussions with Offerors

A. Prior To Submittal Deadline:

Discussions may be conducted with offerors to promote understanding of the purchasing agency's requirements.

B. After Proposal Submittal Deadline:

Discussions may be conducted with offerors whose proposals are determined to be reasonably susceptible of being selected for award, but proposals may be accepted without discussions, in accordance with section 3-143-403, Hawaii Administrative Rules (HAR).

21.100 RFP Amendments

The DHS reserves the right to amend the RFP any time prior to the closing date for the submission of the proposals.

Amendments shall be sent to all offerors who requested copies of the RFP.

21.200 Costs of Preparing Proposal

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

21.300 Provider Participation in Planning

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

21.400 Disposition of Proposals

All proposals become the property of the State of Hawaii. The successful proposal shall be incorporated into the contract and shall be public record. The State of Hawaii shall have the right to use all ideas, or adaptations to those ideas, contained in any proposal received in response to this RFP. Selection or rejection of the proposal shall not affect this right. Written requests for an explanation of rejection shall be responded to in writing within five (5) business days of receipt.

Offerors who submit technical proposals which fail to meet mandatory requirements or fail to meet all the threshold requirements during the technical evaluation phase, shall have their technical and business proposals returned. The business proposal shall be returned unopened.

21.500 Rules for Withdrawal or Revision of Proposals

A proposal may be withdrawn or revised at any time prior to, but not after, the Proposal Due Date of August 11, 2006 provided that a request in writing executed by an offeror or its duly authorized representative for the withdrawal or revision of such proposal is filed with the DHS before the deadline for receipt of proposals. The withdrawal of a proposal shall not prejudice the right of an offeror to submit a new proposal.

21.600 Independent Price Determination

State law requires that a bid shall not be considered for award if the price in the bid was not arrived at independently without collusion, consultation, communication, or agreement as to any matter relating to such prices with any other offeror or with any competitor.

The offeror shall include a certified statement in the proposal certifying that the bid was arrived at without any conflict of interest, as described above. Should a conflict of interest be detected at any time during the term of the contract, the contract shall be null and void and the offeror shall assume all

costs of this project until such time that a new offeror is selected.

21.700 Confidentiality of Information

If the offeror seeks to maintain the confidentiality of sections of the proposal, each page of the section(s) should be marked as "Proprietary" or "Confidential." An explanation to the DHS of how substantial competitive harm would occur if the information were released is required. If the explanation is sufficient, then to the extent permitted by the exemptions in section 92F-13, HRS, the affected section may be deemed confidential. Such information shall accompany the proposal, be clearly marked, and shall be readily separable from the proposal to facilitate eventual public inspection of the non-confidential sections of the proposal. The DHS will maintain the confidentiality of the information to the extent allowed by law. **Note that price is not considered confidential and will not be withheld.** Blanket labeling of the entire document as "proprietary;" however, will result in none of the document being considered proprietary.

21.800 Acceptance of Proposals

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

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

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

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

21.900 Submission of Proposals

Each qualified offeror shall submit only one (1) proposal. More than one (1) proposal shall not be accepted from any offeror. The Proposal Application Identification (Form SPO-H-200) shall be completed and submitted with the proposal (Appendix A).

Six (6) bound copies and one (1) unbound copy of the technical proposal and two (2) bound copies and one (1) unbound copy of the business proposal shall be received by the Issuing Officer no later than 4:30 p.m. (H.S.T.) on August 11, 2006, or postmarked by the USPS no later than August 11, 2006. All mail-ins postmarked by USPS after August 11, 2006, will be rejected. Hand deliveries will not be accepted after 4:30 p.m.,

H.S.T., August 11, 2006. Deliveries by private mail services such as FEDEX shall be considered hand deliveries and will not be accepted if received after 4:30 p.m., H.S.T., August 11, 2006. Proposals shall be mailed or delivered to:

Dona Jean Watanabe
Department of Human Services
Med-QUEST Division/Finance Office
1001 Kamokila Boulevard, Suite 317
Kapolei, Hawaii 96707

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

Hawaii DHS/RFP-MQD-2007-002
QUEST Managed Care to Cover Medicaid and Other Eligible
Individuals Who Are Not Aged, Blind or Disabled
Technical Proposal
(Name of Offeror)

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

Hawaii DHS/RFP-MQD-2007-002
QUEST Managed Care to Cover Medicaid and Other Eligible
Individuals Who Are Not Aged, Blind or Disabled
Business Proposal
(Name of Offeror)

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

22.100 Disqualification of Offerors

An offeror shall be disqualified and the proposal automatically rejected for any one or more of the following reasons:

- Proof of collusion among offerors, in which case all bids involved in the collusive action shall be rejected and any participant to such collusion shall be barred from future bidding until reinstated as a qualified offeror;
- An offeror's lack of responsibility and cooperation as shown by past work or services;
- An offeror's being in arrears on existing contracts with the State or having defaulted on previous contracts;
- An offeror's lack of sufficient experience to perform the work contemplated and/or lack of proper provider network;

- An offeror's lack of a proper license to cover the type of work contemplated if required to perform the required services;
- An offeror shows any noncompliance with applicable laws;
- An offeror's delivery of proposal after the proposal due date;
- An offeror's failure to pay, or satisfactorily settle, all bills overdue for labor and material on former contracts with the State at the time of issuance of this RFP;
- An offeror's lack of financial stability and viability;
- An offeror's failure to complete the Elimination of Barriers to Contracting Between FQHCs/RHS and Health Plans form provided in Appendix Y (if applicable); or
- An offeror's consistently substandard performance related to meeting the MQD requirements from previous contracts.

22.200 Irregular Proposals

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

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

22.300 Rejection of Proposals

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

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

1. Rejection for failure to cooperate or deal in good faith (Section 3-141-201, HAR);

2. Rejection for inadequate accounting system (Section 3-141-202, HAR);
3. Late Proposals (3-143-603, HAR);
4. Inadequate response to RFPs (Section 3-143-609, HAR);
5. Proposal not responsive (Section 3-143-610 (1), HAR); or
6. Offeror not responsible (Section 3-143-610(2), HAR).

22.400 Cancellation of RFP

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

22.500 Opening of Proposals

Upon receipt of proposal by a state purchasing agency at a designated location, proposals, modifications to proposals, and withdrawals of proposals shall be date-stamped and, when possible, time-stamped. All documents so received shall be held in a secure place by the state-purchasing agency and not examined for evaluation purposes until the Proposed Due Date.

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

22.600 Additional Materials and Documentation

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

22.700 Award Notice

A notice of intended contract award, if any, shall be sent to the selected offeror on or about September 5, 2006.

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

The State of Hawaii is not liable for any costs incurred prior to the official starting date of the contract.

22.800 Disputes on Award of Contract

Offerors may file a Notice of Protest against the awarding of the contract. An original and two (2) copies of the Notice to Protest shall be mailed by United States Postal Service (USPS) or hand delivered to the procurement officer who is conducting the procurement (as indicated below) A Notice of Protest regarding an award shall be served within five (5) business days of the postmark of the notice of findings and decision sent to the protester. Delivery services other than USPS shall be considered hand deliveries and considered submitted on the date of the actual receipt by the DHS. The Notice of Protest form, SPO-H-801, is available on the SPO website www2.hawaii.gov/spoh. Only the following may be protested:

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

Head of State Purchasing Agency	Chief Procurement Officer for DHS
Name: Lillian B. Koller, Esq.	Name: Lillian B. Koller, Esq.
Title: Director	Title: Chief Procurement Officer
Mailing Address: P.O. Box 339 Honolulu, Hawaii 96809-0339	Mailing Address: P.O Box 700190 Kapolei, Hawaii 96709-0190
Business Address: 1390 Miller St. Honolulu, Hawaii 96813	Business Address: 1001 Kamokila Boulevard, Suite 317 Kapolei, Hawaii 96707

SECTION 30 BACKGROUND AND DEPARTMENT OF HUMAN SERVICES RESPONSIBILITIES

30.100 Background and Scope of Service

30.110 Scope of Service

The State of Hawaii seeks to improve the health care and to enhance and expand coverage for persons eligible for Medicaid, State Children's Health Insurance Program (SCHIP), and for the uninsured and underinsured by the most cost effective and efficient means through the QUEST, QUEST-Net and QUEST-ACE managed care programs, with an emphasis on prevention and quality health care.

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

30.120 Background

The goals of the QUEST, QUEST-Net, and QUEST-ACE programs are to:

- Improve the health care status of the member population;
- Establish a "provider home" for members through the use of assigned primary care providers (PCPs);
- Establish contractual accountability among the state health plans and health care providers;
- Continue the predictable and slower rate of expenditure growth associated with managed care; and

- Expand and strengthen a sense of member responsibility that leads to more appropriate utilization of the health care system.

30.200 Definitions/Acronyms

Abuse - Incidents or practices of providers that are inconsistent with accepted sound medical practices.

Adverse Action (may also be referred to as an action) - Any one of the following:

- the denial or restriction of a requested service, including the type or level of service;
- the reduction, suspension, or termination of a previously authorized service; the denial, in whole or part, of payment for a service;
- the failure to provide services in a timely manner, as defined in the contract; unreasonable delays in services, or appeals not acted upon within prescribed timeframes;
- for a rural area member or for islands with only one health plan or limited providers, the denial of a member's request to obtain services outside the network:
 - from any other provider (in terms of training, experience, and specialization) not available within the network;
 - from a provider not part of a network that is the main source of a service to the member, provided that the provider is given the same opportunity to become a participating provider as other similar providers;
 - because the only health plan or provider does not provide the service because of moral or religious objections;

- because the member's provider determines that the member needs related services that would subject the member to unnecessary risk if received separately and not all related services are available within the network; and
- the State determines that other circumstances warrant out-of-network treatment.

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

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

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

Annual Plan Change Period - An annual time period established by the DHS during which existing members may transfer between health care plans.

Appeal - A request for review of an action.

Applicant - An individual who submits a signed medical assistance application form as designated by the DHS on behalf of himself or herself and/or other family dependents or an individual has an application submitted on his/her behalf by a responsible party.

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

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

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

Beneficiary - Any person determined eligible by the DHS to receive medical services under the DHS Medicaid programs.

Benefit Year - The state fiscal year from July 1 to June 30. In the event the contract is not in effect for the full fiscal year, any benefit limits will be pro-rated. That is, if the contract is effective for six (6) months of the fiscal year, the benefit limit shall be one-half the limit per benefit year.

Benefits - Those health services to which the member is entitled under the QUEST, QUEST-Net, or QUEST-ACE programs and which the health plan arranges to provide to its members.

Child and Adolescent Mental Health Division (CAMHD) - Child and Adolescent Mental Health Division of the Hawaii Department of Health.

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

Capitation Payment - A payment the DHS makes to a health plan on behalf of each member enrolled for the provision of medical services under the Medicaid State Plan. The payment is made regardless of whether the particular member receives services during the period covered by the payment.

Care Coordinator/Case Manager - An individual who coordinates, monitors and ensures that appropriate and timely care is provided to the member. A case manager may be the recipient's PCP, or specific person selected by the member or assigned by the health plan.

Catastrophic Care - Those cases in which costs for eligible medical and behavioral health services incurred by a health plan, for a member, exceed a specified dollar threshold which is determined by contractual agreement between the DHS and the health plan in a benefit year defined as July 1 through June 30.

Children - All eligibles under age twenty-one (21) years of age.

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

Claim - A bill for services, a line item of services, or all services for one member within a bill.

Clean Claim - A claim that can be processed without obtaining additional information from the provider of the service or its designated representative. It includes a claim with errors originating in a State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

The Centers for Medicare and Medicaid Services (CMS) – The Centers for Medicare and Medicaid Services of the federal Department of Health and Human Services.

Cold-Call Marketing – Any unsolicited personal contact by the health plan with a potential member or member for the purpose of marketing.

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

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

Contract - Written agreement between the DHS and the contractor, which will include the State's Agreement (form AG3-Comp (4/99)), general conditions, any special conditions and/or appendices, this RFP, including all attachments and addenda, and the health plan's proposal.

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

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

Co-Payment - A specific dollar amount or percentage of the charge identified which is paid by a recipient at the time of service to a health care plan, physician, hospital or other provider of care for covered services provided to the recipient.

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

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

Deficit Reduction Act of 2005 (DRA) – Federal legislation that sets forth, among other things, requirements for improved enforcement of citizenship and nationality documentation.

Dental Emergency - An oral condition requiring immediate dental services to control bleeding or pain, eliminate acute infection, treat injuries to teeth or supportive structures, or provide palliative treatment without delay.

Dependent - An applicant's legal spouse or dependent child who meets all eligibility requirements.

Dependent Child - A child under nineteen (19) for whom an applicant or recipient is legally responsible.

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

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

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

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

Emergency Medical Condition – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part. An emergency medical condition shall not be defined on the basis of lists of diagnoses or symptoms.

Emergency Services – Any covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish services and that are needed to evaluate or stabilize an emergency medical condition.

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

Encounter Data - A compilation of encounters. Health plans are required to submit all encounter data to MQD once a month.

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

Enrollee (Potential) – A Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a MCO, who

must make a choice on which plan to enroll into within a specified time designated by the DHS. See also Member Potential.

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

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) – A Title XIX mandated program that covers screening and diagnostic services to determine physical and mental conditions in members less than twenty-one (21) years of age, and health care treatment and other measures to correct or ameliorate any conditions identified during the screening process.

External Quality Review Organization (EQRO) – An organization that meets the competence and independence requirements pursuant to 42CFR 438.354 and performs external quality review.

External Review - A member who has exhausted the health plan's and the State grievance procedure, may file for an external review with the State of Hawaii Insurance Commissioner.

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

Federally Qualified Health Center (FQHC) – An entity that provides outpatient health programs pursuant to Section 1905 (1) (2) (B) of the Social Security Act.

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

Fee-for-service (FFS) - A method of reimbursement based on payment for specific services rendered to a Medicaid recipient.

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

Fraud - The intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or to some other person.

Grievance - An expression of dissatisfaction from a member, member's representative, provider on behalf of a member, or a provider that the health plan must address.

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

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

Hawaii Automated Welfare Information System (HAWI) -. The State of Hawaii certified system which maintains eligibility information for TANF, AFDC, Food Stamp and Medicaid recipients.

Hawaii Prepaid Medicaid Management Information System (HPMMIS) – Computerized system used for the processing, collecting, analysis and reporting of information needed to support Medicaid and SCHIP functions.

Health Care Professional – A physician, podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, speech-language pathologist, audiologist, registered or practical nurse, nurse practitioner, or any other licensed professional who meets the State requirements of a health care professional.

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

Health Maintenance Organization (HMO) – See Managed Care Organizations

Health Plan - Any health care organization, insurance company or health maintenance organization, which provides covered services on a risk basis to enrollees in exchange for capitated payments.

