

Table of Contents

SECTION 10 ADMINISTRATIVE OVERVIEW11

- 10.100 PURPOSE OF THE REQUEST FOR PROPOSAL.....11
- 10.200 AUTHORITY FOR ISSUANCE OF RFP.....12
- 10.300 ISSUING OFFICER.....12
- 10.400 USE OF SUBCONTRACTORS.....13
- 10.500 CAMPAIGN CONTRIBUTIONS BY STATE AND COUNTY CONTRACTORS13
- 10.600 ORGANIZATION OF THE RFP.....13

SECTION 20 RFP SCHEDULE AND REQUIREMENTS.....16

- 20.100 RFP TIMELINE.....16
- 20.200 ORIENTATION.....17
- 20.300 SUBMISSION OF WRITTEN QUESTIONS.....18
- 20.400 NOTICE OF INTENT TO PROPOSE19
- 20.500 TAX CLEARANCE.....19
- 20.600 CERTIFICATE OF GOOD STANDING20
- 20.700 DOCUMENTATION.....21
- 20.800 RULES OF PROCUREMENT.....22
 - 20.810 *No Contingent Fees*22
 - 20.820 *Discussions with Applicants*23
 - 20.830 *RFP Amendments*23
 - 20.840 *Costs of Preparing Proposal*24
 - 20.850 *Provider Participation in Planning*24
 - 20.860 *Disposition of Proposals*.....24
 - 20.870 *Rules for Withdrawal or Revision of Proposals*25
- 20.900 CONFIDENTIALITY OF INFORMATION.....26
- 21.100 ACCEPTANCE OF PROPOSALS27
- 21.200 SUBMISSION OF PROPOSALS27
- 21.300 DISQUALIFICATION OF APPLICANTS29
- 21.400 IRREGULAR PROPOSALS30
- 21.500 REJECTION OF PROPOSALS.....31
- 21.600 CANCELLATION OF RFP32
- 21.700 OPENING OF PROPOSALS32
- 21.800 ADDITIONAL MATERIALS AND DOCUMENTATION33
- 21.900 AWARD NOTICE33
- 22.100 PROTESTS33

SECTION 30 BACKGROUND AND DEPARTMENT OF HUMAN SERVICES RESPONSIBILITIES.....35

- 30.100 BACKGROUND AND SCOPE OF SERVICE.....35
 - 30.110 *Scope of Service*.....35
 - 30.120 *Background*.....35
- 30.200 DEFINITIONS/ACRONYMS36
- 30.300 PROGRAM POPULATION DESCRIPTIONS65

30.310	<i>QUEST</i>	65
30.320	<i>QUEST-Net</i>	67
30.330	<i>QUEST- ACE</i>	67
30.340	<i>Basic Health Hawaii</i>	67
30.350	<i>ACA Basic Health Option</i>	68
30.360	<i>Excluded Populations</i>	68
30.400	OVERVIEW OF THE DEPARTMENT OF HUMAN SERVICES (DHS) RESPONSIBILITIES	69
30.500	ELIGIBILITY AND ENROLLMENT RESPONSIBILITIES	72
30.510	<i>Eligibility Determinations</i>	72
30.520	<i>Enrollment Responsibilities</i>	72
30.530	<i>Initial Enrollment Period for Existing QUEST program Members</i>	76
30.540	<i>Newborn Enrollment</i>	77
30.550	<i>30-Day Grace Period</i>	77
30.560	<i>Annual Plan Change Period</i>	78
30.570	<i>Member Enrollment Limits/Caps</i>	79
30.580	<i>Member Education Regarding Status Changes</i>	81
30.600	DISENROLLMENT RESPONSIBILITIES.....	82
30.700	COVERED BENEFITS AND SERVICES PROVIDED BY THE DHS	85
30.710	<i>State of Hawaii Organ and Transplant (SHOTT) Program</i>	85
30.720	<i>PACE and Pre-PACE Programs</i>	87
30.730	<i>Dental Services</i>	87
30.740	<i>Intentional Termination of Pregnancies (ITOPs)</i>	90
30.800	COVERED BENEFITS AND SERVICES PROVIDED BY OTHER STATE AGENCIES.....	91
30.810	<i>School Based Services</i>	91
30.820	<i>Department of Health (DOH) Programs</i>	91
30.820.1	<i>Behavioral Health Services for Children/Support for Emotional and Behavioral Development (SEBD) Program</i>	91
30.820.2	<i>Kapi'olani Cleft and Craniofacial Clinic and DOH/Family Health Services Division/Children with Special Health Needs (CSHN) Branch</i>	94
30.820.3	<i>Vaccines for Children (VFC) Program</i>	95
30.820.4	<i>Zero-To-Three (Early Intervention) Program</i>	96
30.900	AID TO DISABLED REVIEW COMMITTEE (ADRC)	97
31.100	MONITORING AND EVALUATION	101
31.110	<i>Quality Assessment and Performance Improvement (QAPI) Program</i>	102
31.120	<i>External Quality Review/Monitoring</i>	102
31.130	<i>Case Study Interviews</i>	104
31.200	QUEST POLICY MEMORANDUMS	105
31.300	READINESS REVIEW	105
31.400	INFORMATION SYSTEMS	107
31.410	<i>Hawaii Prepaid Medical Management Information Systems (HPMMIS)</i>	107
SECTION 40	PROVISION OF SERVICES – HEALTH PLAN RESPONSIBILITIES.....	110
40.100	HEALTH PLAN’S ROLE IN MANAGED CARE & QUALIFIED HEALTH PLANS	110
40.200	PROVIDER NETWORK	111
40.210	<i>General Provisions</i>	111
40.220	<i>Specific Minimum Requirements</i>	114

40.230	Availability of Providers.....	118
40.240	Geographic Access of Providers.....	120
40.250	Primary Care Providers (PCPs).....	121
40.260	Direct Access to Women’s Health Specialists	126
40.270	Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs)	126
40.280	Certified Nurse Midwives, Pediatric Nurse Practitioners, Family Nurse Practitioners and Behavioral Health Nurse Practitioners.....	127
40.290	Rural Exceptions.....	128
40.300	PROVIDER “GAG RULE” PROHIBITION.....	129
40.400	PROVIDER CREDENTIALING, RECREDENTIALING AND OTHER CERTIFICATION	131
40.500	PROVIDER CONTRACTS	132
40.600	PROVIDER SERVICES	142
40.610	Provider Education.....	142
40.620	Provider Grievance System	145
40.630	Provider Manual.....	148
40.640	Provider Call-Center/Prior Authorization (PA) Line.....	154
40.650	Web-site for Providers.....	155
40.700	COVERED BENEFITS AND SERVICES	156
	General Overview.....	156
40.710	QUEST Programs.....	158
40.710.1	QUEST: QUEST Adult Benefit Package.....	158
40.710.2	QUEST: QUEST Keiki Benefit Package.....	161
40.720	Behavioral Health Services	162
40.720.1	Additional Behavioral Health Services for Adults.....	163
40.730	Long-Term Care Services.....	164
40.740	Coverage Provisions.....	164
40.740.1	Coverage Provisions for Primary and Acute Care Services.....	164
40.740.2	Coverage Provisions for Behavioral Health Services	194
40.740.2.a	Standard Behavioral Health Services.....	194
40.740.2.b	Additional Behavioral Health Services for Children.....	197
40.740.2.c	Additional Intensive Interventions or Behavioral Health Services for Adults	197
40.740.2.d	Adverse Events Policy/Reporting and other Behavioral Health Reporting.....	204
40.750	Other Covered Services.....	205
40.751	Services for Members with Special Health Care Needs (SHCNs).....	205
40.752	Care Coordination / Case Management System.....	209
40.753	Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services for Children	212
40.754	Treatment for Adults with Diagnosis of Cancer	219
40.760	Other Coordination Activities.....	219
40.761	WIC Coordination	219
40.762	Foster Care/Child Welfare Services (CWS) Children	220
40.763	Collaboration with the Alcohol and Drug Abuse Division (ADAD).....	221
40.764	Kapi’olani Cleft and Craniofacial Clinic and DOH/Family Health Services Division/Children with Special Health Needs (CSHN) Branch.....	222
40.800	OTHER SERVICES TO BE PROVIDED.....	222
40.801	Cultural Competency.....	222