Health Plan Employer Data and Information Set (HEDIS) - A standardized reporting system for health plans to report on specified performance measures which was developed by the National Committee for Quality Assurance (NCQA).

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

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

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

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

Incentive Arrangement – Any payment mechanism under which a health plan may receive additional funds over and above the capitation rates it was paid for meeting targets specified in the contract. Or any payment mechanism under which a provider may receive additional funds from the health plan for meeting targets specified in the contract.

Incurred Costs - (1) Costs actually paid by a health plan to its providers for eligible services (for health plans with provider contracts) or (2) a percentage of standard charge to be negotiated with the DHS

(for plans which provide most services in-house or for capitated facilities), whichever is less. Incurred costs are based on the service date or admission date in the case of hospitalization. For example, all hospital costs for a patient admitted on June 25, 1996 and discharged on July 5, 1996 would be associated with the 1996 benefit year because the admission date occurred during that benefit year. All other costs apply to the benefit year in which the service was rendered.

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

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

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

Managed Care Organization - An entity that has, or is seeking to qualify for, a comprehensive risk contract under the final rule of the

BBA and that is: (1) a federally qualified HMO that meets the requirements under Section 1310(d) of the Public Health Service Act; (2) any public or private entity that meets the advance directives requirements and meets the following conditions: (a) makes the service it provides to its Medicaid members as accessible (in terms of timeliness, amount, duration, and scope) as those services that are available to other Medicaid recipients within the area served by the entity and (b) meets the solvency standards of Section 438.116.

Marketing – Any communication from a health plan to a member or potential enrollee who is not yet enrolled in the health plan, that can reasonably be interpreted as intended to influence the member or potential enrollee to enroll in the particular health plan, or either not to enroll in, or to disenroll from, another health plan.

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

Medicaid - A federal/state program authorized by Title XIX of the Social Security Act, as amended, which provides federal matching funds for a Medicaid program for recipients of federally aided public assistance and SSI benefits and other specified groups. Certain minimal populations and services must be included to receive FFP; however, states may choose to include certain additional populations and services at State expense and also receive FFP.

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

Medical Necessity – Health interventions that the health plans are required to cover within the specified categories that meet the following criteria:

- a. The intervention must be used for a medical condition.
- b. There is sufficient evidence to draw conclusions about the intervention's effects on health outcomes.
- c. The evidence demonstrates that the intervention can be expected to produce its intended effects on health outcomes.
- d. The intervention's beneficial effects on health outcomes outweigh its expected harmful effects.
- e. The health intervention is the most cost-effective method available to address the medical condition.

Medical Condition: is a disease, an illness or an injury. A biological or psychological condition that lies within the range of normal human variation is not considered a disease, illness or injury.

Health Outcomes: are outcomes of medical conditions that directly affect the length or quality of a person's life.

Sufficient Evidence: is considered to be sufficient to draw conclusions, if it is peer-reviewed, is well-controlled, directly or indirectly relates the intervention to health outcomes, and is reproducible both within and outside of research settings.

Health Intervention: is an activity undertaken for the primary purpose of preventing, improving or stabilizing a medical

condition. Activities that are primarily custodial, or part of normal existence, or undertaken primarily for the convenience of the patient, family, or practitioner, are not considered health interventions.

Cost-Effective: is cost-effective if there is no other available intervention that offers a clinically appropriate benefit at a lower cost.

Medical Office - Any outpatient treatment facility staffed by a physician or member of the health plan.

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

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

Medicare - A federal program authorized by Title XVIII of the Social Security Act, as amended, which provides health insurance for persons aged 65 and older and for other specified groups. Part A of Medicare covers hospitalization; Part B of the program covers outpatient services and is voluntary, Part D of the program covers prescription drugs.

Medicare Special Savings Program Recipients – Qualified Medicare Beneficiaries, SLMB's, QI's and QDWI.

Member – A Medicaid/QUEST program recipient who is currently enrolled in a QUEST health plan

Med-QUEST Division (MQD) – Has the responsibility for administering the Medicaid programs for the State Department of Human Services.

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

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

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

Participating - When referring to a health plan it means a health plan that has entered into a contract with the DHS to provide covered services to enrollees. When referring to a health care provider it means a provider who is employed by or who has entered into a contract with a health plan to provide covered services to enrollees.

When referring to a facility it means a facility which is owned and operated by, or which has entered into a contract with a health plan for the provision of covered services to members.

Physician - Any licensed doctor of medicine associated with or engaged by a health plan.

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

Potential Member - A Medicaid recipient who is subject to mandatory enrollment and must choose a health plan in which to enroll within a specified timeframe determined by DHS.

Premium Share - The scheduled dollar amount, based on income, that certain recipients are required to remit each month to the DHS to be eligible to receive covered services.

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

Primary Care - All health care services and laboratory services customarily furnished by or through a general practitioner, family practitioner, internal medicine physician, obstetrician/gynecologist, or pediatrician, to the extent the furnishing of those services is legally authorized in the State.

Primary Care Provider (PCP) - A provider who is licensed in Hawaii and is 1) a physician, either an M.D. (Doctor of Medicine) or a D.O. (Doctor of Osteopathy), and must generally be a family practitioner, general practitioner, general internist, pediatrician or obstetrician/gynecologist (for women, especially pregnant women); or 2) an advanced practice registered nurse who must generally be a family nurse practitioner, pediatric nurse practitioner, nurse midwife; or 3) a licensed physician assistant. PCPs have the responsibility for supervising, coordinating and providing initial and primary care to the member and for initiating referrals and maintaining the continuity of member care.

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

Proposal - The offeror's response to this RFP submitted in the prescribed manner to perform the covered health plan services.

Protected Health Information (PHI) - has the same meaning given under the HIPAA Privacy Rule, 45 CFR 160.103.

Programs - As used in this RFP, refers to QUEST, QUEST-Net and QUEST-ACE, unless otherwise expressly stated.

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

Recipient - An individual, who meets all eligibility requirements and has been determined eligible for Medicaid/QUEST program. Also see member.

Resident of Hawaii - A person who resides in the State or establishes his or her intent to reside in Hawaii as described in Section 17-1714-22, HAR.

Request For Proposal (RFP) – This Request for Proposal number RFP-MQD-2007-002, issued on June 14, 2006.

Rural Health Center (RHC) - An entity that provides outpatient services in a rural area designated as a shortage area and certified in accordance with Subpart S of 42 CFR 405.

Risk Contract – A contract under which the health plan assumes risk for the cost of the services covered under the contract and incurs a loss if the cost of furnishing the services exceeds the payments under the contract, or has a profit if the cost of providing services is less than the payments under the contract.

Risk Corridor – A risk sharing mechanism in which the State and the health plan share in both the profits and losses under the contract outside of predetermined threshold amount so that after an initial corridor in which the health plan is responsible for all losses or retains all profits, the State contributes a portion toward any additional losses and receives a portion of any additional profits.

Risk Factor Adjustments – Adjustments applied to the capitation rates agreed to by the State and the health plan. These adjustments are determined by the State and reflect the age, gender and aid category of each enrolled member and are uniform across all health plans.

Risk Share – Those risks associated with the costs of health care which are shared between the health plan and the DHS. Expenses related to health plan administration are not part of the risk share program (see Appendix T).

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

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

State - The State of Hawaii.

State Children’s Health Insurance Program (SCHIP) – A joint federal-state health care program for targeted, low-income children, established pursuant to Title XXI of the Social Security Act.

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

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

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

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

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

30.300 Program Descriptions

The following programs are included in this RFP. The term “the programs” as used throughout this RFP will be used to include all programs listed below, unless otherwise expressly stated.

30.310 QUEST

QUEST provides for a comprehensive package of medical, dental, and behavioral health benefits to children and adults. (See Sections 30.700 and 40.300).

Children age eighteen (18) and under: Children from families with incomes not exceeding 300% of the federal poverty level (FPL) are eligible for and mandatorily enrolled in QUEST. Children in families with income above the age-specific FPLs (i.e., 100%, 133%, or 185%) must not have other health insurance. Children in families with income above 250% of the FPL and not exceeding 300% will pay a graduated premium, with total premiums for all children in the family not to exceed 5% of family income.

Children age eighteen (18) and under placed in foster care by the State are eligible and mandatorily enrolled in QUEST. QUEST eligible foster children placed out-of-state by the DHS are provided for under the Medicaid fee-for-service program.

Adults: The adults who are eligible for and mandatorily enrolled in QUEST include:

- Pregnant women with a family income not exceeding 185% of the FPL;
- Adults who are Temporary Assistance for Needy Families (TANF) cash recipients but are otherwise not eligible for Medicaid;

- Low-income adults covered under Section 1931 of the Social Security Act;
- Individuals qualifying for transitional medical assistance under Section 1925 of the Social Security Act;
- Participants in the State General Assistance Program; and
- Adults with income not exceeding 100% of the FPL who meet the Medicaid asset level and who are not described in any other category.

This last group is subject to an enrollment cap. For the last several years, the cap has been approximately 125,000 individuals.

Otherwise eligible persons from a Compact of Free Association country (Marshall Islands, Federated States of Micronesia, and Palau) who reside in Hawaii are enrolled in a QUEST health plan if they meet one of the criteria described above. All other QUEST health plan members must meet the citizenship requirements set forth in Chapter 17-1714, Subchapter 4, HAR.

30.320 QUEST-Net

QUEST-Net provides coverage for medical, dental, behavioral health and prescription drug services. (See Section 40.315).

The following are eligible for and are mandatorily enrolled in QUEST-Net:

- Uninsured adults with incomes not exceeding 300% of the FPL who were previously enrolled in QUEST or Medicaid

fee-for-service but who become ineligible because their income or assets exceed QUEST or Medicaid fee-for-service program's limits; and

- QUEST or Medicaid fee-for-service recipients who voluntarily enroll in QUEST-Net.

Adults enrolled in QUEST-Net with incomes exceeding 100% will pay a premium. The State may set a cap on enrollment into QUEST-Net.

Otherwise eligible persons from a Compact of Free Association country (Marshall Islands, Federated States of Micronesia, and Palau) who reside in Hawaii are enrolled in QUEST-Net health plan if the individual meets one of the criteria described above. All other QUEST-Net health plan members must meet the citizenship requirements set forth in Sections 17-1714-28 HAR.

30.330 QUEST- ACE

Uninsured adults with incomes not exceeding 100% of FPL who would be eligible for QUEST but are unable to enroll due to the enrollment cap, and are unable to enroll in QUEST-Net because they were not already QUEST or Medicaid fee-for-service recipients, are eligible for QUEST-ACE benefits as described in Section 40.315 and shall be mandatorily enrolled. These adults will not pay a premium.

Otherwise eligible persons from a Compact of Free Association country (Marshall Islands, Federated States of Micronesia, and Palau) who reside in Hawaii are enrolled in a QUEST-ACE health

plan if the individual meets one of the criteria described above. All other QUEST-ACE health plan members must meet the citizenship requirements set forth in Sections 17-1714-28, HAR.

30.340 Excluded Populations

The following individuals are excluded from participation in managed care under this contract:

- Individuals in the State's Breast and Cervical Cancer Program;
- Individuals who are age sixty-five (65) or older;
- Individuals who are Medicare Special Savings Program Recipients;
- Individuals who reside in a nursing facility (ICF and SNF level of care) after being determined to be at the nursing facility level of care by the DHS or its contractor;
- Individuals who are waitlisted in hospitals for nursing facility placement (after the first 60 days of waitlisting);
- Individuals in the PACE or Pre-PACE programs;
- Individuals who reside in intermediate care facilities for the mentally retarded (ICF-MR);
- Individuals who qualify for medical assistance under the State's Medicaid program as aged, blind, or disabled; and
- Native Americans in Federally Recognized Tribes.

Individuals applying to enter the QUEST program from an inpatient facility located in the continental U.S. or U.S. Territories shall not be enrolled in a health plan until they return

to the State of Hawaii and determined eligible for medical assistance through the Department's programs.

30.400 The Department of Human Services (DHS) Responsibilities

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

- Establish and define the medical and behavioral health benefits to be provided by the health plan;
- Develop the rules, policies, regulations and procedures governing the programs;
- Negotiate and contract with medical and behavioral health plans;
- Determine initial and continued eligibility of recipients;
- Enroll and disenroll members;
- Review and monitor the adequacy of the health plan's provider networks;
- Monitor the quality assessment and performance improvement programs of the health plan and providers;
- Review and analyze utilization of services and reports provided by the health plan;
- Oversee the State Administrative Hearing processes;
- Bill and collect member premiums;
- Monitor the financial status of the programs;
- Analyze the programs to ensure they are meeting the stated objectives;

- Manage the Hawaii Prepaid Medicaid Management Information System (HPMMIS) and the Premium Share Billing System;
- Provide member information to the health plan;
- Conduct a statewide public awareness campaign to help assist individuals in selecting a health plan during the positive enrollment period;
- Review and approve the health plan's marketing materials;
- Establish health plan incentives when deemed appropriate;
- Impose civil or administrative monetary penalties and/or financial sanctions for violations or health plan non-compliance with contract provisions;
- Report criminal conviction information disclosed by providers and report provider application denials pursuant to 42 CFR Part 455.106(b);
- Verify out-of-state provider licenses during provider enrollment and review and monitor provider licenses on an on-going basis;
- Refer member and provider fraud cases to appropriate law enforcement agencies; and
- Coordinate with and monitor fraud and abuse activities of the health plan.

The DHS will comply with, and will monitor the health plan's compliance with, all applicable state and federal laws and regulations.

30.410 Eligibility Determinations

The DHS is the sole authority and is solely responsible for determining eligibility for the programs. Provided the applicant meets all eligibility requirements, the individual will become eligible for Medicaid on:

- The date of the application; or
- If specified by the applicant, any date on which appropriate emergency room or hospital expenses were incurred and which is within the immediate five (5) days prior to the date of application; or
- If the applicant cannot meet eligibility requirements at the time of the application, the applicant will become eligible on the first day of the subsequent month in which all eligibility requirements are met.

30.500 Enrollment Responsibilities

After an individual is determined eligible for the programs, the DHS or its agent will initiate the enrollment process. Within ten (10) calendar days of the individual being determined eligible, the DHS or its agent will provide information and assistance to individuals in selecting a health plan. This information and assistance includes information about the basics of managed care; the populations mandatorily enrolled, those excluded from enrolling, and those that may voluntarily enroll; the health plans available on the island on which the individual lives; and their provider networks.

Enrollment into the health plan will be effective on the day after the Med-QUEST Enrollment Call Center processes the health plan selection, with the following exceptions:

- Positive enrollment for existing members shall be as described in Section 30.510;
- Newborn enrollment shall be as described in Section 30.520; and
- Enrollment of foster care children shall be as described in Section 30.530.

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

The DHS and the health plan shall participate in a daily transfer of enrollment/disenrollment and Third Party Liability (TPL) data through the enrollment and TPL rosters via the MQD FTP file server. The enrollment information will include the case name, case number, member's name, mailing address, date of enrollment, TPL coverage, date & birth, sex, and other data that the DHS deems pertinent and appropriate (Refer to the Health Plan Manual in the Bidder's Library).