40.802	<i>Disease Management</i>	224
40.803	<i>Certification of Physical/Mental Impairment</i>	226
40.900	SECOND OPINION	226
41.100	OUT OF STATE/OFF ISLAND COVERAGE	226
41.200	ADVANCED DIRECTIVES.....	228
41.300	TRANSITION OF CARE TO AND FROM THE HEALTH PLAN.....	229
41.310	<i>Transition to the Health Plan</i>	229
41.320	<i>Transition from the Health Plan</i>	230
41.330	<i>Transition of Care Policies and Procedures</i>	232
SECTION 50	HEALTH PLAN ADMINISTRATIVE REQUIREMENTS.....	233
50.100	HEALTH PLAN ELIGIBILITY RESPONSIBILITIES	233
50.200	HEALTH PLAN ENROLLMENT RESPONSIBILITIES	233
50.210	<i>Health Plan Responsibilities Related to Enrollment Changes Occurring When a Member is Hospitalized</i>	235
50.220	<i>PCP Selection</i>	237
50.230	<i>Member Status Change</i>	237
50.240	<i>Enrollment for Newborns</i>	238
50.250	<i>Enforcement of Documentation Requirements</i>	238
50.260	<i>Informational Brochure</i>	238
50.300	DISENROLLMENT	238
50.310	<i>Acceptable Reasons for Health Plan Disenrollment Requests</i>	238
50.320	<i>Unacceptable Reasons for Health Plan Initiated Disenrollment Requests</i>	239
50.330	<i>Aid to Disabled Review Committee (ADRC)</i>	239
50.340	<i>State of Hawaii Organ and Tissue Transplant (SHOTT) Program</i>	239
50.400	MEMBER SERVICES	240
50.410	<i>General Requirements</i>	240
50.420	<i>Member Education</i>	241
50.430	<i>Requirements for Written Materials</i>	243
50.440	<i>Member Handbook Requirements</i>	245
50.450	<i>Member Rights</i>	249
50.460	<i>Provider Directory</i>	251
50.470	<i>Member Identification (ID) Card</i>	253
50.480	<i>Member Toll-Free Call Center</i>	254
50.490	<i>Internet Presence/Web-Site</i>	256
50.495	<i>Interpretation Services</i>	257
50.500	VALUE-DRIVEN HEALTH CARE.....	257
50.510	<i>Background</i>	257
50.520	<i>Primary Care Providers</i>	258
50.530	<i>Hospitals</i>	261
50.540	<i>Vertically Integrated Organizations</i>	261
50.550	<i>Value-Driven Health Care Schedule</i>	262
50.600	MARKETING AND ADVERTISING	263
50.610	<i>Allowable Activities</i>	263
50.620	<i>Prohibited Activities</i>	264
50.630	<i>State Approval of Materials</i>	265

50.700	QUALITY IMPROVEMENT	266
50.710	<i>Accreditation</i>	266
50.720	<i>General Provisions</i>	266
50.730	<i>Quality Assessment and Performance Improvement (QAPI) Program</i>	269
50.740	<i>Medical Records Standards</i>	274
50.750	<i>Performance Improvement Projects (PIPs)</i>	278
50.760	<i>Practice Guidelines</i>	280
50.770	<i>Performance Measures</i>	282
50.780	<i>Performance Incentives</i>	283
50.790	<i>Non-duplication Strategy</i>	283
50.800	UTILIZATION MANAGEMENT PROGRAM (UMP)	284
50.900	AUTHORIZATION OF SERVICES	288
51.100	MEMBER GRIEVANCE SYSTEM	291
51.105	<i>General Requirements</i>	291
51.110	<i>Recordkeeping</i>	293
51.115	<i>Inquiry Process</i>	294
51.120	<i>Authorization of Representation (AOR)</i>	294
51.125	<i>Grievance Process</i>	295
51.130	<i>State Grievance Review</i>	296
51.135	<i>Appeals Process</i>	297
51.140	<i>Expedited Appeal Process</i>	300
51.145	<i>State Administrative Hearing for Regular Appeals</i>	302
51.150	<i>Expedited State Administrative Hearings</i>	303
51.155	<i>Continuation of Benefits During an Appeal or State Administrative Hearing</i>	304
51.165	<i>Notice of Action</i>	306
51.200	INFORMATION TECHNOLOGY	310
51.210	<i>General Requirements</i>	310
51.220	<i>Expected Functionality</i>	310
51.230	<i>Method of Data Exchange with MQD</i>	311
51.240	<i>Compliance with the Health Insurance Portability and Accountability Act (HIPAA)</i>	311
51.250	<i>Possible Audits of Health Plan Information Technology</i>	311
51.260	<i>Health Plan Information Technology Changes</i>	312
51.270	<i>Disaster Planning and Recovery Operations</i>	312
51.300	FRAUD & ABUSE	312
51.310	<i>General Requirements</i>	312
51.320	<i>Reporting and Investigating Suspected Fraud and Abuse</i>	313
51.330	<i>Compliance Plan</i>	315
51.340	<i>Employee Education About False Claims Recovery</i>	317
51.350	<i>Child and Adult Abuse Reporting Requirements</i>	318
51.400	HEALTH PLAN PERSONNEL	318
51.410	<i>General Requirements</i>	318
51.420	<i>Specific Descriptions</i>	322
51.500	REPORTING REQUIREMENTS	325
51.510	<i>General Requirements</i>	325
51.520	<i>Provider Network and Service Reports</i>	331
51.520.1	<i>Provider Network Adequacy and Capacity Report</i>	331

51.520.2	<i>GeoAccess (Or Similar Program) Reports</i>	333
51.520.3	<i>PCP Report</i>	334
51.520.4	<i>Timely Access Report</i>	335
51.520.5	<i>FQHC or RHC Services Rendered Report</i>	336
51.520.6	<i>Provider Suspensions and Termination Report</i>	337
51.520.7	<i>Provider Complaints and Claims Report</i>	337
51.520.8	<i>Value-Driven Health Care Report</i>	339
51.530	<i>Covered Benefits and Services Reports</i>	339
51.530.1	<i>CMS 416 Report – EPSDT</i>	339
51.540	<i>Member Services Reports</i>	340
51.540.1	<i>Outreach for Medical Assistance Eligibility Renewal</i>	340
51.540.2	<i>Call Center Report</i>	340
51.540.3	<i>Interpretation Services Report</i>	341
51.540.4	<i>Requests for Documents in Alternate Languages Report</i>	342
51.540.5	<i>Member Grievance and Appeals Report</i>	342
51.540.6	<i>CAHPS® Consumer Survey</i>	343
51.540.7	<i>Special Health Care Needs (SHCN) Report</i>	343
51.540.8	<i>Behavioral Health Services Report</i>	344
51.540.9	<i>ADRC Report</i>	345
51.550	<i>Quality Assessment and Performance Improvement (QAPI) Program Reports</i>	345
51.550.1	<i>Accreditation Update</i>	345
51.550.2	<i>QAPI Program Description</i>	346
51.550.3	<i>Performance Improvement Projects (PIP) Report</i>	347
51.550.4	<i>Health Plan Employer Data and Information Set (HEDIS) Report</i>	347
51.560	<i>Utilization Management Reports</i>	348
51.560.1	<i>Prior Authorization Requests Denied/Deferred</i>	348
51.560.2	<i>Report of Over-Utilization and Under-Utilization of Drugs</i>	349
51.560.3	<i>Report of Over-Utilization and Under-Utilization of Services</i>	350
51.570	<i>Administration and Financial Reports</i>	351
51.570.1	<i>Fraud and Abuse Summary Reports</i>	351
51.570.2	<i>Provider Education and Training Report</i>	352
51.570.3	<i>Employee Suspension and Termination Report</i>	352
51.570.4	<i>QUEST Financial Reporting Guide</i>	353
51.570.5	<i>Third Party Liability (TPL) Cost Avoidance Report</i>	353
51.570.6	<i>Disclosure of Information on Annual Business Transaction Report</i>	354
51.570.7	<i>Encounter Data/Financial Summary Reconciliation Report</i>	356
51.570.8	<i>Medicaid Contracting Report</i>	356
51.570.9	<i>QUEST Dashboard</i>	356
51.580	<i>Encounter Data Reporting</i>	357
51.580.1	<i>Accuracy, Completeness and Timeliness of Encounter Data Submissions</i>	357
51.600	<i>REPORT SUBMISSION</i>	359
51.610	<i>Financial Penalties and Sanctions</i>	359
51.620	<i>Health Plan Certification</i>	360
51.630	<i>Follow-Up by Health Plans/Corrective Action Plans/Policies and Procedures</i>	361
51.700	<i>READINESS REVIEW</i>	362
51.710	<i>Required Review Documents</i>	362