Except as provided for in Section 30.510, 30.520 and 30.540, the DHS or its agent will assign any individual who does not select a health plan within ten (10) calendar days according to the auto-assignment algorithm described in Appendix H. If no

members of a household have selected a health plan, the entire household shall be auto-assigned to the same plan.

30.510 Positive Enrollment Period for Existing Members

From November 2, 2006 through December 31, 2006, all individuals who are existing members of health plans will be required to select a health plan. This sixty (60) day period is hereby referred to as the positive enrollment period for existing members. All enrollments which occur during this period will be effective on February 1, 2007.

In the event an individual who is an existing member of a program health plan does not select a health plan during this period, the DHS will assign the individual to a health plan according to the auto-assignment algorithm described in Appendix H. If no members of a household have selected a health plan, the entire household shall be auto-assigned to the same plan.

To assure a smooth transition into a new health plan during the positive enrollment period for existing members, all prior authorizations approved by a member's "old" health plan, shall be honored by the "new" health plan, for at least forty-five (45) calendar days, or until the member's medical needs have been assessed by the PCP assigned to the member in the new health plan.

30.520 Newborn Enrollment

Throughout the term of the contract, newborns will be enrolled into the health plan of the mother retroactive to the date of birth. The newborn auto-assignment will be effective for at least the first thirty (30) calendar days following the birth. The DHS will notify the mother that she may select a different health plan for her newborn at the end of the thirty (30) day period.

If the newborn's mother is not enrolled in a QUEST plan or is receiving services under the Medicaid fee-for-service program at the time of birth, the newborn will be covered under the Medicaid fee-for-service program until a health plan is selected. The DHS reserves the right to disenroll the newborn if the newborn is later determined to be ineligible for QUEST and will do so at the end of the current month. The DHS will notify the health plan of the disenrollment by electronic media. The DHS will make capitation payments to the health plan for the months in which the newborn was enrolled in the health plan.

30.530 Children in Foster Care

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

30.540 Special Considerations Regarding Enrollment into QUEST-Net

The DHS will enroll members moving from QUEST to QUEST-Net into the same health plan in which they were enrolled for QUEST. The DHS will not provide a choice to the member until the next annual plan change period unless there is cause, as defined in Section 30.600. Nothing in this section negates the members' rights.

30.550 90-Day Grace Period

The DHS will allow existing members to change health plans without cause for the first ninety (90) days (February 1, 2007 – May 2, 2007) from the effective date of positive enrollment in that health plan regardless of whether enrollment is a result of selection or auto-assignment. The DHS will educate PCPs about how to assist members in changing health plans during the 90-day grace period.

The DHS will allow newly determined eligible individuals to change health plans without cause for the first ninety (90) days of enrollment in their health plan, regardless of whether enrollment is a result of selection or auto-assignment.

The DHS will process the plan change request and enrollment in the new health plan will be the first day of the following month in which the plan change was requested. After the initial ninety (90) day grace period for both existing and newly determined eligible individuals, members will only be allowed to change plans during the Annual Plan Change Period, as described in

Section 30.560, or as outlined in Section 30.600 (the ability to change health plans when the member's PCP is not in the network of the health plan in which the member is enrolled is an acceptable reason for a member to change health plans).

The DHS will enroll members in the same health plan and not allow the ninety (90) day grace period after the initial enrollment in the following situations:

- A member is changing eligibility categories within or between the programs; or
- A member has lost eligibility for a period of less than sixty (60) days, unless the period of ineligibility spans the annual plan change period in which case the member will have the ability to choose a new health plan or be re-enrolled in the previous health plan (even if the DHS has capped the health plan during their period of lapsed eligibility).

30.560 Annual Plan Change Period

The DHS will hold a health plan change period at least annually to allow members the opportunity to change health plans without cause.

The first annual plan change period will be in September, 2007. Thereafter, unless circumstances prevent the DHS from administering the annual plan change, it will occur during May of each year with coverage being effective starting on July 1 of that year. The DHS may establish additional plan change periods as

deemed necessary on a limited basis (e.g., termination of a health plan during the contract period).

At least sixty (60) calendar days prior to the end of the plan year, the DHS will mail, to all households with individuals who are eligible to participate in the annual plan change period, an information packet which describes the plan change period. The DHS shall include in the information packet, an informational brochure that includes information about the health plans. The DHS shall prorate the total cost of printing the informational brochure among the health plans.

If during any annual plan change period during this contract period, no health plan selection is made and the member is enrolled in a returning plan (the health plan has a current and new contract with the DHS), the person will remain in the current health plan. This policy also applies to a person enrolled in a returning plan that is capped (see Section 30.570).

If during any annual plan change period during this contract period, no health plan selection is made and the member is enrolled in a non-returning health plan (the health plan has a current, but not a new contract with the DHS), the DHS will auto-assign the member to a health plan using the DHS established auto-assignment algorithm (see Appendix H).

30.570 Member Enrollment Caps

The DHS will implement enrollment caps as follows:

Islands with 3 or more plans	50% of island enrollment
Islands with 2 or fewer plans	no cap

Prior to all annual plan changes periods, the DHS will review the enrollments of the health plans. The DHS will implement an enrollment cap on any health plan that has an enrollment equal to or exceeding the enrollment cap for the island. The enrollment cap will be implemented immediately and will remain in effect for the fiscal year.

If a plan is capped, it will not be available during the annual plan change period nor to new enrollees. There are three exceptions to this policy:

1. Newborns born to mothers enrolled in the capped plan will be enrolled with the mother; or
2. Newly determined eligibles who have PCPs who are exclusive to the capped plan will be allowed to enroll in the capped plan. The capped plan will provide the DHS with a listing of exclusive PCP providers, which will be verified with the other health plans; or
3. Members who have lost eligibility for a period of less than sixty (60) days may return to the capped plan.

As part of the review of enrollment conducted prior to all annual plan change periods, the DHS may lift a cap provided the enrollment is at least 5% below the enrollment cap for that island. If the DHS lifts the cap the health plan will be listed as an option for the island during the annual plan change period.

At the start of the next fiscal year (July 1), the health plan will also become available to new members.

The DHS will review each health plan's enrollment by island generally in September of each year but after completion of the annual plan change period and enrollment has been completed to determine if caps should be implemented. If one health plan has obtained an enrollment exceeding the enrollment cap for the island, the DHS will cap the health plan's enrollment. The enrollment cap will be applied immediately and will be reviewed once again in February in anticipation of the annual plan change period.

The DHS reserves the right to lift an enrollment cap at any time, including but not limited to February and September.

30.580 Hospitalizations During Enrollment Changes

When a hospitalized member changes health plans (such as during the annual plan change period) or is disenrolled from the plan and transferred to the Medicaid fee-for-service program, the plan in which the member was enrolled on the date of admission remains financially responsible for inpatient services, transportation, meals and lodging for an attendant, if applicable, through discharge as long as the member remains in the same acute care facility regardless of a lowering of the level of care.

The DHS will provide covered health services to program eligibles admitted to an acute care hospital while covered by the Medicaid fee-for-service program and shall continue coverage

under Medicaid fee-for-service through discharge regardless of a lowering of the level of care for inpatient services. This includes payment for travel, meals and lodging for an attendant if necessary. The health plan into which the hospitalized member has been enrolled shall be financially responsible for the member's care upon discharge from the acute care hospital.

If an individual is admitted to the acute care hospital on the date of enrollment in a health plan, the health plan shall be financially responsible for the entire hospital stay.

30.590 Member Education Regarding Status Changes

The DHS will educate members concerning the necessity of providing, to the health plan and the DHS, any information impacting their member status. The following events could impact the member's status and may effect 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 residence and/or mailing address;

- Institutionalization (e.g., state mental health hospital or prison);
- TPL coverage which includes accident related medical condition;
- Inability of the member to meet citizen documentation requirements as required in the Deficit Reduction Act (DRA) Section 6037;
- Telephone number; or
- Other household changes.

30.600 Disenrollment Responsibilities

The DHS shall be the sole authority allowed to disenroll a member from a health plan and from the programs. The DHS will process all disenrollment requests submitted in writing by the member or his or her representative.

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

- Member no longer qualifies based on the medical assistance eligibility criteria or voluntarily leaves the programs;
- Member chooses another plan during the annual plan change period;
- Member does not pay the required premium (for members with premium share requirements);
- Member's PCP is not in the health plan's provider network and is in the provider network of a different health plan;
- Death of a member;
- Incarceration of the member;
- Member enters the State Hospital;
- Determination by the DHS or their contractor that the member meets the nursing facility level of care;
- Member is waitlisted at an acute hospital for a long-term care bed (after 60 days);
- Member is transferred to an ICF-MR facility;
- Member is determined disabled or blind by the DHS;
- Member is age 65 or older;

- Member becomes a PACE or Pre-Pace participant;
- Member is in foster care and has been moved out-of-state by the DHS;
- Member becomes a Medicare Special Savings Program recipient beneficiary;
- Member enters a home and community based waiver program and qualifies for the Medicaid fee-for-service program;
- Member provides false information with the intent of enrolling in the programs under false pretenses; or
- Member requests disenrollment for cause, at any time, due to:
 - An administrative appeal decision;
 - Provisions in administrative rules or statutes;
 - A legal decision;
 - Relocation of the member to a service area where the health plan does not provide service;
 - An administrative decision for foster children which is the result of an agreement between the DHS, the child welfare service worker and the health plan involved;
 - The health plan's refusal, because of moral or religious objections, to cover the service the member seeks as allowed for in Section 40.280;
 - The member's need for related services (for example a cesarean section and a tubal ligation) to be performed at the same time and not all related services are available within the network and the member's PCP or another provider determines that

receiving the services separately would subject the member to unnecessary risk;

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

The DHS will not re-enroll a member who is responsible for payment of premium until all delinquent premiums in arrears have been paid in full.

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

30.610 Special Considerations Regarding Disenrollment from QUEST-Net

The DHS will allow an individual who has voluntarily chosen to participate in QUEST-Net but is eligible for Medicaid fee-for-service to disenroll from a health plan and return to Medicaid fee-for-service at any time.

30.620 Waitlisted for a Long-Term Care Bed or Placement in a Long-Term Care Facility (LTC)

The DHS, an acute care facility, provider, or the health plan may identify individuals believed to be eligible for long-term care. However, the DHS or its agent is solely responsible for determining whether the person meets the requirements for long-term care services using guidelines currently in place (See Appendix I).

If the health plan believes the member is eligible for a long-term care facility, the health plan or facility must also obtain a determination of disability from the DHS through the Aid to Disabled Review Committee (ADRC) process described in Sections 30.780 and 50.230 before the recipient can be disenrolled from the health plan into the Medicaid fee-for-service program. An approved Form 1147 alone will not be sufficient to have a member disenrolled from a health plan.

Once the DHS or its agent determines the member disabled and an approved Form 1147 is submitted to the DHS or its agent, the eligibility worker will be notified to disenroll the member and to transfer the person to the Medicaid fee-for-service program. Disenrollment will become effective no later than the first day of the second month from the month in which the disability determination was approved. The health plan shall be responsible for coordinating and paying for the member's care until the member is disenrolled from the health plan or if hospitalized at a nursing facility level of care up to sixty (60) days on the waitlist, whichever is earlier. As long as the health

plan is responsible for the member's care, the health plan shall make all medical necessity decisions on the placement of the member. The health plan may decide to place the person in a waitlist bed, nursing facility bed or maintain the person at home with home care and appropriate supports.

The State will assume financial responsibility for the member when the person is disenrolled from the health plan and transferred to the Medicaid fee-for-service program or on the 61st day if the person is in an acute waitlisted nursing facility bed and disenrollment has not been accomplished. The health plan shall notify the facility and the DHS on the 61st day that the State will assume financial responsibility for acute waitlisted nursing facility services. The disenrollment will be retroactively applied to become effective on the 61st day of waitlisted services. If a member is not approved for nursing facility level of care, the person will remain in the health plan. If the health plan transfers the member to a long-term care facility or places the member on a waitlist and the DHS's agent does not agree with the placement, that member will remain in the health plan and the health plan remains financially responsible for all services.

30.700 Covered Benefits and Services Provided by the DHS or other Designated Entity

30.710 State of Hawaii Organ and Transplant (SHOTT) Program

The DHS will provide transplants which are not experimental or investigational and not covered by the health plan through the SHOTT Program. The SHOTT Program covers adults and children

for liver, heart, heart-lung, lung and allogenic and autologous bone marrow transplants. In addition, children will be covered for transplants of the small bowel with or without liver. Children and adults must meet specific medical criteria as determined by the State and the SHOTT Program contractor. The health plan shall submit a Form 1144 to request an evaluation by the SHOTT Program and also a Form 1180 to determine if the member meets disability criteria. The State and the SHOTT Program contractor will determine eligibility of individuals for transplants except those transplants provided by the health plan. If the DHS and the SHOTT Program contractor determine the individual meets the transplant criteria, the individual will be disenrolled from the health plan and transferred to the SHOTT program.

30.720 PACE and Pre-PACE Programs

Medicaid recipients or health plan members who are determined eligible for or elect to participate in the PACE or Pre-PACE Program shall not be enrolled in, or will be disenrolled from, the programs. These individuals will receive all covered services under the Medicaid fee-for-service program.

30.730 Dental Services

The DHS will provide dental services to health plan members under age twenty-one (21).

The DHS will provide a limited dental services package, in addition to the emergency dental services, for adult members.

The health plan shall be responsible for providing referrals, follow-ups, coordination and provision of appropriate medical services related to medically necessary dental needs as identified in Section 40.320.

30.740 School Health Services

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

30.750 Department of Health (DOH) Programs

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

30.751 *Vaccines for Children (VFC) Program*

The VFC program replaces public and private vaccines for children participating in DHS's QUEST programs. The MQD will not reimburse the health plan for any privately acquired vaccines which can be obtained from the Hawaii VFC program. The cost of vaccines for children is not included in the capitation rate paid to the health plans. The fee for the administration of the vaccine is included in the capitation rate. Providers shall enroll and complete appropriate forms for VFC participation.

If the DOH health center receives authorization from the health plan to provide immunization, the health plan shall be financially responsible for the administration of the immunization.

30.752 *Zero-To-Three Program*

The DOH administers and manages the Zero-to-Three and Healthy Start program services and the cost of those services are not included in the health plan's capitation rate.

The Zero-to-Three program provides services for the developmentally delayed, biologically at risk and environmentally at risk children aged zero to three years old. The services are for screening and assessment and home visitation services. The health plan is responsible, during the EPSDT screening process, for identifying and referring children who may qualify for these services. The DOH programs will evaluate and determine eligibility for these programs. The health plan remains responsible for providing all other medically necessary services under the plan and EPSDT screens/services including evaluations to confirm the medical necessity of the service.