51.720	Updated GeoAccess Reports.....	367
51.730	Health Plan Provider Network.....	367
SECTION 60	FINANCIAL RESPONSIBILITIES.....	368
60.100	THE DHS RESPONSIBILITIES	368
60.110	Daily Rosters/Health Plan Reimbursement	368
60.120	Capitation Payments for Changes in Rate Codes.....	369
60.130	Collection of Premium Shares for Members.....	370
60.140	Gain Share Program	370
60.200	INCENTIVES FOR HEALTH PLAN PERFORMANCE.....	370
60.210	Childhood Immunizations (20%).....	373
60.220	Plan All-Cause Readmissions (30%).....	373
60.230	Controlling High Blood Pressure (15%).....	373
60.240	Comprehensive Diabetes Care (20%)	373
60.250	Getting Needed Care (15%)	374
60.300	HEALTH PLAN RESPONSIBILITIES	374
60.310	Provider and Subcontractor Reimbursement.....	374
60.320	Non-Covered Services	378
60.330	Physician Incentives	379
60.340	Payment for Health Care Acquired Conditions (HAC)	380
60.350	Co-Payments.....	380
60.400	THIRD PARTY LIABILITY (TPL).....	381
60.410	Background.....	381
60.420	Responsibilities of the DHS	382
60.430	Responsibilities of the Health Plan.....	382
60.500	CATASTROPHIC CARE.....	384
60.510	Introduction	384
60.520	The DHS Responsibilities Regarding Catastrophic Care.....	384
60.530	Health Plan Responsibilities Regarding Catastrophic Care	385
SECTION 70	SPECIAL TERMS AND CONDITIONS.....	388
70.100	CONTRACT DOCUMENTS	388
70.200	CONFLICT BETWEEN CONTRACT DOCUMENTS, STATUTES AND RULES.....	388
70.300	LICENSING AND ACCREDITATION	390
70.400	SUBCONTRACTOR AGREEMENTS	390
70.500	RETENTION OF MEDICAL RECORDS.....	394
70.600	RESPONSIBILITY FOR TAXES	395
70.700	FULL DISCLOSURE.....	396
70.710	Business Relationships.....	396
70.720	Litigation	397
70.800	CONFLICT OF INTEREST	397
70.900	EMPLOYMENT OF DEPARTMENT PERSONNEL	397
71.100	FISCAL INTEGRITY.....	398
71.110	Warranty of Fiscal Integrity.....	398
71.120	Performance Bond.....	398
71.200	TERM OF THE CONTRACT	400

71.300	INSURANCE.....	402
71.310	<i>Liability Insurance Requirements</i>	402
71.320	<i>Reinsurance</i>	405
71.400	MODIFICATION OF CONTRACT.....	405
71.500	CONFORMANCE WITH FEDERAL REGULATIONS.....	406
71.600	TERMINATION OF THE CONTRACT.....	406
71.610	<i>Termination for Default</i>	406
71.620	<i>Termination for Expiration or Modification of the Programs by CMS</i>	407
71.630	<i>Termination for Bankruptcy or Insolvency</i>	408
71.640	<i>Procedure for Termination</i>	409
71.650	<i>Termination Claims</i>	412
71.700	CONFIDENTIALITY OF INFORMATION.....	413
71.800	AUDIT REQUIREMENTS.....	416
71.810	<i>Accounting Records Requirements</i>	416
71.820	<i>Inclusion of Audit Requirements in Subcontracts</i>	417
71.900	ONGOING INSPECTION OF WORK PERFORMED.....	417
72.100	DISPUTES.....	418
72.200	LIQUIDATED DAMAGES, SANCTIONS AND FINANCIAL PENALTIES.....	419
72.210	<i>Liquidated Damages</i>	419
72.220	<i>Sanctions</i>	419
72.230	<i>Special Rules for Temporary Management</i>	423
72.300	COMPLIANCE WITH LAWS.....	424
72.310	<i>Wages, Hours and Working Conditions of Employees Providing Services</i>	425
72.320	<i>Compliance with other Federal and State Laws</i>	425
72.400	MISCELLANEOUS SPECIAL CONDITIONS.....	427
72.410	<i>Use of Funds</i>	427
72.420	<i>Prohibition of Gratuities</i>	427
72.430	<i>Publicity</i>	427
72.440	<i>Force Majeure</i>	428
72.450	<i>Attorney's Fees</i>	428
72.460	<i>Time is of the Essence</i>	429
SECTION 80	MANDATORY AND TECHNICAL PROPOSAL	430
80.100	INTRODUCTION.....	430
80.200	MANDATORY REQUIREMENTS.....	431
80.210	<i>Attachment: Transmittal Letter</i>	431
80.220	<i>Company Background Narrative</i>	433
80.230	<i>Attachment: Other Documentation</i>	434
80.240	<i>Attachment: Risk Based Capital</i>	435
80.300	TECHNICAL PROPOSAL.....	435
80.310	<i>Experience and References (12 pages maximum not including attachments)</i>	435
80.315	<i>Provider Network and Services (30 pages maximum not including attachments)</i>	439
80.315.1	<i>Provider Network Narrative (included in page maximum)</i>	439
80.315.2	<i>Attachment: Required Providers (not included in page maximum)</i>	440
80.315.3	<i>Attachment: Maps of Providers (not included in page maximum)</i>	444
80.315.4	<i>Availability of Providers Narrative (included in page maximum)</i>	444

80.315.5	Provider Services Narrative – General Requirements (included in page maximum).....	445
80.320	Covered Benefits and Services (30 pages maximum)	445
80.320.1	Covered Benefits and Services Narrative	445
80.320.2	Behavioral Health Narrative	446
80.320.3	Prescription Drug Narrative	447
80.320.4	Early and Periodic Screening Diagnosis and Treatment (EPSDT) Narrative	447
80.320.5	Care Coordination/Case Management (CC/CM) System/Services Narrative	448
80.320.6	Transition of Care Narrative	450
80.325	Member Services (18 pages maximum)	451
80.325.1	Member Services Narrative - General Member Services	451
80.325.2	Member Services Narrative - Toll-free Call Center and Twenty-Four Hour Nurse Line.....	451
80.325.3	Member Grievance System Narrative.....	452
80.330	Quality Assessment and Performance Improvement (QAPI) (36 pages maximum).....	453
80.330.1	QAPI Narrative – QAPI Program	453
80.330.2	QAPI Narrative – General Provisions.....	455
80.330.3	QAPI Narrative – Value-Based Purchasing	455
80.330.4	QAPI Narrative - Performance Measures	456
80.330.5	QAPI Narrative - Delegation of QAPI Program Activities	456
80.330.6	QAPI Narrative - Medical Records Standards	457
80.330.7	QAPI Narrative – Practice Guidelines.....	457
80.330.8	Disease Management (DM) Programs Narrative.....	457
80.335	Utilization Management Program and Authorization of Services (8 pages maximum).....	458
80.335.1	Utilization Management Program (UMP) Narrative	458
80.340	Health Plan Administrative Requirements (18 pages maximum)	459
80.340.1	Health Plan Administrative Requirements Narrative - Fraud and Abuse	459
80.340.2	Health Plan Administrative Requirements Attachment and Narrative - Organization Charts (Attachment) and Narrative on Organization Charts	460
80.340.3	Health Plan Administrative Requirements Narrative - Organization and Staffing Table.....	460
80.340.4	Health Plan Administrative Requirements Narrative - Reporting Requirements	460
80.340.5	Health Plan Administrative Requirements Narrative – Encounter Data Reporting Requirements.....	461
80.340.6	Health Plan Administrative Requirements Narrative- Information Technology	461
80.340.7	Financial Responsibilities Narrative - Third Party Liability.....	463
SECTION 90	RATE STRUCTURE	464
90.100	INTRODUCTION.....	464
90.200	OVERVIEW OF THE RATE STRUCTURE	464
90.300	RATE DEVELOPMENT	465
90.400	FUTURE RATE SETTING	467
SECTION 100	EVALUATION AND SELECTION.....	468
100.100	INTRODUCTION.....	468
100.200	EVALUATION COMMITTEE(S)	469
100.300	MANDATORY PROPOSAL EVALUATION	469
100.400	TECHNICAL PROPOSAL EVALUATION	470
100.500	SELECTION OF APPLICANTS	471

Appendices

Appendix A Written Question Format

Appendix B Proposal Application Identification Form (SPO-H 200)

Appendix C Gain Share Program

Appendix D Dental Procedures Which are the Responsibility of the Health Plan

Appendix E SEBD Program Services

Appendix F Covered Preventive Services for Adults and Children

Appendix G SMI Diagnoses for Adults

Appendix H DHS 1147 and Instructions

Appendix I EPSDT Information

Appendix J QUEST Memo ADM-1009

Appendix K DHS Contracting Documents

Appendix L Proposal Forms

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 at the time of proposal submission to provide improved access and enhanced quality healthcare services to eligible non-aged, non-disabled members for medically necessary medical and behavioral health services. 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 the date identified in Section 20.100.