30.753 *Craniofacial Review Panel*

The Craniofacial Review Panel (Panel), coordinated by the DOH/Family Health Services Division/Children with Special Health Needs Branch, performs multidisciplinary evaluation, case management and treatment planning for children with serious craniofacial conditions. For health plan members, the Panel may conduct evaluations and provides treatment recommendations

for health plan members. When the Panel is convened, the health plan shall participate in the Panel meetings if one of their members is involved. The health plan shall provide transportation for the child and parent/guardian, if necessary, to attend the Panel meeting(s).

30.760 Behavioral Health Services for Adults with Serious Mental Illness (SMI)

Adult members, as determined by the DHS to be SMI shall be enrolled in the behavioral health managed care (BHMC) plan. Persons who are SMI are defined as persons who, as a result of a mental disorder, exhibit emotional, cognitive, or behavioral functioning which is so impaired as to interfere substantially with their capacity to remain in the community without supportive treatment or services of a long-term or indefinite duration. Additional criteria for designation of a member as a SMI can be found in Appendix J.

The BHMC plan shall provide to its adult members a full range of behavioral health services including inpatient, outpatient therapy and drug treatment, including Clozaril and tests to monitor the member's response to therapy, and intensive case management. Adult members who have been designated as SMI and who require alcohol and/or drug abuse treatment and/or rehabilitative services shall receive these services from the BHMC plan.

Adults with SMI who have been determined disabled by the DHS shall be disenrolled from the health plan into the Medicaid fee-for-service program for services.

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

The Child and Adolescent Mental Health Division (CAMHD) will provide acute inpatient psychiatric and outpatient behavioral health services to children and adolescents age three (3) through age twenty (20) who the DHS determines are in need of intensive mental health services and are determined eligible for the SEBD Program. For the purposes of the contract, children and adolescents determined eligible for SEBD are persons with special health care needs.

30.780 Aid to Disabled Review Committee (ADRC)

The ADRC determines the disability status of persons who are not in receipt of Retirement, Survivors and Disability Insurance (RSDI) and Social Security Insurance (SSI) disability benefits. If the health plan identifies a member that they believe would meet the disability criteria, they should refer the member to DHS-Medical Standards Branch for an evaluation by the ADRC utilizing the DHS Form 1180. Individuals that are determined to be disabled will be disenrolled from the health plan no later than the first day of the second month from the month in which the ADRC approved the individual. The health plan shall be responsible for providing the necessary medical services to the member until the disenrollment effective date.

30.800 Monitoring and Evaluation

The DHS has developed the Hawaii Medicaid Managed Care Quality Assessment and Performance Improvement Strategy, designed to establish standards for access to care, and quality of care/services as well as to identify and address opportunities for improvement as outlined in 42 CFR Part 438, Subpart D. (Appendix K)

As part of these monitoring responsibilities the DHS will:

- Assess the quality and appropriateness of care and services furnished to all members, with particular emphasis on care/services provided to members with special health care needs;
- Regularly monitor and evaluate the health plan's compliance with the standards established by the State in accordance with federal law and regulations; and
- Arrange for annual, external independent reviews of the quality outcomes and timeliness of, and access to, the services covered under each health plan contract
Reference Section 30.820.

30.810 Quality Assessment and Performance Improvement (QAPI) Program Monitoring

In accordance with 42 CFR 438.240(e), Program Review by the State, the DHS will review, at least annually, the impact and effectiveness of each health plan's QAPI Program. The scope of

the DHS review also includes monitoring of the systematic processes developed and implemented by the health plan to conduct its own internal evaluation of the impact and effectiveness of its QAPI program as well as to effect necessary improvements.

The DHS will evaluate the health plan's QAPI Program utilizing a variety of methods, including but not limited to:

- Document reviews;
- Reviewing and evaluating the QAPI Program reports regularly required by the DHS (e.g. member grievances and appeals reports, provider complaints, grievances and appeals reports, reports of suspected cases of fraud and abuse, the HEDIS report, performance improvement project (PIPs) reports, QAPI Program Description/Workplan, the QAPI Program Annual Evaluation Report, etc.);
- Reviewing, evaluating or validating implementation of specific policies and procedures or special reports relating to areas such as:
 - Enrollee rights and protections;
 - Care/services provided to enrollees with special health care needs;
 - Utilization management (e.g. under and over utilization of services);
 - Access to care standards, including the:
 - Availability of services;
 - Adequate capacity and services;

- Continuity and coordination of care;
- Coverage and authorization of services;
- Structure and Operation Standards, including:
 - Provider selection;
 - Enrollee information;
 - Confidentiality;
 - Enrollment and disenrollment;
 - Grievance systems;
 - Subcontractual relationships and delegation;
- Measurement and Improvement Standards;
- Practice guidelines;
- QAPI Program;
- Health information systems;
- Conducting on-site reviews to interview health plan staff for clarification, review records, or validate implementation of processes/procedures; and
- Reviewing medical records.

The DHS may elect to monitor the activities of the health plan using its own personnel or may contract with qualified personnel to perform functions specified by the DHS. Upon completion of its review, the DHS or its designee shall submit a report of its findings to the health plan.

30.820 External Quality Review/Monitoring

The DHS through its agent will perform, on an annual basis, an external, independent review of the quality outcomes, timeliness of, and access to, services provided by the health plans. The DHS will contract with an External Quality Review Organization

(EQRO) to monitor the health plan's compliance with all applicable provisions of 42 CFR Part 438, Subpart D.

Specifically, the EQRO will provide the following mandatory activities:

- Validation of Performance Improvement Projects (PIP), required by the DHS to comply with requirements in 42 CFR Part 438.240(b)(1);
- Validation of health plan performance measures (HEDIS measures) required by the State; and
- A review to determine the health plan's compliance with standards established by the State to comply with 42 CFR 438.204 which requires a State Quality Strategy relating to access to care, structure and operations and quality assessment and improvement.

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

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

The EQRO will also perform the following optional external quality review (EQR) activities:

- Administration and reporting the results of the CAHPS® 3.OH Consumer Survey. The survey will be conducted annually, administered to an NCQA-certified sample of members enrolled in each health plan and analyzed using NCQA guidelines. The EQRO will provide an overall report of survey results to the DHS, and the DHS and the health plan will receive a copy of their health plan-specific raw data by island;
- Administration and reporting of the results of the Provider Satisfaction Survey. This survey will be conducted every other year within the broad parameters of CMS' protocols for conducting Medicaid EQR surveys (the DHS, CMS 2002, Final Protocol, Version 1.0 -- *Administering of Validating Surveys: Two Protocols for Use in Conducting Medicaid External Quality Review Activities.*) The EQRO will assist the DHS in developing a survey tool to gauge PCPs' and specialists' satisfaction in areas such as how providers feel about managed care, how satisfied providers are with reimbursement, and how providers perceive the impact of health plan utilization management on their ability to provide quality care. The EQRO will provide the DHS with a report of findings, including the raw data broken down by island. Each health plan will receive a diskette with its plan-specific raw data per island from the EQRO; and

- Providing technical assistance to the health plan to assist them in conducting activities related to the mandatory and optional EQR activities.

In compliance with 42 CFR 438.358, the EQRO must submit an annual technical report of all the EQR activities conducted to the DHS.

30.830 Conduct Case Study Interviews

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

30.900 QUEST Policy Memorandums

The DHS issues policy memorandums to offer clarity on policy or operational issues or legal changes impacting the health plan. The health plan shall comply with the requirements of all the policy memorandums during the course of the contract and execute each QUEST memorandum when distributed by MQD during the period of the contract. QUEST memorandums are available in the Bidder's Library.

31.100 Readiness Review

Prior to February 1, 2007 the DHS or its agent will conduct a readiness review of the health plan in order to provide assurances that the health plan is able and prepared to perform all administrative functions required by this contract and to provide high quality service to members.

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

- Provider network composition and access;
- Quality Assessment and Performance Improvement (QAPI) program standards;
- Utilization Management Program (UMP) strategies; and
- Any and all required policies and procedures.

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

If the health plan is unable to demonstrate its ability to meet the requirements of the contract, as determined by the DHS, within the time frames specified by the DHS, the DHS may terminate the contract in accordance with Section 72.100.

31.200 Information Systems

31.210 Hawaii Prepaid Medicaid Management Information Systems (HPMMIS)

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

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

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

Receiving/transmitting of data files between the health plans and HPMMIS is done via the MQD FTP file server. The MQD requires that health plans install the DHS approved Virtual Private Network (VPN) software that is provided to the health plan free of charge. The VPN software allows the MQD and health plans to securely transfer member, provider, and encounter data via the internet.

The MQD also operates the Premium Share Billing system that administers the billing and collection of the members' share of their monthly premium rate when applicable.

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

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

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

SECTION 40 PROVISION OF SERVICES – HEALTH PLAN RESPONSIBILITIES

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

QUEST, QUEST-Net and QUEST-ACE are managed care programs and, as such, all medical and behavioral health benefits to members shall be provided in a managed care system. The health plan, through an integrated care coordination/case management system, shall provide for the direction, coordination, monitoring and tracking of the medical and behavioral health services needed by the members. The health plan shall also provide each member with a PCP who assesses the member’s health care needs and provides/directs the services to meet the member’s needs. The health plan shall develop and maintain a provider network capable of providing the required individualized health services needed by the members.

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

40.200 Provider Network

40.210 Required Providers

The health plan shall develop and maintain a provider network that is sufficient to ensure that access and appointment wait times defined in Section 40.220 will be met. This network of providers shall provide the benefits defined in Section 40.300.

The health plan shall have written policies and procedures for the selection and retention of providers. In developing and maintaining the network, the health plan must consider the following:

- The anticipated enrollment;
- The expected utilization of services, taking into consideration the characteristics and health needs of specific populations in the health plan;
- The number and types (in terms of training, experience and specialization) of providers required to furnish the contracted services;
- The numbers of network providers who are not accepting new patients; and
- The geographic location of providers and members, considering distance, travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for members with disabilities.

The health plan shall not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification. This is not to be construed as requiring that the health plan contract with providers beyond the number necessary to meet the needs of its members, precluding the health plan from using different reimbursement amounts for different specialties or for different practitioners in the same specialty, or precluding the health plan from establishing measures that are designed to maintain quality of services and control costs and is consistent with its responsibilities to members. If the health plan will not include individuals or groups of providers of a specialty grouping in its network, it shall provide the information in its proposal.

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

The following is a listing of the minimum required components of the provider network. This is not meant to be an all-inclusive listing of the components of the network, rather the health plan may add components, or the DHS may require that the health

plan add components as required based on the needs of the members or due to changes in federal or state statutes. At a minimum, the network shall include the following:

- Hospitals, including, at a minimum, 3 on Oahu, 1 on Maui, 1 on Kauai, and 2 on Hawaii (1 in East Hawaii and 1 in West Hawaii);
- Emergency transportation providers (both ground and air);
- Non-emergency transportation providers (both ground and air);
- Primary Care Providers;
- Physician specialists, including psychiatrists, cardiologists, neurologists, surgeons, ophthalmologists, pulmonologists, orthopedists;
- Pharmacies;
- Laboratories which have either a CLIA certificate or a waiver of a certificate of registration;
- Physical, occupational, audiology and speech and language therapists;
- Behavioral health providers, including licensed therapists, counselors and substance abuse counselors;
- State licensed Special Treatment Facilities for the provision of adolescent substance abuse therapy/treatment;
- Optometrists;
- Home health agencies and hospices;
- Physician Assistants;
- Providers of lodging and meals associated with obtaining necessary medical care; and
- Sign language and foreign language translators.

The health plan is encouraged, though not required, to include the Adult Mental Health Division's Community Mental Health Centers in its provider network.

The health plan is solely responsible for ensuring it has the network capacity to serve the expected enrollment in the service area, that it offers an appropriate range of services and access to preventive and primary care services, and that it maintains a sufficient number, mix, and geographic distribution of providers of services. At a minimum, the health plan shall have the following in its network:

Provider Type	Number of Providers Required
Primary Care Providers	1 per 600 members
Physician Specialists	
Cardiology	1 per 5,000 members
Nephrology	1 per 10,000 members
Neurology	1 per 10,000 members
Gastroenterology	1 per 7,500 members
Hematology/Oncology	1 per 10,000 members
Surgical Specialists	
Ophthalmology	1 per 5,000 members
Otolaryngology	1 per 7,500 members
General Surgery	1 per 5,000 members
Orthopedics	1 per 5,000 members
Obstetrics/Gynecology	1 per 3,000 women members
Urology	1 per 10,000 members
Neurosurgery	1

Provider Type	Number of Providers Required
Other	
Behavioral Health Providers	1 per 1,200 members

In addition, for Oahu, Maui, Kauai, and Hawaii each health plan shall have the following:

Provider Type	Minimum # Required
Cardiology	1 per hospital
Obstetrics/Gynecology	2 per island*
Gastroenterology	1 per hospital
Ophthalmology	1 per hospital
Otolaryngology	1 per hospital
General Surgery	1 per hospital
Orthopedics	1 per hospital
Psychiatry (In geographic areas with a demonstrated shortage of qualified physicians, a behavioral health APRN-Rx may assume the role of a psychiatrist in order to meet network adequacy requirements.)	3 for Oahu, 2 for Hawaii*, 2 for Maui, 1 for Kauai and 1 for Molokai
Hospitals	3 for Oahu, 1 for Maui, 1 for Kauai, 2 for Hawaii*

* For Hawaii, the requirement of 2 means 1 for East Hawaii (i.e., Hilo) and 1 for West Hawaii (i.e., Waimea-Kona).

The physician specialties must be available at the hospital to which the health plan's PCPs admit if the specialty is available in

the community. If the specialty is not available in the community, the requirement is not applicable.

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

The health plan shall require that a provider (either PCP or medical specialist) with an ambulatory practice who does not have admission and treatment privileges have written arrangements with another provider with admitting and treatment privileges with an acute care hospital within the health plan's network and on the island of service.

The health plan shall maintain written policies and procedures for the credentialing and re-credentialing of network providers, using standards established by the NCQA.

The health plan shall require that all providers have a unique physician identifier. Effective May 23, 2007, in accordance with 45 CFR 160.103, the health plan shall require that each applicable provider have a national provider identifier (NPI).

At a minimum, the health plan shall require that all providers meet all applicable state and federal regulations, including Medicaid requirements such as licensing, certification and recertification requirements. The health plan shall not include in its network any providers or providers whose owners or managing employees have been excluded from participation by the Department of Health and Human Services (DHHS), Office of Inspector General (OIG), or have been excluded by the DHS from participating in the Hawaii Medicaid program. The health plan shall be responsible for routinely checking the MQD exclusion list and shall immediately terminate any provider(s) or affiliated provider(s) whose owners or managing employees are found to be excluded. The health plan shall report provider application denials or termination to the DHS where individuals were on the exclusions list. In addition, any criminal conviction information provided by the provider to the health plan shall be shared with the DHS.