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

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

10.200 Authority for Issuance of RFP

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

10.300 Issuing Officer

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

Ms. Patricia M. Bazin

Department of Human Services/Med-QUEST Division

1001 Kamokila Boulevard, Suite 317

Kapolei, Hawaii 96707

Telephone: (808) 692-7739

10.400 Use of Subcontractors

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

10.500 Campaign Contributions by State and County Contractors

Pursuant to section 11-205.5, HRS, campaign contributions are prohibited from specified State or county government contractors during the term of the contract if the contractors are paid with funds appropriated by a legislative body. For more information, refer to the Campaign Spending Commission webpage (www.hawaii.gov/campaign).

10.600 Organization of the RFP

This RFP is composed of 10 sections plus appendices:

- Section 10 – Administrative Overview – Provides general information on the purpose of the RFP, the authorities relating to the issuance of the RFP, the use of subcontractors and the organization of the RFP.
- Section 20 – RFP Schedule and Requirements - Provides information on the rules and schedules for procurement.
- Section 30 – Background and DHS Responsibilities – Describes the current Medicaid populations 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 – Special Terms and Conditions – Describes the terms and conditions under which the work shall be performed.
- Section 80 – Technical Proposal – Defines the required format of the technical proposal and the minimum information to be provided in the proposal.
- Section 90 – Proposed Capitation Rates – Defines the methodology that DHS uses for setting capitation rates.
- Section 100 – Evaluation and Selection – Defines the evaluation criteria and explains the evaluation process.

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

SECTION 20 RFP SCHEDULE AND REQUIREMENTS

20.100 RFP Timeline

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

Issue RFP	August 8, 2011
Orientation	August 15, 2011
Submission of Written Technical Proposal Questions	August 22, 2011
Notice of Intent to Propose	August 29, 2011
Written Responses to Technical Proposal Questions	September 14, 2011
Proposal Due Date	October 7, 2011
Proposal Evaluation Period	October 8 to November 11, 2011
Issue Proposed Capitation Rates with Supporting Documentation	October 7, 2011
Proposed Capitation Rates Orientation	October 17, 2011
Submission of Written Proposed Capitation Rate Questions	October 19, 2011
Written Responses to Proposed Capitation Rate Questions	November 2, 2011
Issue Final Capitation Rates	November 7, 2011
Capitation Rate Meeting with Applicants to discuss Final Capitation Rates	November 9, 2011
Contract Award	November 14, 2011
Contract Effective Date	December 1, 2011
Commencement of Services to Members	April 1, 2012
Commencement of Quality Portion of Auto-Assignment	July 1, 2013

20.200 Orientation

An orientation for applicants in reference to this RFP will be held on the date identified in Section 20.100 from 9:00 to 10:00 am Hawaii Standard Time (H.S.T.) Room 577A in the Kakuhihewa Building, 601 Kamokila Boulevard, Kapolei, Hawaii. In addition, applicants may access the orientation via teleconference at:

Call-In Number: 1-866-792-1155

Access Code: 655369

A second orientation for applicants for the proposed capitation rates will be held on the date identified in Section 20.100 from 9:00 to 11:00 am H.S.T. via meeting in person, via teleconference, or by another method deemed appropriate by DHS.

Applicants 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 must be submitted in writing on the date identified in Section 20.100 in accordance with the process identified in Section 20.300, Submission of Written Questions.

20.300 Submission of Written Questions

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

Dona Jean Watanabe
Med-QUEST Division-Finance Office
1001 Kamokila Boulevard, Suite 317
Kapolei, Hawaii 96707-2005
Email Address: questrfp@medicaid.dhs.state.hi.us

The written questions shall reference the RFP section, page and paragraph number in the format provided in Appendix A. Applicants must submit written questions on the technical proposal by 12:00 p.m. (H.S.T.) on the date identified in Section 20.100, and on the proposed capitation rates by 4:30 p.m. (H.S.T) on the date identified in Section 20.100. The DHS shall respond to the written questions no later than the date identified in Section 20.100. No verbal responses shall be considered as official.

20.400 Notice of Intent to Propose

Applicants shall submit a Notice of Intent to Propose to the Issuing Officer no later than the date identified in Section 20.100. Submission of a Notice of Intent to Propose is not a prerequisite for the submission of a proposal, but it is necessary that the Issuing Officer receive the letter by this deadline to assure proper distribution of amendments, questions and answers and other communication regarding this RFP.

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

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

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) is 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. 2010) which is available at the DOTAX and IRS office in the State of Hawaii or the DOTAX website, and by mail or fax:

DOTAX Website (Forms <http://www.state.hi.us/tax/tax.html> & Information):
DOTAX Information: 1-800-222-3329

The applicant 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 shall be required to obtain a Certificate of Good Standing from the State of Hawaii, 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” that may be obtained from <http://hawaii.gov/dcca/breg/online>. To register or to obtain a “Certificate of Good Standing” by phone, call (808) 586-2727 (M-F 7:45 a.m. to 4:30 p.m. H.S.T.). 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 Documentation

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

- EPSDT Periodicity Schedule
- Health plan reporting forms
- HEDIS
- Medicaid Fee Schedule

- Medicaid Provider Manual
- Memoranda of Agreements between DHS and DOH
- Performance Improvement Projects (PIP) policy
- QUEST Health Plan Enrollment Manuals
- QUEST Policy Memorandum (2009 to present)
- QUEST Financial Reporting Guide
- Other pertinent data

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

20.800 Rules of Procurement

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

20.810 No Contingent Fees

No applicant shall employ any company or person, other than a bona fide employee working solely for the applicant or company regularly employed as its marketing agent, to solicit or secure this contract, nor shall it pay or agree to pay any company or person, other than a bona fide employee working solely for the applicant or a company regularly employed by the applicant as its marketing

agent, any fee commission, percentage, brokerage fee, gift, or other consideration contingent upon or resulting from the award of a contract to perform the specifications of this RFP.

20.820 Discussions with Applicants

A. Prior To Submittal Deadline:

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

B. After Proposal Submittal Deadline:

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

20.830 RFP Amendments

The DHS reserves the right to amend the RFP any time prior to the closing date for the submission of the proposals. Amendments shall be sent to all applicants who requested copies of the RFP from the DHS pursuant to Section 20.400.

20.840 Costs of Preparing Proposal

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

20.850 Provider Participation in Planning

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

20.860 Disposition of Proposals

All proposals become the property of the State of Hawaii. The successful proposal shall be incorporated into the contract. A copy of successful and unsuccessful proposal(s) shall be public record as part of the procurement file as described in Section 3-143-616, HAR, pursuant to Chapter 103F, HRS. The State of Hawaii shall have the right to use all ideas, or adaptations to those ideas, contained in any proposal received in response to

this RFP. Selection or rejection of the proposal shall not affect this right. Written requests for an explanation of rejection shall be responded to in writing within five (5) business days of receipt.

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

20.870 Rules for Withdrawal or Revision of Proposals

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

After the Proposal Due Date as defined in Section 20.100, all proposals timely received shall be deemed firm offers that are binding on the applicants for ninety (90) days.

During this period, applicants may neither modify nor withdraw its proposals without written authorization or invitation from the DHS.

20.900 Confidentiality of Information

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

21.100 Acceptance of Proposals

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

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

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

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

21.200 Submission of Proposals

Each qualified applicant shall submit only one (1) proposal. More than one (1) proposal shall not be accepted from any applicant. The Proposal Application Identification (Form

SPO-H-200) shall be completed and submitted with the proposal (Appendix B).