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

The health plan shall report on its network as described in Section 51.400.

40.220 Availability of Providers

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

- Immediate care (twenty-four (24) hours a day, seven (7) days a week) and without prior authorization for emergency medical situations;
- Appointments within twenty-four (24) hours for urgent care and for PCP pediatric sick visits;
- Appointments within seventy-two (72) hours for PCP adult sick visits;
- Appointments within twenty-one (21) days for PCPs (routine visits for adults and children); and
- Appointments within six (6) weeks for visits with a specialist or for non-emergency hospital stays.

The health plan shall establish mechanisms to ensure that network providers comply with these acceptable wait times; monitor providers regularly to determine compliance; and take corrective action if there is a failure to comply.

The health plan shall ensure that all network providers accept members for treatment, unless providers have a full panel and are not accepting new program members. The health plan shall also ensure that network providers do not intentionally

segregate members in any way from other persons receiving services. The health plan shall ensure that members are provided services without regard to race, color, creed, sex, religion, health status, income status, or physical or mental disability. The health plan shall ensure that its network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service, if the provider sees only Medicaid recipients.

If the health plan's network is unable to provide medically necessary covered services to a particular member within its network or on the island of residence, the health plan shall adequately and timely provide these services out-of-network or transport the member to another island to access the service(s) for as long as it is unable to provide them on the island of residence. The health plan shall notify the out-of-network providers providing services to its members that payment by the plan is considered as "payment-in-full" and that it cannot "balance bill" the members for these services. The health plan is prohibited from charging the member more than it would have if the services were furnished within the network.

40.230 Primary Care Providers (PCPs)

The health plan shall implement procedures to ensure that each member is assigned a PCP who shall be an ongoing source of primary care appropriate to his or her needs and that this PCP is formally designated as primarily responsible for coordinating the health care services furnished to the member.

Each PCP shall be licensed in Hawaii as:

1. A physician, either an M.D. (Doctor of Medicine) or a D.O. (Doctor of Osteopathy), and shall be one of the following: a family practitioner, general practitioner, general internist, pediatrician or obstetrician/gynecologist;
2. An advanced practice registered nurse recognized by the State Board of Nursing as a family nurse practitioner, pediatric nurse practitioner, or certified nurse midwife;
3. A physician's assistant recognized by the State Board of Medical Examiners as a licensed physician assistant.

The health plan may allow specialists or other health care practitioners to serve as PCPs for members with chronic conditions provided the health plan submits to the DHS prior to implementation a plan for monitoring their performance as PCPs.

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

The PCP is responsible for supervising, coordinating, and providing all primary care to each assigned member. In addition, the PCP is responsible for coordinating and initiating referrals for specialty care (both in and out-of-network), maintaining continuity of each member's health care and maintaining the member's medical record, which includes documentation of all services provided by the PCP as well as any

specialty services. The health plan shall require that PCPs fulfill these responsibilities for all members.

The health plan shall have PCPs with admission and treatment privileges in a minimum of one (1) general acute care hospital within the health plan's network and on the island of service. If a PCP (including specialists acting as PCPs) with an ambulatory practice does not have admission and treatment privileges, the provider shall have written arrangements with at least one other provider with admitting and treatment privileges with an acute care hospital within the health plan's network. The health plan shall validate the provider's arrangement and take appropriate steps to ensure arrangements are satisfactory prior to PCP patient assignment.

The health plan shall establish policies and procedures on choosing and changing PCPs. These PCP policies and procedures shall not establish unreasonable limits on the frequency that a member may choose a new PCP and the criteria for changing PCPs. To the extent possible and appropriate, the health plan shall allow each member to have freedom of choice in choosing his or her PCP. The health plan's PCP policies and procedures shall apply equally to members residing on islands with multiple plans as well as to members residing on islands with only one plan.

The health plan shall describe the policies and procedures for selecting and changing PCPs in its Member Handbook.

The health plan shall submit the PCP policies and procedures to the DHS for review and approval within thirty (30) days of contract award. If the health plan revises its PCP policies and procedures during the term of the contract, the DHS must be advised and copies of the revised policies and procedures must be submitted to the DHS for review and prior approval.

If a PCP ceases participation in the health plan's provider network the health plan shall send written notice to the members who have chosen the provider as their PCP or were seen on a regular basis by the provider. This notice shall be issued within fifteen (15) calendar days after receipt or issuance of the termination notice, to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. The health plan shall be responsible for ensuring a seamless transition for the member so that continuity of care will be preserved until a new PCP has been selected.

40.240 Direct Access

The health plan shall provide female members with direct in-network access to a women's health specialist for covered care necessary to provide her routine and preventive health care services. Women's routine and preventive health care services include, but are not limited to, breast cancer screening (clinical breast exam), pap smears and pelvic exams. This direct, in-network access is in addition to the member's designated source of primary care if the PCP is not a women's health specialist.

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

The health plan shall contract with FQHCs and RHCs located in the State, unless the health plan can demonstrate to the CMS and the DHS that it has both adequate capacity and an appropriate range of services for vulnerable populations.

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

The health plan shall ensure that members have appropriate access to certified nurse midwives, pediatric nurse practitioners, family nurse practitioners, and behavioral health nurse practitioners through either provider contracts or referrals. This includes certified nurse midwives, pediatric nurse practitioners, family nurse practitioners, and behavioral health nurse practitioners who participate in the program as part of a clinic or group practice. Services provided by certified nurse midwives, pediatric nurse practitioners, family nurse practitioners, and behavioral health practitioners, if requested and available in the geographic area in which the member resides, must be provided. If there are no providers of the specific services in the area, the health plan will not be required to fly the member to another island to access these services.

If the health plan does not have these providers in its network, it may choose to arrange and provide the service(s) through an out-of-network provider in a timely manner. Alternatively, if the health plan chooses not to use out-of-network providers, the

health plan must allow the member to change to a plan which does have these providers in its network if the member expresses a desire for services rendered by one of these provider types.

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

40.270 Rural Exceptions

In areas in which there is only one health plan, any limitation the health plan imposes on the member's freedom to choose between PCPs may be no more restrictive than the limitation on disenrollment under 42 CFR 438.56(c) and Sections 30.520, 30.540 and 30.600 of this RFP. In this case the member must have the freedom to:

- Choose from at least two (2) PCPs or case managers;
- Obtain services from any other provider under any of the following circumstances:
 - The service or type of provider (in terms of training, experience, and specialization) is not available within the health plan;
 - The provider is not part of the network but is the main source of a service to the member, is given the opportunity to become a participating provider under the same requirements for participation in the health plan, and chooses to join the network. If this provider chooses not to join the network, or does not

meet the necessary qualifications to join, the health plan shall transition the member to an in-network provider within sixty (60) calendar days. If the provider is not appropriately licensed or is sanctioned, the health plan shall transition the member to another provider immediately;

- Select an out-of-network provider because the only provider in-network and available to the member does not, because of moral or religious objections provide the services the member seeks or all related services are not available;
- The member's PCP determines that the member needs related services that would subject the member to unnecessary risk if received separately and not all of the related services are available within the network; and
- The State determines that other circumstances warrant out-of-network treatment.

40.280 Provider "Gag Rule" Prohibition

The health plan may not restrict physicians or other health care professionals from advising their patients about their medical conditions or diseases and the care or treatment required, regardless of whether the care or treatment is covered under the contract, if the professional is acting within the lawful scope of practice. Under the current law, all members are entitled to receive from their provider, the full range of medical advice and counseling appropriate for their condition. The health plan is prohibited from imposing any type of prohibition, disincentive,

penalty, or other negative treatment upon a provider for discussing or providing any information regarding treatment options and medically necessary or appropriate care, including no treatment, even if the information relates to services or benefits not provided by the health plan.

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

- The DHS within one-hundred twenty (120) days prior to adopting the policy with respect to any service;
- The DHS with the submission of its proposal to provide services under this RFP;
- Members within ninety (90) days of adopting the policy with respect to any service; and
- Members and potential members before and during enrollment.

40.290 Provider Services

The health plan shall be responsible for educating the providers on managed care and all program requirements. Providers shall be informed of the health plan's referral process, prior authorization process, the role of the PCP, availability of care coordination/case management services and how to access these services, the role of care coordinators, members' rights and

responsibilities, reporting requirements, circumstances and situations under which the provider may bill a member for services or assess charges or fees, and the grievance/appeals process for providers. The grievance and appeals process shall provide for the timely and effective resolution of any disputes between the health plan and provider(s).

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

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

those benefits if the health plan's adverse action is upheld.

The health plan shall ensure that the providers are aware of their responsibilities for compliance with the Americans with Disabilities Act (ADA) including providing sign language interpretation services.

The health plan shall have policies and procedures for a provider grievance system that includes provider complaints, provider grievances and provider appeals. These policies and procedures shall be submitted to the DHS for review and approval within thirty (30) days of contract award. Provider complaints, provider grievances and provider appeals shall be resolved within sixty (60) days of the day following the date of submission to the health plan. Providers may utilize the provider grievance system to resolve issues and problems with the health plan (this includes a problem regarding a member). A provider may file a grievance or appeal on behalf of a member by following the procedures outlined in Section 50.800 Member Grievance System.

A provider, either contracted or non-contracted, may file a provider complaint in the following areas:

- Benefits and limits, for example, limits on behavioral health services or formulary;
- Eligibility and enrollment, for example long wait times or inability to confirm enrollment or identify the PCP;

- Member issues, including members who fail to meet appointments or do not call for cancellations, instances in which the interaction with the member is not satisfactory; instances in which the member is rude or unfriendly; or other member-related concerns; and
- Health plan issues, including difficulty contacting the health plan or its subcontractors due to long wait times, busy lines, etc; problems with the health plan's staff behavior; delays in claims payments; denial of claims; claims not paid correctly; or other health plan issues.

The health plan shall log all provider complaints and total the number of provider complaints which were received and resolved. Unresolved provider complaints shall be logged as either:

- A – the provider complaint is expected to be resolved by the reporting date to the state, or
- B – the provider complaint will unlikely be resolved by the reporting date to the state.

The health plan shall process the following as provider grievances and not as provider complaints:

- Issues related to availability of health services from the health plan to a member, for example delays in obtaining or inability to obtain emergent/urgent services; medications; specialty care; ancillary services such as transportation; medical supplies, etc.;

- Issues related to the delivery of health services, for example, the PCP did not make referral to a specialist; medication was not provided by a pharmacy; the member did not receive services the provider believed were needed; provider is unable to treat member appropriately because the member is verbally abusive or threatens physical behavior;
- Issues related to the quality of service, for example, the provider reports that another provider did not appropriately evaluate, diagnose, prescribe or treat the member; the provider reports that another provider has issues with cleanliness of office, instruments, or other aseptic technique was used; the provider reports that another provider did not render services or items which the member needed; or the provider reports that the plan's specialty network cannot provide adequate care for a member.

The health plan shall submit to the DHS, quarterly provider grievance reports that meet the requirements outlined in QUEST MEMO ADM 0311 (dated January 28, 2004), Attachment A-6, Provider Grievance Instructions.

40.295 Provider Contracts

All contracts between providers and the health plan shall be in writing. The health plan shall submit to the DHS for review and approval a model for each type of provider contract within five (5) days of contract award and at the DHS's request at any point during the contract period.

The health plan's written provider contracts shall:

- Prohibit the provider from seeking payment from the member for any covered services provided to the member within the terms of the contract and require the provider to look solely to the health plan for compensation for services rendered, with the exception of nominal cost sharing pursuant to the Hawaii Medicaid State plan;
- Require the provider to cooperate with the health plan's quality improvement and utilization review and management activities;
- Include provisions for the immediate transfer to another PCP or health plan if the member's health or safety is in jeopardy;
- Not prohibit a provider from discussing treatment or non-treatment options with members that may not reflect the health plan's position or may not be covered by the health plan;
- Not prohibit, or otherwise restrict, a provider from acting within the lawful scope of practice, from advising or advocating on behalf of a member for the member's health status, medical care, or treatment or non-treatment options, including any alternative treatments that might be self-administered;
- Not prohibit, or otherwise restrict, a provider from advocating on behalf of the member to obtain necessary health care services in any grievance system or utilization review process, or individual authorization process;

- Require providers to meet appointment waiting time standards pursuant to the terms of this contract;
- Provide for continuity of treatment in the event a provider's participation terminates during the course of a member's treatment by that provider;
- Require that providers comply with HIPAA provisions and maintain the confidentiality of member's information and records;
- Prohibit discrimination with respect to participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of such license or certification. This provision should not be construed as any willing provider law, as it does not prohibit the health plan from limiting provider participation to the extent necessary to meet the needs of the members. Additionally, this provision shall not preclude the health plan from using different reimbursement amounts for different specialties or for different practitioners in the same specialty. This provision also does not interfere with measures established by the health plan that are designed to maintain quality and control costs;
- Prohibit discrimination against providers serving high-risk populations or those that specialize in conditions requiring costly treatments;
- Specify that CMS and the DHS or their respective designee will have the right to inspect, evaluate, and audit any pertinent books, financial records, medical records,

documents, papers, and records of any provider involving financial transactions related to this contract and for the monitoring of quality of care being rendered with/without the specific consent of the member;

- Specify covered services and populations;
- Require provider submission of complete and accurate encounter data on a monthly basis and any and all medical records to support encounter data upon request from the health plan with/without the specific consent of the member, DHS or its designee for the purpose of validating encounters;
- Require provider to certify claim/encounter submissions to the plan as accurate and complete;
- Require the provider to provide medical records or access to medical records by the health plan and the DHS or its designee, within sixty (60) days of a request. Refusal to provide medical records, access to medical records or inability to produce the medical records to support the claim/encounter shall result in recovery of payment;
- Include the definition and standards for medical necessity, pursuant to the definition in this contract;
- Specify rates of payment and require that providers accept such payment as payment in full for covered services provided to members, as deemed medically necessary and appropriate under the health plan's quality improvement and utilization management program, less any applicable member cost sharing pursuant to this contract;
- Specify acceptable billing and coding requirements;

- Require that providers comply with the health plan's cultural competency plan;
- Require that any marketing materials developed and distributed by providers relating to the programs be submitted to the health plan to submit to the DHS for approval prior to distribution;
- Specify that in the case of newborns the health plan shall be responsible for any payment owed to providers related to the newborn;
- Comply with 42 CFR 434 and 42 CFR 438.6;
- Require that providers not employ or subcontract with individuals or entities whose owner or managing employees are on the state or federal exclusions list;
- Prohibit providers from making referrals for designated health services to health care entities with which the provider or a member of the provider's family has a financial relationship;
- Require providers of transitioning members to cooperate in all respects with providers of other health plans to assure maximum health outcomes for members;
- Require that providers who impose a no-show fee for QUEST-Net or QUEST-ACE members inform the members in advance of imposing the no-show fee, or their intent to apply such a fee and what members must do to avoid such an assessment (e.g., how many hours in advance an individual member needs to cancel an appointment); and
- Require that providers submit a Form DHS 1147 to the DHS or its designee when they identify an individual they

believe is eligible for long-term care level of services and the Form 1180 to the ADRC to determine disability status.