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

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-2011-003
QUEST Managed Care to Cover Medicaid and Other Eligible
Individuals Who Are Not Aged, Blind or Disabled
Technical Proposal
(Name of Applicant)

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

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

21.300 Disqualification of Applicants

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

- Proof of collusion among applicants, in which case all bids involved in the collusive action shall be rejected and any applicant participating in such collusion shall be barred from future bidding until reinstated as a qualified applicant;
- An applicant's lack of responsibility and cooperation as shown by past work or services;

- An applicant's being in arrears on existing contracts with the State or having defaulted on previous contracts;
- An applicant shows any noncompliance with applicable laws;
- An applicant's delivery of proposal after the proposal due date;
- An applicant's failure to pay, or satisfactorily settle, all bills overdue for labor and material on former contracts with the State at the time of issuance of this RFP;
- An applicant's lack of financial stability and viability;
- An applicant's consistently substandard performance related to meeting the MQD requirements from previous contracts;
- An applicant's lack of sufficient experience to perform the work contemplated;
- An applicant's lack of proper provider network; or
- An applicant's lack of a proper license to cover the type of work contemplated if required to perform the required services.

21.400 Irregular Proposals

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

- The transmittal letter is unsigned by an applicant or does not include 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 applicant 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.

21.500 Rejection of Proposals

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

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

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

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

21.600 Cancellation of RFP

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

21.700 Opening of Proposals

Proposals, modifications to proposals, and withdrawals of proposals shall be date-stamped and, when possible, time-stamped upon receipt by the DHS. All documents so received shall be held in a secure place by the state-purchasing agency and not 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.

21.800 Additional Materials and Documentation

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

21.900 Award Notice

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

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

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

22.100 Protests

Applicants may file a Notice of Protest against the awarding of the contract. The Notice of Protest form, SPO-H-801, is available on the State Procurement Office (SPO) website <http://hawaii.gov/spo/spoh/> in the Quicklinks/Forms and Instructions for Private Providers and Applicants section. Only the following may be protested:

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

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

Head of State Purchasing Agency	Chief Procurement Officer for DHS
Name: Kenneth S. Fink, MD, MGA, MPH	Name: Patricia McManaman, Esq.
Title: Administrator	Title: Chief Procurement Officer
Mailing Address: P.O. Box 700190 Honolulu, Hawaii 96709-0190	Mailing Address: P.O Box 339 Kapolei, Hawaii 96809-0339
Business Address: 1001 Kamokila Boulevard, Suite 317 Kapolei, Hawaii 96707	Business Address: 1001 Kamokila Boulevard, Suite 317 Kapolei, Hawaii 96707

SECTION 30 BACKGROUND AND DEPARTMENT OF HUMAN SERVICES RESPONSIBILITIES

30.100 Background and Scope of Service

30.110 Scope of Service

The State of Hawaii seeks to improve the health care and to enhance and expand coverage for persons eligible for Medicaid, State Children’s Health Insurance Program (SCHIP), and for the uninsured and underinsured by the most cost effective and efficient means through the QUEST 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 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 to slow the rate of expenditure growth associated with managed care;

- Provide access to and receive coordinated and comprehensive high quality health care; and
- Expand and strengthen a sense of member responsibility that leads to a more appropriate utilization of the health care system.

30.200 Definitions/Acronyms

Abuse - Any practices that are inconsistent with sound fiscal, business, or medical practice and result in unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards or contractual obligations (including the terms of the RFP, contracts and requirements of state and federal regulations) for health care in the managed care setting. Incidents or practices of providers that is inconsistent with accepted sound medical practices.

Action (may also be referred to as an adverse 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 Section 40.230 (availability of providers);

- the failure of the health plan to act 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.

Acute Care – Medical care provided under the direction of a physician for a condition having a relatively short duration.

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

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.

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

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 period established by the DHS during which existing members may transfer between health care plans.

Appeal - A request for review of an action.

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

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

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

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

Basic Health Hawaii (BHH) - BHH is the program through which individuals ineligible for Medicaid/CHIP due to citizenship status receives QUEST Programs benefit packages.

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

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

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

Benefit Year - The calendar year from January 1 to December 31. In the event the contract is not in effect for the full calendar year, any benefit limits shall be pro-rated. For example, if the contract is effective for six (6) months of the calendar year, the benefit limit shall be one-half the limit per benefit year.

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

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 member'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 that is determined by contractual agreement between the DHS and the health plan in a benefit year defined in Section 30.200.

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

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

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

Chronic Condition – Any on-going physical, behavioral, or cognitive disorder, including chronic illnesses, impairments and disabilities. There is an expected duration of at least twelve (12) months with resulting functional

limitations, reliance on compensatory mechanisms and service use or needs beyond what is normally considered routine.

Claim - A 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.

Cold-Call Marketing – Any unsolicited personal contact by the health plan with a potential member or member for 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, Federally Qualified Health Center (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 that includes 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 that are designated by the DHS.

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

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

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

Cultural Competency – A set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance, and respect for cultural differences and similarities within, among and between groups and the sensitivity to know how these differences

influence relationships with members. This requires a willingness and ability to draw on community-based values, traditions and customs, to devise strategies to better meet culturally diverse member needs, and to work with knowledgeable persons of and from the community in developing focused interactions, communications and other supports.

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

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

Dental Emergency - An oral condition that does not include services aimed at restoring or replacing teeth and shall include services for relief of dental pain, eliminate acute infection, treat acute injuries to teeth or supportive structures of the oro-facial complex.

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

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

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

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) – A mandated program under Title XIX of the Social Security Act that provides services for children up to age 21 years that emphasizes the importance of prevention through early screening for medical, dental and behavioral health conditions and timely treatment of conditions that are detected. The State covers all services under Title XIX of the Social Security Act that are included in Section 1905 (a) of the Social Security Act, when medically needed, to correct or ameliorate defects and physical and mental illness and conditions discovered as a result of EPSDT screening. The State is required to report on an annual basis its provisions of the EPSDT program's services.

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 based on 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 member enrolled in the health plan on the date of service.

Encounter Data - A compilation of encounters.

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

Enrollee (Potential) – A Medicaid member 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 Potential Member.

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.

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

External Review - A review process available to a member pursuant to Hawaii Revised Statutes Section 432E-6, as amended by Act 230, SLH 2011.

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

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

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

Gain Share – The gains associated with health plan savings related to health care expenses that are shared between the health plan and the DHS (see Appendix C).

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

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 (HAWI) System - The State of Hawaii certified system that maintains eligibility information for Temporary Assistance for Needy Families/Temporary Assistance for Other Needy Families (TANF/TAONF), General Assistance (GA), Aid to the Aged, Blind, and Disabled (AABD), Aid to Families with Dependent Children (AFDC), Supplemental Nutrition Assistance Program (SNAP) and Medical Assistance members.

Hawaii Prepaid Medical Management Information System (HPMMIS) – Federally certified Medicaid Management Information System (MMIS) used for the processing, collecting, analysis and reporting of information needed to support Medicaid and 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, licensed clinical social worker, 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 that are developed by the National Committee for Quality Assurance (NCQA).

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

HIPAA – The Health Insurance Portability and Accountability Act that was enacted in 1996. Title I of HIPAA protects health insurance coverage for workers and their families when they change or lose their jobs. Title II, the Administrative Simplification (AS) provisions, requires the establishment of national standards for electronic healthcare transactions and national identifiers for providers, health insurance plans and employers. The HIPAA AS provisions also address the security and privacy of health information.

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 health plans that provide most services in-house or for capitated facilities), whichever is less. Incurred costs are based on the service date or admission date in the case of hospitalization. For example, all hospital costs for a patient admitted on December 22, 2010 and discharged on January 5, 2011 would be associated with the 2010 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 requests disenrollment, but does not express dissatisfaction.

Interperiodic Screens - EPSDT screens that occur between the comprehensive EPSDT periodic screens for determining the existence of physical or mental illnesses or conditions. An example of an interperiodic screen is a

physical examination required by the school before a child can participate in school sports and a comprehensive periodic screen was performed more than three (3) months earlier.

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

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

Marketing – Any communication from a health plan to a member or potential enrollee who is not yet enrolled in the health plan, that can reasonably be interpreted as

intending to influence the member or potential enrollee to enroll in the particular health plan, or dissuade them from enrolling into, or disenrolling from, another health plan.

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

Medicaid - 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 members of federally aided public assistance and Supplemental Security Income (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 Facility – An inpatient hospital or surgical outpatient facility.

Medical Necessity – As defined in Section 432E-1.4, HRS.

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 health professional services of physicians, other health professionals and paramedical personnel that are generally and customarily provided in the service area and performed, prescribed, or directed by the attending physician or other provider.

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

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

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

Qualifying Individuals (QIs) and Qualified Disabled Working Individuals (QDWI).

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

Med-QUEST Division (MQD) – The State entity responsible for administering the Medical Assistance programs under the State of Hawaii, Department of Human Services, for the State.

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

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

PACE- The Program of All-Inclusive Care for the Elderly (PACE) is a capitated benefit authorized by the Balanced Budget Act of 1997 (BBA) that features a comprehensive service delivery system and integrated Medicare and Medicaid financing.

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

Participating - When referring to a health plan it means a health plan that has entered into a contract with the DHS to provide covered services to enrollees. When referring to a health care provider it means a provider who is employed by or who has entered into a contract with a health plan to provide covered services to enrollees. When referring to a facility it means a facility 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 – A licensed doctor of medicine or doctor of osteopathy.

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

Potential Member – A Medicaid member who is subject to mandatory enrollment and must choose a health plan in

which to enroll within a specified timeframe determined by DHS. See also Enrollee (Potential).

Premium Share - The scheduled dollar amount, based on income, that certain members 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 the State of Hawaii and is (1) a physician, either an M.D. (Doctor of Medicine) or a D.O. (Doctor of Osteopathy), and must generally be a family practitioner, general practitioner, general internist, pediatrician or obstetrician/gynecologist (for women, especially pregnant women); or (2) an advanced practice registered nurse with prescriptive authority; or (3) a licensed physician assistant. 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.

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

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

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

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

Programs –Refers to a managed care MQD program described in Section 30.300, 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.

Provider Complaint – An expression of dissatisfaction made by a provider 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.

Provider Grievance – A provider's expression of dissatisfaction about:

- 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 a 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 harm;
- 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.

QUEST- QUEST is the capitated managed care program that provides health care benefits to individuals, families, and children with income up to a specified federal poverty level (FPL). It provides a standard benefits package to non-pregnant adults and an enhanced benefit package to children and pregnant women.

QUEST- ACE- QUEST- Adult Coverage Expansion (QUEST-ACE) represents an eligibility expansion category for non-pregnant childless adults with income not exceeding 133% and for adults with children who have income 101-133%.

QUEST Expanded Access (QExA) – The capitated managed care program that provides all covered acute, primary and long-term care services to individuals eligible as aged, blind or disabled (ABD) under the Medicaid State Plan.

QUEST- Net- The QUEST-Net represents an eligibility expansion category for non-pregnant adults with incomes up to 133% who were previously enrolled in QUEST, QExA, or FFS.

QUEST Programs- The QUEST programs refer to QUEST, QUEST-ACE, QUEST- Net, and Basic Health Hawaii (BHH).

Recipient - An individual, who meets all eligibility requirements and has been determined eligible for a Medical Assistance program. Also, see Enrollee and Member.

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

Request For Proposal (RFP) – This Request for Proposal number RFP-MQD-2011-003, issued on August 8, 2011.

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

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

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

Special Treatment Facility – A facility, as defined in Section 11-98-02, HAR, that provides a therapeutic residential program for care, diagnoses, treatment or rehabilitation services for socially or emotionally distressed persons, mentally ill persons, persons suffering from substance abuse, and developmentally disabled persons.

State - The State of Hawaii.

State Children’s Health Insurance Program (SCHIP)

– A joint federal-state health care program for uninsured, targeted, low-income children, established pursuant to Title XXI of the Social Security Act.

State Fiscal Year (SFY) - The twelve (12) month period

for Hawaii’s fiscal year that runs from July 1 through June 30.

Subcontract - Any written agreement between the health

plan and another party to fulfill the requirements of the contract.

Support for Emotional and Behavioral Development (SEBD)

– A program for behavioral health services for children and adolescents administered by CAMHD.

Temporary Assistance to Needy Families (TANF) -

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

Third Party Liability (TPL) – Any person, institution,

corporation, insurance company, public, private or governmental entity who is or may be liable in contract, tort or otherwise by law or equity to pay all or part of the medical cost of injury, disease or disability of a member or to Medicaid.

Urgent Care - The diagnosis and treatment of medical conditions which are serious or acute but pose no immediate threat to life 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.

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

30.300 Program Population Descriptions

QUEST-related programs are mandatory managed care programs that provide a different package of medical and behavioral health benefits to the following individuals if they meet the Medical Assistance financial and non-financial eligibility requirements for individuals and families.

30.310 QUEST

QUEST is the program provides one benefit package for children and another benefit package for adults. The benefit package for children shall be referred to as QUEST Keiki, and the benefit package for adults shall be referred to as QUEST Adult. (See Section 40.710)

Children under age nineteen (19) years: 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 Medicaid age-specific FPLs (i.e., 100%, 133%, or 185%) must not have other health insurance.

Eligible children under age nineteen (19) years placed in foster care by the State and children under age twenty-one (21) years who receive Title IV-E foster care maintenance payments or are covered under a Title IV-E Adoption Assistance Agreement are 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 are the following:

- 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; and
- Medically needy AFDC-related children and adults who have met their spend-down obligation.

30.320 QUEST-Net

QUEST-Net provides coverage for medical, dental, behavioral health and prescription drug services. (Benefit package shall be QUEST-Adult in Section 40.710.1.)

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

- Adults previously enrolled in QUEST, QUEST Expanded Access, or FFS with income not exceeding 133% of FPL, and who voluntarily enroll in QUEST-Net.

30.330 QUEST- ACE

Uninsured adults ineligible for QUEST with incomes not exceeding 133% of FPL subject to the QUEST-ACE enrollment limit are eligible for QUEST-ACE benefits as described in Section 40.710.1 in QUEST- Adult and shall be mandatorily enrolled.

30.340 Basic Health Hawaii

The Basic Health Hawaii program is a state-funded program for individuals who are not eligible for the Medicaid program. This includes uninsured non-pregnant adults, 19 years and older, who are residing in Hawaii

under a Compact of Free Association with the United States, or are qualified aliens residing in the US for less than 5 years. Recipients must reside in Hawaii. The benefits for the Basic Health Hawaii program are described in Section 40.710.1 in QUEST- Adult.

30.350 ACA Basic Health Option

The DHS may add a program that shall meet the requirements of the Basic Health Option under the ACA, for adults with household income 134-200% of the federal poverty level (FPL) and for adults with household income below 134% of the FPL who do not qualify for Medicaid because of immigration status.

30.360 Excluded Populations

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

- Individuals in the Federal and State's Breast and Cervical Cancer Program;
- Individuals who are age sixty-five (65) or older with income <100% FPL or are Medicare beneficiaries;
- Individuals who are Medicare Special Savings Program Members;
- 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 (after the first 60 days of residing in the nursing facility have passed);

- Individuals who are waitlisted in hospitals for nursing facility placement (after the first 60 days of waitlisting have passed);
- Individuals who are receiving home and community based services in a private home or in a residential setting who are at nursing facility level of care (ICF or SNF);
- Individuals in a 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;
- Individuals enrolled in the State of Hawaii Organ and Transplant Program (SHOTT); and
- Native Americans in Federally Recognized Tribes.

Individuals who are residents of the State 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 Overview of the Department of Human Services (DHS) Responsibilities

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

- Establish and define the medical 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 the health plans;
- Determine initial and continued eligibility of members;
- Enroll and disenroll members;
- Provide benefits and services as described in Section 30.700;
- Conduct the readiness review as described in Section 51.700 and determine if health plan is ready to commence services on the date described in Section 20.100.
- Review and monitor the adequacy of the health plan's provider networks;
- Monitor the quality assessment and performance improvement programs of the health plan and providers;
- Review and analyze utilization of services and reports provided by the health plan;
- Participate in the State Administrative Hearing processes;
- Monitor the 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;
- Review and approve the health plan's marketing materials;
- Review and approve all health plan materials that are distributed to their members;
- Establish health plan incentives when deemed appropriate;
- Oversee the activities of other MQD contracts, including but not limited to the SHOTT program contractor;
- Impose civil or administrative monetary penalties and/or financial sanctions for violations or health plan non-compliance with contract provisions;
- Report criminal conviction information disclosed by providers and report provider application denials pursuant to 42 CFR Section 455.106(b);
- Verify out-of-state provider licenses during provider enrollment and review and monitor provider licenses on an on-going basis;
- Refer member and provider fraud cases to appropriate law enforcement agencies; and
- Coordinate with and monitor fraud and abuse activities of the health plan.

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

30.500 Eligibility and Enrollment Responsibilities

30.510 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 shall become eligible for Medical Assistance, enter into their QUEST program, and be enrolled in their health plan due to prior period coverage on:

- The date of the application; or
- If specified by the applicant, any date on which appropriate medical 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 shall become eligible on the first day of the subsequent month in which all eligibility requirements are met.