Contracts with subcontractors (non-providers) are addressed in Section 70.500.

The health plan shall submit to the DHS all finalized and executed contracts thirty (30) days after the date of contract award. The health plan shall submit to the DHS all finalized and executed contracts that have not been previously submitted at the following times:

- Sixty (60) days after the date of contract award;
- Ninety (90) days after the date of contract award; and
- One hundred twenty (120) days after the date of contract award.

The health plan shall continue to solicit provider participation throughout the contract term.

40.300 Covered Benefits and Services

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

as described in Section 50.600 as long as the services furnished to the member can be reasonably expected to achieve their purpose.

The health plan shall provide all preventive services as defined in Appendix L and all required EPSDT services defined in Section 40.380.

Included in the services to be provided to adults and children are the medical services required as part of a dental treatment. The health plan shall provide and be financially responsible for medical services related to the dental services and for certain dental procedures performed by both dentists (oral surgeons) and physicians (primarily plastic surgeons, otolaryngologists and general surgeons), as defined in Appendix M. Section 40.320 provides further description of the health plan's responsibilities.

With the exception of covering services specifically excluded by the federal Medicaid requirements, the health plan may, at its own option, choose to provide additional services, either non-covered services or services in excess of the required covered services. The health plan shall provide a description of any additional services it will provide to the DHS within thirty (30) days of contract award.

For new adult enrollments into the program, the health plan may apply a one-month waiting period for any *additional services* that are not included in the Medicaid State Health Plan. The health plan shall use the guidelines provided in Appendix N. The health

plan is prohibited from applying a one-month waiting period on individuals under the age of twenty-one (21), pregnant members or adult members who have had a break in coverage of sixty (60) days or less.

40.305 Medical Services to be Provided to QUEST Members

The health plan shall provide the following services:

- Acute inpatient hospital services for medical, surgical, psychiatric, and maternity/newborn care including:
 - Room and board
 - Nursing care
 - Medical supplies, equipment and drugs
 - Diagnostic services
 - Physical, occupational, speech and language therapy services
 - Other medically necessary services
- Outpatient hospital services including:
 - Twenty-four (24) hours, seven (7) days per week emergency room services
 - Ambulatory surgery center services
 - Urgent care services
 - Medical supplies, equipment and drugs
 - Diagnostic services
 - Therapeutic services including chemotherapy and radiation therapy
 - Other medically necessary services
- Preventive services including (See Appendix L for more details on preventive services):

- Initial and interval histories, comprehensive physical examinations and developmental assessments
- Immunizations
- Family planning
- Diagnostic and screening laboratory and x-ray services, including screening for tuberculosis
- Prescribed drugs including blood and blood products medically necessary to optimize the member's medical condition and behavioral health prescription drugs to children receiving services from CAMHD.:
 - Medication management and patient counseling
- Radiology/laboratory/other diagnostic services including:
 - Radiology and imaging (including screening mammograms)
 - Screening laboratory tests such as PKUs
 - Diagnostic laboratory tests
 - Therapeutic radiology
 - Other medically necessary diagnostic services
- Physician services
- Maternity services
 - Prenatal care
 - Prenatal laboratory screening tests and diagnostic tests
 - Treatment of missed, threatened, and incomplete abortions
 - Delivery of infant
 - Postpartum care
 - Prenatal vitamins
- Other practitioner services including:

- Optometry
- Certified nurse midwife service
- Licensed Advanced Practice Registered Nurse service that include family, pediatric and psychiatric health specialties
- Other medically necessary practitioner services provided by licensed or certified health care providers
- Therapeutic services including:
 - Physical therapy
 - Occupational therapy
 - Speech therapy
 - Audiology services
 - Other medically necessary therapeutic services including services which would prevent institutionalization
- Durable medical equipment and medical supplies including:
 - Oxygen tanks and concentrators
 - Ventilators
 - Wheelchairs
 - Crutches, canes
 - Eyeglasses
 - Orthotic devices
 - Prosthetic devices
 - Hearing aids
 - Pacemakers
 - Medical supplies, such as surgical dressings and ostomy supplies

- Other medically necessary durable medical equipment covered by the Hawaii Medicaid program
- Home health agency services including:
 - Skilled nursing
 - Home health aides
 - Therapeutic services such as physical, speech, occupational and audiology therapy
 - Medical supplies and durable medical equipment
 - Other therapies, services and supplies and equipment to prevent institutionalization
- Hospice services
- Long-term care services (SNF/ICF and subacute or waitlisted for SNF/ICF and subacute bed in an acute hospital for a maximum of sixty (60) days)
- Cornea and kidney transplants and bone graft services
- Transportation services, both emergency and non-emergency, ground and air
- Language translation/interpretation services, sign language interpretation
- Emergency services (see Section 40.335)
- Sterilizations and hysterectomies when federal requirements are met (see Section 40.360)
- Substance Abuse Services (room and board in Special Treatment Facilities for adolescents is not covered but therapy/treatment provided in the facility is the responsibility of the health plan)

40.310 Excluded Services

The health plan shall not provide the following services:

- Experimental, investigational services, or services of generally unproven benefit, supplies, equipment, devices and drugs of unproven benefit;
- Treatment of pulmonary tuberculosis when treatment is available at no charges to the general public;
- Treatment of Hansen’s Disease after a definite diagnosis has been made except for surgical or rehabilitative procedures to restore useful function; and
- Drugs not approved by the U.S. Food and Drug Administration or deemed “less than effective” (DESI 5 and 6) by CMS.

Other specific exclusions are listed in Appendix O.

The health plan may provide additional services to its members, so long as these services are not prohibited by federal or state law.

40.315 Medical Services to be Provided for QUEST-Net/QUEST-ACE Members

The health plan shall provide the following services per benefit year for individuals age twenty-one (21) and over in QUEST-Net and QUEST -ACE:

- Emergency medical situations as defined in Section 40.335;
- Ten (10) inpatient hospital days. There is no maternity benefit for members. However, the health plan shall refer

QUEST-Net and QUEST-ACE members who become pregnant to their eligibility worker to determine their qualifications for QUEST, nursery, rehabilitation, or skilled nursing facility level of care;

- Twelve (12) outpatient medical visits (alcohol and substance abuse services are included as part of medical visits);
- Six (6) mental health outpatient visits. If all six (6) are used and the member has not used all twelve (12) outpatient medical visits, up to six (6) of the twelve (12) outpatient medical visits may be allocated to mental health outpatient visits (thereby giving the member a maximum of twelve (12) mental health outpatient visits and six (6) outpatient medical visits);
- Three (3) ambulatory surgeries (include surgeries performed in a free-standing ambulatory surgery center (ASC), physician's office, outpatient hospital, and hospital ASC);
- Diagnostic tests (laboratory tests, x-ray services, nuclear medicine) associated with the twelve (12) outpatient medical visits);
- Immunizations for diphtheria and tetanus;
- Family planning services including family planning drugs, supplies and devices which are limited to generic birth control pills, medroxyprogesterone acetate (Depo-Provera) and diaphragms;
- Limited prescription drugs one (1) Cephalosporin agent, one (1) Erythromycin agent, one (1) Penicillin agent, Trimethoprim with Sulfamethoxazole, Ophthalmic

Sulfacetamide, and Otic Polymixin/Neomycin/
Hydrocortisone); and

- Translation Services/Interpreter Services.

The health plan shall provide the above identified medical and behavioral health services to QUEST-Net and QUEST-ACE members. The services do not include case management, outreach services, or transportation. More specific rules for exclusions and other limitations on the QUEST-Net and QUEST-ACE benefits and services are available in the DHS's Administrative Rules. QUEST-Net and QUEST-ACE members may be billed directly by the rendering provider for any non-covered services and for covered services exceeding the established limits. The health plan shall make an effort to notify the member prior to the health service being provided that it is not a covered benefit or that they will be exceeding the coverage limits.

Individuals under the age of twenty-one (21) in QUEST-Net receive the same benefit package as individuals under age twenty-one (21) in QUEST or Medicaid fee-for-service and the State shall reimburse the health plan the QUEST rate for each QUEST-Net member under the age of twenty-one (21).

40.320 Medical Services Related to Dental Needs

The health plan shall provide any dental services or medical services resulting from a dental condition that are provided in a medical facility (e.g., inpatient hospital and ambulatory surgery center). This includes medical services provided to QUEST adults

and children that are required as part of a dental treatment and certain dental procedures performed by both dentists (oral surgeons) and physicians (primarily plastic surgeons, otolaryngologists and general surgeons), as defined in Appendix M.

Specifically, the health plan shall be responsible for:

- Referring EPSDT eligible members to the Medicaid fee-for-service dental program for EPSDT dental services and other dental needs if not provided by the plan;
- Providing referral, follow-up, coordination and provision of appropriate medical services related to medically necessary dental needs including but not limited to emergency room treatment, hospital stays, ancillary inpatient services, operating room services, excision of tumors, removal of cysts and neoplasms, excision of bone tissue, surgical incisions, treatment of fractures (simple & compound), oral surgery to repair traumatic wounds, surgical supplies, blood transfusion services, ambulatory surgical center services, x-rays, laboratory services, drugs, physician examinations, consultations and second opinions;
- Providing sedation services associated with dental treatment, when performed in an acute care setting, by a physician anesthesiologist, shall be the responsibility of the health plan. Sedation services administered by an oral and maxillofacial surgeon, or other qualified dentist anesthetist, in a private office or hospital-based outpatient

clinic for services that are not medically related shall be the responsibility of the Medicaid fee-for-service dental program;

- Providing dental services performed by a dentist or physician that are needed due to a medical emergency (e.g., car accident) where the services provided are primarily medical; and
- Providing dental services in relation to oral or facial trauma, oral pathology (including but not limited to infections of oral origin and cyst and tumor management) and craniofacial reconstructive surgery, performed on an inpatient basis in an acute care hospital setting shall be the responsibility of the health plan.

The health plan shall work closely and coordinate with the DHS or its agent to assist members in finding a dentist, making appointments and coordinating transportation and translation services.

The health plan is not responsible for services that are provided in private dental offices, government sponsored or subsidized dental clinics and hospital based outpatient dental clinics, including but not limited to the dental programs affiliated with the Queen's Medical Center.

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

40.325 Services for Members with Special Health Care Needs (SHCNs)

The health plan shall use the State-defined criteria below to identify members with SHCNs as quickly as possible. An adult with SHCNs is an individual who is twenty-one (21) years of age or older and has chronic physical or behavioral conditions that require health related services of a type or amount beyond that required by adults generally. These members shall be identified by the health plan through its quality improvement and utilization review processes or by the individual's PCP and referred for case management or other medical services for management of high risk pregnancies or chronic medical conditions such as asthma, diabetes, hypertension, chronic obstructive lung disease.

A child with SHCNs is an individual under twenty-one (21) years of age who has a chronic physical, developmental, behavioral, or emotional condition and who also requires health and related services of a type or amount beyond that generally required by children. These members shall be identified by the health plan through its quality improvement and utilization review processes or by the individual's PCP. These children are then referred for case management or other medical services for management of these conditions. The health plan shall develop policies and procedures to identify the following groups of children with SHCN:

- Children who take medication for any behavioral/medical condition that has lasted or is expected to last at least twelve (12) months (excludes vitamins and fluoride);
- Children who are limited in their ability to do things that most children of the same age can do because of a serious medical/behavioral health condition that has lasted or is expected to last at least twelve (12) months;
- Children who need or receive speech therapy, occupational therapy, and/or physical therapy for a medical condition that has lasted or is expected to last as least twelve (12) months; and
- Children who need or receive treatment or counseling for an emotional, developmental, or behavioral problem that has lasted or is expected to last at least twelve (12) months.

The health plan shall assess all children identified with SHCNs within thirty (30) calendar days of identification by the PCP or the health plan to determine if the individual is eligible for case management services. All assessments shall be performed by appropriately trained and credentialed health care professionals.

If the member, either adult or child, meets the SHCN eligibility criteria, the health plan shall:

- Generate a treatment plan that is developed by the member's PCP with the member's participation, and in consultation with any specialist caring for the member;
- Approve the treatment plan in a timely manner;

- Ensure that the treatment plan is in accordance with all applicable State quality assurance and utilization review standards ;
- Coordinate care with other State agencies and community organizations in order to prevent duplication of benefits; and
- Provide access to providers who are experienced in delivering the appropriate care, are available, and are physically accessible. If an appropriate in-network provider is not available the health plan shall allow SHCN members to see an out-of-network provider. In addition, the health plan shall permit either a standing referral, an adequate number of direct access visits to specialists as determined by the member's PCP, or allow the member to select a specialist as a PCP.

The health plan shall have case managers/care coordinators to provide assistance to the PCP in coordinating care for SHCN members and ensure that in coordinating care, the member's privacy is protected in accordance with the applicable confidentiality requirements in Section 71.200.

The health plan shall, as part of its QAPI program, have in effect mechanisms to assess the quality and appropriateness of care furnished to members with SHCNs. (See Appendix K).

40.330 Disease Management

The health plan shall have disease management programs for asthma and diabetes. The health plan shall select at least two (2) other programs from the following: congestive heart failure, HIV/AIDS, high risk pregnancy, or obesity management.

The health plan's disease management programs shall:

- Have a systematic method of identifying and enrolling members in each program;
- Utilize evidence-based clinical practice guidelines;
- Emphasize the prevention of exacerbation and complications of the diseases;
- Incorporate educational components for both members and providers,
- Utilize an integrated, comprehensive approach to patient care that extends beyond a focus on the prescription drug line item;
- Takes a member-centered approach to providing care by addressing psychological aspects, caregiver issues and treatment of diseases using nationally recognized standards of care;
- Incorporate culturally appropriate interventions, including but not limited to taking into account the multi-lingual, multi-cultural nature of the member population;
- Focus interventions on the member through activities such as disease and dietary education, instruction in health self-management, and medical monitoring;

- Have established measurable benchmarks and goals which are specific to each disease and are used to evaluate the efficacy of the disease management programs; and
- Be analyzed to determine if costs have been lowered by reducing the use of unnecessary or redundant services or by avoiding costs associated with poor outcomes.

The health plan shall develop policies and procedures for its disease management programs. The health plan shall submit these policies and procedures to the DHS for review and approval within thirty (30) calendar days of contract award.

The health plan shall annually review the disease management programs and revise as necessary based upon new treatments and innovations in the standard of care.

40.335 Emergency Services

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

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

- Placing the physical or mental health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part;
- Serious harm to self or others due to an alcohol or drug abuse emergency;
- Injury to self or bodily harm to others; or
- With respect to a pregnant woman having contractions: (1) that there is adequate time to effect a safe transfer to another hospital before delivery, or (2) that transfer may pose a threat to the health or safety of the woman or her unborn child.