30.520 Enrollment Responsibilities

After an individual is determined eligible for the programs, the DHS or its agent shall initiate the enrollment process. Within ten (10) calendar days of the individual being determined eligible, the DHS or its agent shall 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 and those excluded from enrolling; and how to access information on the health plans' provider networks. The DHS shall provide new recipients an informational booklet that includes this information. The DHS shall prorate the total cost of printing the informational booklet among the health plans.

Enrollment into the health plan shall be effective on the day the DHS determines eligibility as described in Section 30.510, with the following exceptions:

- Initial enrollment for existing QUEST program members shall be as described in Section 30.530;
- Newborn enrollment shall be as described in Section 30.540;
- Changes made during annual plan change period shall be described in Section 30.560; and
- Enrollment of foster care children shall be as described in Section 30.520.

The DHS or its agent shall provide the member with written notification of the health plan in which the member is enrolled and the effective date of enrollment. 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 Secure File Transfer (SFT) file server. The enrollment information shall include the case name, case number, member's name, mailing address, date of enrollment, TPL coverage, date of birth, sex, and other data that the DHS deems pertinent and appropriate.

The DHS or its agent shall auto-assign individuals into a health plan. The individual may select a health plan within ten (10) calendar days of receipt of the enrollment letter. This ten (10) day period starts five (5) days after the date the DHS issues the enrollment letter to the member (the DHS assumes mail time of five (5) days). Their choice shall be effective the first day of the following month. The DHS shall make the auto-assignment according to the following algorithm:

- Sixty (60%) of the auto-assign algorithm shall be split equally amongst each of health plans;
- Forty (40%) of the auto-assign algorithm shall be based upon quality factors that may include but not be limited to the following quality measures:
 - CAHPS scores; and
 - HEDIS measures;
- The quality portion of the auto-assign algorithm shall be updated on an annual basis;

- The quality portion of the auto-assign shall not be implemented until the date indicated in Section 20.100;
- Prior to implementing the quality portion of the auto-assign, the auto-assign algorithm shall be split equally amongst each health plan; and
- Health plans shall be allowed to waive their right to participate in the auto-assignment algorithm.

DHS shall inform the health plan of the specifications of each measure for auto-assign algorithm no less than fourteen (14) days prior to the beginning of the time period from which the data is being measured.

All members of a newly eligible household shall be auto-assigned to the same plan.

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

The DHS shall keep members enrolled in the same QUEST health plan if they remain eligible for QUEST benefits but their eligibility category changes. The DHS shall not provide a choice to the member until the next annual plan change period unless there is cause, as defined in Section

30.600. Nothing in this section negates the members' rights.

30.530 Initial Enrollment Period for Existing QUEST program Members

Prior to the Commencement of Services to Members date identified in Section 20.100, all individuals in the populations identified in Section 30.300 shall be required to select a health plan. The thirty (30) day period in the ninety days (90) prior to Commencement of Services to Members is hereby referred to as the initial enrollment period for existing members. All enrollments that occur during this period shall be effective on the Commencement of Services to Members date identified in Section 20.100.

In the event an individual does not select a health plan during this period, the DHS shall assign the individual to a health plan according to the auto-assignment algorithm described in Section 30.520. All members of the household shall be auto-assigned to the same plan.

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

To assure a smooth transition into a new health plan during the enrollment period for existing members, health plan requirements are described in Section 41.300.

30.540 Newborn Enrollment

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

If the newborn's mother is not enrolled in a QUEST plan or is receiving services under QExA or FFS at the time of birth, the newborn shall be auto-assigned into a QUEST health plan until member makes choice of health plan in accordance with Section 30.520.

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

30.550 30-Day Grace Period

The DHS shall allow existing members to change health plans without cause for the first thirty (30) days after Commencement of Services to Members as described in Section 20.100 regardless of whether enrollment is a result of selection or auto-assignment. The DHS shall educate

providers about to option for members to make health plan changes during the 30-day grace period.

The DHS shall process the plan change request and enrollment in the new health plan shall be the first day of the following month in which the plan change was requested. After the initial thirty (30) day grace period for both existing and newly determined eligible individuals, members shall 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.

30.560 Annual Plan Change Period

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

The annual plan change period shall occur annually. 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 benefit year, the DHS shall mail, to all households with individuals who are eligible to participate in the annual plan change period, an information packet that describes the plan change period process. The DHS shall include in the information packet an informational newsletter that includes information about 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 shall remain in the current health plan. This policy also applies to a person enrolled in a returning plan that is capped (see Section 30.570).

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 shall auto-assign the member to a health plan using the DHS established auto-assignment algorithm in Section 30.520.

30.570 Member Enrollment Limits/Caps

The DHS shall implement enrollment caps as follows:

Island	Enrollment Cap
Oahu	60% of island enrollment
All other islands	No cap

Health plan(s) may choose to enact enrollment limits of members into their health plan. Health plan(s) shall notify DHS of their enrollment limit no less than sixty (60) days prior to Initial Enrollment (Section 30.530). Enrollment limits shall be enacted Statewide. DHS shall not allow

health plan(s) to enact island-specific enrollment levels. Health plans may notify DHS of adjustment to enrollment limits no less than sixty (60) days prior to Annual Plan Change (Section 30.560). Enrollment limits shall apply only to new members and not to existing members.

Prior to all annual plan change periods, the DHS shall review the enrollments of the health plans. The DHS shall 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 shall be implemented immediately and remain in effect for the benefit year.

If a health plan has an enrollment limit/cap, it shall not be available during the annual plan change period or to new enrollees. There are four exceptions to this policy:

1. Newborns born to mothers enrolled in the capped plan shall be enrolled with the mother; or
2. Newly determined eligibles that have PCPs who are exclusive to the capped plan within the previous sixty (60) days shall be allowed to enroll in the capped plan. The capped plan shall provide the DHS with a listing of exclusive PCP providers, which shall 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; or
4. Foster Children.

The DHS reserves the right to lift an enrollment cap at any time.

30.580 Member Education Regarding Status Changes

The DHS shall educate members concerning the necessity of providing, to the health plan and the DHS, any information affecting their member status. The following events could affect the member's status and may affect the eligibility of the member:

- Death of the member or family member (spouse or dependent);
- Birth;
- Marriage;
- Divorce;
- Adoption;
- Transfer to long-term care;
- Change in health status (e.g., pregnancy or permanent disability);
- Change of residence or mailing address;
- Institutionalization (e.g., state mental health hospital, Hawaii Youth Correctional Facility, or prison);
- TPL coverage that includes accident related medical condition;
- Inability of the member to meet citizenship, alien status, photo and identification documentation

requirements as required in the Deficit Reduction Act (DRA) Section 6037 and in other federal law;

- Telephone number;
- Change or addition of Social Security Number (SSN);
or
- Other household changes.

30.600 Disenrollment Responsibilities

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

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

- Member no longer qualifies based on the medical assistance eligibility criteria or voluntarily leaves the programs;
- Death of a member;
- Incarceration of the member;
- Member enters the State Hospital;
- Member enters the Hawaii Youth Correctional Facility;
- 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 the QExA program;

- Member is transferred to an ICF-MR facility;
- Member has a physical or developmental disability;
- Member is blind as defined by the DHS;
- Member turns age 65;
- 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 member beneficiary; or
- Member provides false information with the intent of enrolling in the programs under false pretenses.

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

- Member chooses another health plan during the annual plan change period;
- Member's PCP is not in the health plan's provider network and is in the provider network of a different health plan; 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 40.300;
- The member's need for related services (for example a cesarean section and a tubal ligation) to be performed at the same time and not all related services are available within the network and the member's PCP or another provider determines that receiving the services separately would subject the member to unnecessary risk;
- Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's health care needs, lack of direct access but not limited to certified nurse midwives, pediatric nurse practitioners, family nurse practitioners, women's health care specialists for breast cancer screenings, pap smears and pelvic exams, if available in the geographic area in which the member resides.

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

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

30.700 Covered Benefits and Services Provided by the DHS

30.710 State of Hawaii Organ and Transplant (SHOTT) Program

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

For other non-experimental or investigational transplants not covered by the health plan, the DHS shall provide transplants through the SHOTT program. The SHOTT Program covers adults and children (from birth through the month of their 21st birthday). These transplants may include liver, heart, heart-lung, lung, kidney, kidney-pancreas, and allogenic and autologous bone marrow transplants. In addition, children may be covered for transplants of the small bowel with or without liver. Children and adults must meet specific medical criteria as determined by the State and the SHOTT Program contractor.