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

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

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

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

The health plan shall base coverage decisions for emergency services on the severity of the symptoms at the time of presentation and shall cover emergency services when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson. The emergency room physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the health plan, who shall be responsible for coverage and payment. The health plan, however, may establish arrangements with a hospital whereby the health plan may send one of its own physicians with appropriate emergency room privileges to assume the attending physician's responsibilities to stabilize, treat, and transfer the member, provided that such arrangement does not delay the provision of emergency services.

The health plan shall not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency medical condition under the prudent layperson standard, turned out to be non-emergency in nature. If an emergency screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition does not exist, then the determining factor for payment liability shall be whether the

member had acute symptoms of sufficient severity at the time of presentation. In this case, the health plan shall pay for all screening and medically necessary services provided.

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

The member who has an emergency medical condition shall not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

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

40.340 Post-Stabilization Services

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

The health plan shall be responsible financially for post-stabilization services that are not prior authorized or pre-certified by an in-network provider or organization representative, regardless of whether the services are provided within or outside the health plan's network of providers.

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

- The health plan does not respond to the provider's request for pre-certification or prior authorization within one hour;
- The health plan cannot be contacted;
- The health plan's representative and the attending physician cannot reach an agreement concerning the member's care and a health plan physician is not available for consultation. In this situation the health plan shall give the treating physician the opportunity to consult with an in-network physician and the treating physician may continue with care of the member until a health plan physician is reached or one of the criteria outlined below are met.

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

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

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

40.345 Urgent Care Services

The health plan shall provide urgent care services as necessary. Such service shall not be subject to prior authorization or pre-certification.

40.350 Services for Pregnant Women and Expectant Parents

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

the health plan before prescribing a length of stay up to forty-eight (48) or ninety-six (96) hours.

The health plan is also prohibited from:

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

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

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

- Availability and accessibility of appropriate outpatient and inpatient facilities capable of dealing with complicated perinatal problems.

40.355 Family Planning Services

The health plan shall provide access to family planning services within the network. However, member freedom of choice may not be restricted to in-network providers. The health plan shall inform members of the availability of family planning services and shall provide services to members wishing to prevent pregnancies, plan the number of pregnancies, plan the spacing between pregnancies, or obtain confirmation of pregnancy. These services shall include, at a minimum, the following:

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

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

40.360 Sterilizations Hysterectomies, and Intentional Termination of Pregnancies (ITOPs)

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

- The member is at least twenty-one (21) years of age at the time consent is obtained;
- The member is mentally competent;
- The member voluntarily gives informed consent by completing the Informed Consent for Sterilization Form DSSH 1146;
- The provider completes the Informed Consent for Sterilization Form DSSH;
- At least thirty (30) days, but not more than one-hundred eighty (180) days, have passed between the date of informed consent and the date of sterilization, except in the case of premature delivery or emergency abdominal surgery. A member may consent to be sterilized at the time of premature delivery or emergency abdominal surgery, if at least seventy-two (72) hours have passed since informed consent for sterilization was signed. In the case of premature delivery, the informed consent must have been given at least thirty (30) days before the expected date of delivery (the expected date of delivery must be provided on the consent form);
- An interpreter is provided when language barriers exist. Arrangements are to be made to effectively communicate

the required information to a member who is visually impaired, hearing impaired or otherwise disabled; and

- The member is not institutionalized in a correctional facility, mental hospital or other rehabilitative facility.

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

- The member voluntarily gives informed consent by completing the Hysterectomy Acknowledgement Form (DSSH 1145);
- The member has been informed orally and in writing that the hysterectomy will render the individual permanently incapable of reproducing (this is not applicable if the individual was sterile prior to the hysterectomy or in the case of an emergency hysterectomy); and
- The member has signed and dated a "Patient's Acknowledgement of Prior Receipt of Hysterectomy Information" form prior to the hysterectomy.

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

- It is performed solely for the purpose of rendering a member permanently incapable of reproducing;
- There is more than one purpose for performing the hysterectomy but the primary purpose was to render the member permanently incapable of reproducing; or

- It is performed for the purpose of cancer prophylaxis.

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

The health plan is not responsible for covering ITOPs or related services performed for family planning purposes. The health plan shall cover treatment of medical complications occurring as a result of an elective termination and treatments for spontaneous, incomplete or threatened terminations for ectopic pregnancies.

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

40.365 Prescription Drugs

The health plan shall be permitted to develop its own formulary of prescribed and over the counter medications provided members have access to drugs not specifically listed on the formulary if the drugs are medically necessary for the treatment of a member's medical condition.

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

plan's formulary. At a minimum, the health plan shall have a process to provide an emergency supply of medication to the member until the health plan can make a medically necessary determination.

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

40.370 Behavioral Health

The health plan shall provide all medically necessary behavioral health services, to QUEST adults and child members. These services include:

- Twenty-four (24) hour care for acute psychiatric illnesses including:
 - Room and board
 - Nursing care
 - Medical supplies and equipment
 - Diagnostic services
 - Physician services
 - Other practitioner services as needed
 - Other medically necessary services
- Ambulatory services including twenty-four (24) hours, seven (7) days per week crisis services
- Acute day hospital/partial hospitalization including:
 - Medication management
 - Prescribed drugs

- Medical supplies
- Diagnostic tests
- Therapeutic services including individual, family and group therapy and aftercare
- Other medically necessary services
- Methadone treatment services which include the provision of methadone or a suitable alternative (e.g. LAAM), as well as outpatient counseling services
- Prescribed drugs (excluding Clozaril or Clozapine)
 - Medication management and patient counseling
- Diagnostic/laboratory services including:
 - Psychological testing
 - Screening for drug and alcohol problems
 - Other medically necessary diagnostic services
- Psychiatric or psychological evaluation
- Physician services
- Therapeutic services including:
- Occupational therapy
- Other medically necessary therapeutic services

The services listed above are subject to the following established limits when provided to individuals age twenty-one (21) and older. A benefit year is defined as the period between July 1 through June 30. The health plan may, at its option, exceed the limits on behavioral health services. Individuals under age twenty-one (21) are not subject to the behavioral health limits.

- Coverage will be limited to twenty-four (24) hours of outpatient visits and thirty (30) days of hospitalization per benefit year.
- Each day of inpatient hospital services may be exchanged for two (2) days of non-hospital residential services, two (2) days of partial hospitalization services, two (2) days of day treatment or two (2) days of intensive outpatient services. The plan may substitute each inpatient day for two (2) outpatient hours, if the twenty-four (24) hours or outpatient benefit is exhausted.

The health plan may utilize a full array of effective interventions and qualified professionals such as psychiatrists, psychologists, counselors, social workers, registered nurses and others. Substance abuse counselors shall be certified by the State Department of Health Alcohol and Drug Abuse Division (ADAD). Additionally, substance abuse services which can only have limits or prior authorization requirements that are co-extensive with physical treatments, shall be provided in a treatment setting accredited according to the standards established by ADAD. The health plan is encouraged to utilize currently existing publicly funded community-based substance abuse treatment programs, which have received ADAD oversight, through accreditation and monitoring. Methadone/LAAM services are covered for acute opiate detoxification as well as maintenance. The health plan may develop its own payment methodologies for Methadone/LAAM services.

The health plan shall be responsible for providing behavioral health services to persons who have been involuntarily committed for evaluation and treatment under the provisions of Chapter 334, HRS to the extent that these services are deemed medically necessary by the health plan's utilization review procedures and are within the established limits.

The health plan is not obligated to provide behavioral health services to those adult members:

- Who have reached the member's limit of covered behavioral health services under QUEST; or
- Whose diagnostic, treatment or rehabilitative services are determined to not be medically necessary by the health plan; or
- Who have been determined eligible for and have been transferred to the behavioral health managed care (BHMC) plan, as described in Section 40.800; or
- Who have been criminally committed for evaluation or treatment in an inpatient setting under the provisions of Chapter 706, HRS. These individuals will be disenrolled from the programs and will become the clinical and financial responsibility of the appropriate State agency. The psychiatric evaluation and treatment of members who have been criminally committed to ambulatory mental health care settings will be the clinical and financial responsibility of the appropriate State agency. The health plan shall remain responsible for providing medical services to these members.

40.375 Collaboration with the Alcohol and Drug Abuse Division (ADAD)

The ADAD provides substance abuse treatment programs, which may be accessed by the members. The health plan has the following responsibilities as it relates to coordinating with ADAD and providing services to its members:

- Providing assistance to members who wish to obtain a slot, either by helping them contact ADAD or its contractor or referring the member to a substance abuse residential treatment provider to arrange for the utilization of an ADAD slot;
- Providing appropriate medically necessary substance abuse treatment services while the member is awaiting an ADAD slot;
- Providing all medical costs for the member while the member is in an ADAD slot;
- Coordinating with the ADAD provider following the member's discharge from the residential treatment program; and
- Placing the member into other appropriate substance abuse treatment programs following discharge from the residential treatment program.

40.380 Children's Medical and Behavioral Health Services (EPSDT Services)

The health plan shall provide Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services to members

younger than twenty-one (21) years of age (including foster children and subsidized adoptions). The health plan shall comply with Sections 1902(a)(43) and 1905(r) of the Social Security Act and federal regulations at 42 CFR Part 441, Subpart B, that require EPSDT services, including outreach and informing, screening, tracking, and diagnostic and treatment services.

The health plan shall develop an EPSDT plan that includes written policies and procedures for conducting outreach, informing, tracking, and follow-up to ensure compliance with the periodicity schedules. The EPSDT plan shall emphasize outreach and compliance monitoring for members under age twenty-one (21), taking into account the multi-lingual, multi-cultural nature of the member population, as well as other unique characteristics of this population. The EPSDT plan shall include procedures for follow-up of missed appointments, including missed referral appointments for problems identified through EPSDT screens and exams. The health plan shall also include procedures for referrals to the DHS contractor providing dental care coordination services for the Medicaid fee-for-service program for needed dental care. The health plan shall be responsible for medical services related to dental needs as described in Sections 40.300 and 40.321.

The health plan shall submit its EPSDT plan to the DHS for review and approval within thirty (30) days of contract award.

The health plan shall be responsible for training providers and monitoring compliance with EPSDT program requirements.

The health plan shall require that all providers participating in a health plan, utilize the standard EPSDT screening form prescribed by the DHS when screening and treating EPSDT eligible members.

The health plan's outreach and informing process shall:

- Include notification of all newly enrolled families with EPSDT aged members about the EPSDT program within sixty (60) days of enrollment. This requirement includes informing pregnant women and new mothers either before or shortly after giving birth that EPSDT services are available; and
- Include notification to EPSDT eligible members and their families about the benefits of preventive health care, how to obtain timely EPSDT services (including translation and transportation services), and providing health education and anticipatory guidance. This includes informing pregnant women within twenty-one (21) days after confirmation of pregnancy and new mothers within fourteen (14) days after birth that EPSDT services are available.

The health plan's informing shall:

- Be done orally (on the telephone, face-to-face or films/tapes) or in writing. Informing may be done by health plan personnel or health care providers. The health

plan shall follow-up with families with EPSDT-eligible members who, after six (6) months of enrollment, have failed to access EPSDT screens and services;

- Be done in non-technical language at or below a 6th (6.9 grade level or below) grade reading level and use accepted methods for informing persons who are blind or deaf, or cannot read or understand the English language, in accordance with Section 50.320; and
- Stress the importance of preventive care; describe the periodicity schedule; provide information about where and how to receive services; inform members that transportation and scheduling assistance is available upon request; description of how to access services; state that services are provided without cost; describe what resources are available for non-plan services; and describe the scope and breadth of the health services available. Annual informing by the health plan is required for EPSDT members who have not accessed services during the prior year.

The health plan shall conduct the following three (3) types of screens on EPSDT eligible members:

- Complete periodic screens according to the EPSDT periodicity schedule in Appendix P and the requirements detailed in the State Medicaid Manual. The health plan shall strive to provide periodic screens to one hundred percent (100%) of eligible members; minimum compliance

is defined as providing periodic screens to eighty (80) percent of eligible members;

- Interperiodic screens; and
- Partial screens.

The health plan shall provide all medically necessary diagnostic and treatment services to correct or ameliorate a medical, dental or behavioral health problem discovered during an EPSDT screen (complete periodic, interperiodic, or partial). This includes, but is not limited to, timely immunizations and tuberculosis screening; diagnosis and treatment of defects in vision and hearing; and, diagnosis and treatment of acute and chronic medical, dental and behavioral health conditions.

If it is determined at the time of the screening that immunization is needed and appropriate to provide at that time, the health plan shall insure that the provider administers the immunizations. With the exception of the services provided by the DOH, the health plan shall be responsible for providing all services listed in Section 40.305 on Medical Services and Section 40.370 on Behavioral Health Services to EPSDT eligible members under EPSDT. Members under age 21 are not subject to the behavioral health limits.

The health plan shall provide additional medical services determined as medically necessary to correct or ameliorate defects of physical illness and conditions discovered as a result of EPSDT screens. Examples of services are: prescription drugs not on the health plan's formulary, durable medical equipment

typically not covered for adults, chiropractic care, personal care services, private duty nursing services, and certain non-experimental medical and surgical procedures.

Services are required to be covered under EPSDT if the services are determined to be medically necessary to treat a condition detected at an EPSDT screening visit.

The health plan is responsible for coordinating services with the Department of Education (DOE) and DOH for individuals determined to be eligible for SEBD by the DHS or its contractor for medically necessary outpatient behavioral health services that are required for the educational needs of the member provided by DOE and DOH. However, the family does have the option of receiving therapeutic services from the health plan rather than DOE or DOH. In the event the family selects this option the health plan shall provide said therapeutic services. DOH and DOE will be responsible for providing the following services:

- Crisis Management;
- Crisis Residential Services;
- Biopsychosocial Rehabilitative Programs – Level 1;
- Biopsychosocial Rehabilitative Programs – Level 2;
- Partial Hospitalization;
- Intensive Family Intervention;
- Therapeutic Living Supports;
- Therapeutic Foster Supports; and
- Hospital-based residential services.

If a child is determined not to be eligible for SEBD, the health plan is responsible for all medically necessary medical and behavioral health services.

The health plan is not responsible for providing health interventions which have not proven to be effective by peer-reviewed, well-controlled studies, which directly or indirectly relates to the intervention of health outcomes and is reproducible both within and outside of research settings.

The health plan shall establish a process that provides information on compliance with EPSDT requirements. The process shall track and be sufficient to document the health plan's compliance with these sections.

The health plan shall submit an annual CMS 416 report to the DHS. The DHS, at its sole discretion, may add additional data to the CMS 416 report if it determines that it is necessary for monitoring and compliance purposes.

Appendix P provides additional information on the EPSDT services to be provided.

40.385 Vaccines for Children (VFC) Program

The State of Hawaii participates in the VFC program, a federally funded program that replaces public and private vaccines for Medicaid, QUEST and QUEST-Net children. These vaccines are distributed to qualified providers who administer them to

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

40.390 Appropriate Levels of Care

The health plan shall provide members with levels of care appropriate to their medical needs. For a member with documented medical needs which cannot be provided in his or her home and who does not qualify for care in the home, medically necessary long-term care services shall be provided.

The health plan shall arrange for placement in a nursing facility if it becomes aware of a member who may be eligible for placement into a nursing facility or home and community based services program. Refer to Appendix Q for a description of the process for the referral and determination of eligibility process for long term care services. The health plan shall be responsible for referring to the DHS or its contractor who determines eligibility for long term care services in a nursing facility or home and community based program so that the DHS or its contractor may evaluate the referral.

40.395 Subacute Level of Care

The health plan may establish a subacute level of care for payment purposes. Subacute level of care is a level of care needed by a member not requiring inpatient acute care, but who needs more intensive nursing care than is provided at the skilled nursing level of care. Qualifying requirements for facilities to establish subacute levels of care, subacute patient care characteristics, and reimbursement principles are defined in the HAR Chapters 17-1737 and 17-1739.

40.400 Care Coordination/Case Management System

The health plan shall have a Care Coordination/Case Management (CC/CM) system that complies with the requirements in 42 CFR 438.208, and is subject to DHS approval. At a minimum, the CC/CM system shall provide for:

- Timely access and delivery of health care/services required by members;
- Continuity of members' care; and
- Coordination and integration of members' care.

This system shall function within the health plan's QAPI program to assist the PCP and other providers in the health plan's network to provide the care needed to optimize a member's health outcome, and must therefore, be readily accessible to the PCP and member, not placing unnecessary burdens on the PCP or compromising good medical care. As part of this CC/CM, the health plan shall, at a minimum, have in place processes and

protocols as noted in Appendix K, MQD QAPI Standards, Standard VIII: Continuity of Care System, including issues/standards relating to members with SHCN. These processes are:

- Providing care coordination to support the PCP and other providers in the network in providing good medical care to members;
- Providing referrals to members for care coordination or other programs or agencies;
- Coordinating with community programs that provide services to a member which are not covered by the programs;
- Providing continuity of care when members transition to other programs (e.g., behavioral health managed care plan, Medicaid fee-for-service program, Medicare);
- Providing continuity of care when members are discharged on medications which are normally prior authorized or not on the plan's formulary;
- Identifying members who have the greatest need for CC/CM, particularly those members who have chronic conditions;
- Coordinating services and ensuring continuity of care with other health plans from whom the member receives services; and
- Providing the results of its identification and assessment of any member with SHCNs to other QUEST health plans so that those activities are not duplicated.

The health plan shall also have procedures in place to ensure that, in the process of coordinating care, each member's privacy is protected consistent with confidentiality requirements of 45 CFR parts 160 and 164 and Section 71.200.

As part of the CC/CM system, the health plan shall ensure each member has a PCP who directs the member's care. The health plan shall educate members on accessing services and assist them in making informed decisions about their care.

The health plan shall also educate providers on its processes and procedures for receiving and approving referrals for treatment. Finally, the health plan shall have on staff or on contract, care coordinators who can assist the PCP in coordinating care for members with more complex needs, in obtaining translation services, in arranging for transportation, and in referring members to appropriate programs such as Zero-To-Three, Healthy Start, and Medicaid's Home and Community Based Waiver Programs.

40.500 Second Opinions

The health plan shall provide for a second opinion in any situation when there is a question concerning a diagnosis, the options for surgery or the treatment of a health condition when requested by the member, any member of the health care team, a parent(s) or legal guardian(s), or a DHS social worker exercising custodial responsibility. The second opinion shall be provided by a qualified health care professional within the network or the health plan shall arrange for the member to

obtain a second opinion outside the provider network. The second opinion shall be provided at no cost to the member.

40.600 Craniofacial Review Panel Recommendations

The health plan shall abide by all recommendations of the Panel, unless it can demonstrate alternative equally appropriate treatment that the Panel and the member's treatment team deem appropriate. The health plan's Medical Director(s) may appeal any of the Panel's recommendations to the Med-QUEST Medical Director.

The health plan shall aid in the coordination of treatment in cases involving coverage by more than one health plan and shall facilitate the processing of preauthorization requests and claims. If a member changes health plans (either through the annual plan change period or moves to another island), the "old" health plan shall assist the "new" health plan by providing information on the panel recommendations, the treatment provided, and the progress to date and shall coordinate with the "new" health plan to ensure a smooth transition.

40.700 Advance Directives

The health plan shall maintain written policies and procedures for advance directives in compliance with 42 CFR 438.6(i)(1)-(2) and 42 CFR 422.128. For purposes of this section, the term "MA organization" in 42 CFR 422.128 shall refer to the health plan. Such advance directives shall be included in each member's medical record. The health plan shall provide these policies to

all members 18 years of age or older and shall advise members of:

- Their rights under the law of the State of Hawaii, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives; and
- The health plan's written policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience. See 42 CFR 422.128(b)(1)(ii).

The information must include a description of current State law and must reflect changes in State laws as soon as possible, but no later than ninety (90) days after the effective date of the change. The health plan's information must inform members that complaints concerning noncompliance with the advance directive requirements may be filed with the DHS.

The health plan shall not condition the provision of care or otherwise discriminate against an individual based on whether or not a member has executed an advance directive. The health plan shall ensure compliance with requirements of Hawaii law regarding advance directives.

The health plan shall educate its staff about its advance directive policies and procedures, situations in which advance directives may be of benefit to members, and the health plan's responsibility to educate and assist members who choose to

make use of advance directives. The health plan shall educate members about their ability to direct their care using this mechanism and shall specifically designate which staff members or network providers are responsible for providing this education. The health plan shall provide these policies and procedures to its providers and upon request to CMS and DHS.

40.800 Behavioral Health Managed Care (BHMC) Health Plan

Adult members who have been initially determined by the health plan and confirmed by the DHS to have a SMI shall be enrolled in the behavioral health managed care (BHMC) plan. Children who are determined to be in need of the SEBD program will receive inpatient acute psychiatric and outpatient behavioral health services through the DOE and the DOH (See Section 30.770). There may be situations when an individual who needs SEBD presents to the health plan or provider for behavioral health services and the individual wishes to use health plan coverage for services. The health plan shall pay for these services if the following criteria are met:

1. The individual is enrolled in the health plan;
2. The provider is in the health plan's network;
3. The health plan has determined that the service(s) meets the criteria of medical necessity; and
4. The service is a covered Medicaid benefit.

The health plan shall be responsible for all behavioral health services provided to children that meet the criteria for SEBD. When the individual requests the health plan to provide the

services as opposed to DOE or DOH, in these circumstances, the health plan shall follow the procedures in Section 30.770. The DHS will reimburse the health plan for these services.

40.810 Health Plan Referral for an Evaluation

The health plan is responsible for making the initial determination of whether or not an adult member has a SMI (using the definition in Appendix J). Once the health plan has made this determination, the health plan shall refer the adult member to the DHS for an evaluation to confirm the initial diagnosis. The forms and procedures to be used may be found in the Bidder's Library.

Although most children and adolescents who meet the criteria for needing SEBD screens will be identified by the DOE, in the case that a health plan identifies a child it believes meets the criteria for needing SEBD screens but is not receiving services through the DOH or DOE, the health plan shall refer the child to CAMHD to determine if the child is eligible to receive services.

The health plan shall complete and include with all referrals, the necessary forms and documentation of illness (admission and discharge summaries, day hospital admission and discharge summaries, outpatient admission and discharge summaries, psychological test results, and other pertinent documents). The health plan is responsible for the cost of completing the forms and obtaining documentation. In the event that CAMHD requests that the member submit to an interview, the health

plan shall provide and pay for transportation to the evaluation site for child and parent/guardian.

If denied eligibility to SEBD services by CAMHD, CAMHD must provide written denial and notification of appeal rights. The health plan has the right to appeal any denial of SMI or SEBD determination to the DHS.

Appendix R provides a more detailed description of this process.

40.820 Enrollment into BHMC

The health plan shall be responsible for providing all behavioral health services to a member determined eligible for BHMC within the established benefit limits, until the BHMC plan enrollment date unless the member is in an inpatient setting on the date of enrollment in which case the member shall remain the health plan's responsibility until discharge. The health plan shall not receive any additional compensation for maintaining the CC/CM functions as these services are included in the capitation rate. The health plan shall be relieved of its responsibility for providing all behavioral health services and coordinating all behavioral health services relating to the member's care once he or she is enrolled in the BHMC plan. The health plan shall be responsible for medical services except for behavioral health services while the member is in a BHMC plan.

Upon determination by the DHS that a member no longer meets the criteria for enrollment in the BHMC plan, the DHS will disenroll the member and notify the health plan. Upon the date

of disenrollment from the BHMC plan, the health plan shall provide the appropriate mental health, drug abuse or alcohol abuse services within the established benefit limits.

The health plan shall coordinate all transfers, either into or out of the BHMC plan, of their members to ensure smooth transfers and to minimize care disruptions. The health plan shall coordinate medical services with the BHMC while the member is in a BHMC plan.

40.900 Out-of-State and Off-Island Coverage

The health plan shall provide any medically necessary covered treatments or services that are required by the member. If these services are not available in the State or on the island in which the member resides, the health plan shall provide for these services whether off-island or out-of-state. This includes referrals to an out-of-state or off-island specialist or facility, transportation to and from the referral destination for an off-island or out-of-state destination, lodging, and meals for the member and any needed attendant. However, if the service is available on a member's island of residence, the health plan may require the member to obtain the needed services from specified providers as long as the provider is in the same geographic location as the member and the member can be transferred.

The health plan shall provide out-of-state and off-island emergency medical services and post-stabilization services for all members and all out-of-state and off-island medically necessary EPSDT covered services to members under age twenty-one (21).

The health plan may require prior authorization for non-emergency off-island and out-of-state services.

The health plan shall be responsible for the transportation costs to return the individual, and their attendant if applicable, to the island of residence upon discharge from an out-of-state or off-island facility when services were approved by the health plan. Transportation costs for the return of the member to the island of residence shall be the health plan's responsibility even if the member is being or has been disenrolled from the health plan during the out-of-state or off-island stay.

Medical services in a foreign country are not covered for either children or adults.

41.100 Other Services to be Provided

41.110 Cultural Competency Plan

The health plan shall have a comprehensive written cultural competency plan that will:

- Identify the health practices and behaviors of the members;
- Design programs, interventions and services which effectively address cultural and language barriers to the delivery of appropriate and necessary health services;
- Describe how the health plan will ensure that services are provided in a culturally competent manner to all members so that all members including those with limited English

proficiency and diverse cultural and ethnic backgrounds understand their condition(s), the recommended treatment(s) and the effect of the treatment on their condition including side effects;

- Describe how the health plan will effectively provide services to people of all cultures, races, ethnic backgrounds and religions in a manner that recognizes, affirms and respects the worth of the individual members and protects and preserves the dignity of each; and
- Comply with, and ensure that providers participating in the health plan's provider network comply with, Title VI of the Civil Rights Act of 1964, 42 U.S.C. Section 2000d, 45 CFR Part 80 and 42 CFR 438(c)(2), 42 CFR 438.100(d), 42 CFR 438.6(d)(4) and (f)..

The health plan shall provide to all in-network providers a summary of the cultural competency plan that includes a summary of information on how the provider may access the full cultural competency plan from the health plan at no charge to the provider.

The health plan shall submit the cultural competency plan to the DHS for review and approval within thirty (30) days of contract award.

41.120 Transportation Services

The health plan shall provide transportation to and from medically necessary medical appointments for members who have no means of transportation, who reside in areas not served

by public transportation, or cannot access public transportation due to their disability.

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

In the event there is insufficient access to specialty providers (including but not limited to psychiatrists and APRN-Rxs), the health plan shall make arrangements to transport providers.

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

The health plan shall provide transportation for a member under the age of twenty-one (21), and their attendant, for medically

necessary evaluations required by the Craniofacial Review Panel and to attend case presentations by the Panel.

41.130 WIC Coordination

The health plan shall coordinate the referral of potentially eligible women, infants, and children to the Supplemental Nutrition Program for Women, Infants, and Children (WIC) program and the provision of health data within the timeframe required by WIC, from their providers.

41.140 Certification of Physical or Mental Impairment

The health plan shall provide for all re-evaluations of disability for the general assistance program for TANF recipients and Medicaid (evaluations submitted to the ADRC) except that the DHS is responsible for the following:

- The initial disability determination for all public financial assistance programs; and
- The re-evaluations of disability (determinations of continued mental or physical impairment) for the financial assistance program entitled General Assistance, except for TANF recipients.

The health plan shall utilize the panel of providers provided by the DHS for all evaluations for mental disability.

41.150 Foster Care/Child Welfare Services (CWS) Children

In addition to providing all medically necessary services under EPSDT, the health plan shall be responsible for providing the pre-placement physicals (prior to placement) and comprehensive examinations (within forty-five (45) days after placement into a foster care home) including medication dispensed when a physical examination shows a medical need, for children with an active case with CWS. A comprehensive examination shall have all of the components of an EPSDT visit and the health plan shall reimburse the provider the same rate as for an EPSDT visit. The health plan shall have procedures in place to assist CWS workers in obtaining a necessary physical examination within the established timeframe through a provider in its network. Physical examinations may take place in either an emergency room or physician's office. However, the health plan shall be responsible for the examination even if a network provider is unable to provide the examination. If the provider is not a network provider within the health plan the non-network provider must understand and perform all the components of the comprehensive EPSDT examinations and be a licensed provider.

The health plan shall be familiar with the medical needs of CWS children and shall identify person(s) within the health plan that may assist the foster parent/guardian and case worker to obtain appropriate needed services for the foster child. If a PCP change is necessary and appropriate (e.g., the child has been relocated), the health plan shall accommodate the PCP change request without restrictions.

The case worker may also request a change in health plan outside of the annual plan change period without limit if it is in the best interest of the child. Disenrollment shall be at the end of the month in which the request is made.

41.200 Transition of Care

The old health plan shall cooperate with the member and the new health plan in transitioning the care of a member who is enrolling in a new health plan. The health plan shall cooperate and assist the new health plan with obtaining the member's medical records and other vital information. If the member moves to a different service area in the middle of the month, the existing health plan shall remain responsible for the care and the cost of the services provided to the member for the remainder of the month or through discharge if the member is hospitalized. If the member is being discharged from an out-of-state or off-island facility, the old health plan is responsible for returning the individual to the island of residence and arranging for the transition services even if the individual is disenrolled from the health plan prior to discharge from the facility.

The new health plan shall honor all prior authorization requests for at least forty-five (45) days or until the member's medical needs have been assessed by the PCP assigned to the member in the new health plan.