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

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

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

- If the individual is not disabled, he/she shall be re-enrolled into the same health plan in which he/she was enrolled prior to the transplant evaluation, effective the 1st day of the following month.

- If the individual is determined permanently disabled, he/she is transferred to one of the QExA health plans, effective the 1st day of the second month following the receipt of a completed ADRC packet per the established ADRC process.
- If the individual's condition changes to make him/her a better candidate for a transplant, the health plan in which he/she belongs may resubmit him/her for re-consideration for the transplant program.

30.720 PACE and Pre-PACE Programs

Medicaid members 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 shall be disenrolled from, the programs.

30.730 Dental Services

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

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

The health plan shall be responsible for providing referrals, follow-ups, coordination, and provision of appropriate

medical services related to medically necessary dental needs. The health plan shall provide dental services that are medically necessary to treat medical conditions.

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

Specifically, the health plan shall be responsible for:

- Referring EPSDT eligible members to the DHS Dental Program contractor for EPSDT dental services and other dental needs not provided by the plan;
- Providing referral, follow-up, coordination, and provision of appropriate medical services related to medically necessary dental needs, including but not limited to emergency room treatment, hospital stays, ancillary inpatient services, operating room services, excision of tumors, removal of cysts and neoplasms, excision of bone tissue, surgical incisions, treatment of fractures (simple & compound), oral surgery to repair traumatic wounds, surgical supplies, blood transfusion services, ambulatory surgical center

services, x-rays, laboratory services, drugs, physician examinations, consultations, and second opinions;

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

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

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

30.740 Intentional Termination of Pregnancies (ITOPs)

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

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

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

30.800 Covered Benefits and Services Provided by Other State Agencies

30.810 School Based Services

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

30.820 Department of Health (DOH) Programs

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

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

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

Health plans shall have a process in place to identify and refer to CAMHD, children/youth that are unstable, of

moderate-high risk, and in need of the SEBD program. The eligibility criteria for the CAMHD program include:

- The member is age three through twenty (3-20) years;
- The member has a DSM IV, Axis 1 primary diagnosis for at least 6 months except for the following substance abuse, learning disorders, communication disorders, pervasive developmental disorders include of autism disorder, Rett's disorder, childhood disintegrative disorder or Asperger's disorder;
- The DSM IV, Axis I primary diagnosis listed above may be covered if the diagnosis is secondary to a qualifying primary Axis I mental health disorder;
- The member's Child and Adolescent Functional Assessment Scale (CAFAS) score is 80 or greater; and
- The CAMHD Medical Director or designated qualified mental health professional reviews and makes the determination of SEBD eligibility.
- Members that do not meet the eligibility criteria, but based upon assessment by the health plan's medical director that additional services are medically necessary for the member's health and safety, shall be referred to the CAMHD for provisional eligibility on a case-by-case basis.

The CAMHD program is a program carved out of the health plan responsibilities. The health plan shall work

with CAMHD in transitioning members in and out of the CAMHD program.

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

- The member is unable to engage or demonstrate benefit or maintenance of benefit from additional services despite maximum intervention for at least twelve (12) months; OR
- All of the following:
 - CAFAS < 80; and
 - Stable for at least six (6) months with no anticipated change; and
 - Able to remain stable without intensive additional services.
- Members that meet the discharge criteria, but are assessed by CAMHD's medical director to need additional medically necessary services for the member's health and safety, may continue to stay in the CAMHD program for a specified additional length of time with approval by the health plan's medical director.

Members that are assessed as no longer needing additional intensive behavioral health services shall continue to have access to all other behavioral

services offered by the health plan found in Section 40.740.2. Should a member again meet criteria for the provision of additional intensive behavioral health interventions, the member shall again be provided these services by CAMHD.

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

The Kapi'olani Cleft and Craniofacial Clinic is a multidisciplinary program that services children with cleft and craniofacial disorders across the state. The clinic provides the services of pediatric dentists, orthodontists, oral surgeons, Ear Nose and Throat specialists, pediatric psychiatrists, audiologists, speech and feeding specialists, neonatologists, geneticists, and genetic counselors. The clinic coordinates with QUEST health plans for reimbursement of these services as well as coordination of care for QUEST members receiving care at the clinic.

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

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

The health plan shall also aid in coordination of care in cases involving coverage by more than one health plan and shall facilitate the processing of prior authorization requests and claims. If a member changes health plans (either through the annual plan change period or moves to another island), the originating health plan shall assist the accepting health plan by providing information on the clinic's multidisciplinary recommendations, treatment provided, and progress to date. The originating health plan shall coordinate with the accepting health plan to ensure a smooth transition.

30.820.3 Vaccines for Children (VFC) Program

The health plan shall be responsible for ensuring that their members receive all necessary childhood immunizations. The State of Hawaii participates in the VFC program, a federally funded program that replaces public and private vaccines for QUEST children under the age of twenty-one (21). These vaccines are distributed to qualified providers who administer them to children. Providers shall enroll and complete appropriate forms for VFC participation.

As a result, the health plan shall not be reimbursed for any privately acquired vaccines that can be obtained through

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

30.820.4 Zero-To-Three (Early Intervention) Program

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

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

30.900 Aid to Disabled Review Committee (ADRC)

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

If the QUEST health plan identifies a member that it believes would meet the disability criteria, the health plan shall refer the member to DHS/MQD for an ADRC evaluation utilizing the ADRC packet (DHS Forms 1180, 1128, 1127). Specifically, the health plan shall submit to the ADRC Coordinator in MQD, the following forms and documentation:

- A DHS 1180, "ADRC Referral and Determination";
- A completed DHS 1127, "Medical History and Disability Statement";
- A completed DHS 1128 "Disability Report"; and
- Any current and additional documentation from the medical provider or the health plan, which provides supporting evidence for physical or mental disability, including diagnosis and prognosis (e.g. clinical

progress notes, history and physical reports, discharge summaries).

- A CMS 2728 may be substituted for DHS 1128 for ADRC referrals on clients with end stage renal disease. A DHS 1270 may be substituted for DHS 1128 for ADRC referrals on clients coming through the Benefit, Employment and Support Services Division (BESSD).

The health plan shall provide all necessary medical services to the member until the disenrollment effective date for a member who has been determined to be disabled. If the ADRC does not determine that a member meets the disability criteria, the health plan shall continue to provide all services to the member.

Individuals who are determined to be disabled shall be disenrolled from the QUEST health plan and enrolled into a QExA health plan. The QUEST health plan shall be responsible for providing all medical services to the member until the effective date of enrollment into QExA, which is no later than the first day of the second month following the date the ADRC packet is approved by DHS. From the effective date of QExA coverage forward, the QExA health plan becomes responsible for all member services except as defined in Section 50.210.

If a QExA health plan identifies a member as not disabled, the QExA health plan shall submit an ADRC packet to re-

evaluate the disability status. The QExA health plan also submits for ADRC re-evaluation of individuals that have been identified in previous ADRC determinations to need a re-evaluation within a specified timeframe. Individuals that are found not disabled shall be disenrolled from the QExA health plan and enrolled into the QUEST health plan no later than the first day of the second month following the date the ADRC determination of not disabled is made by DHS.

Newborns of QUEST moms are enrolled into the same QUEST plan as the mom, effective from the date of birth. If the QUEST health plan believes the newborn of the QExA mom is disabled, the QUEST health plan shall attach the signed DHS Form 1180 to the DHS Form 1179, checking the box stating "ADRC Requested/Disabled," and submit an ADRC packet. If found disabled, the newborn shall be enrolled into a QExA health plan no later than the first day of the second month following the date the ADRC is approved by DHS with QExA coverage effective from the date of birth. Non-disabled newborns of QExA moms shall be auto-assigned into a QUEST health plan until member makes choice of health plan in accordance with Section 30.520.

The ADRC packet is also required to be submitted with the DHS Form 1144 to request for State of Hawaii Organ and Tissue Transplant (SHOTT) program services. Once approved for SHOTT, the member shall be disenrolled from

the health plan, converted to FFS, and transitioned to SHOTT. Prior to exiting from SHOTT, the member shall be re-evaluated for disability and placed in the appropriate QUEST or QExA program based on the disability determination.

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

<http://www.ssa.gov/disability/professionals/bluebook/>.

Members with a medical or psychological condition that is not permanent shall be required to be re-evaluated after one year and before fourteen (14) months from the effective date of QExA enrollment. DHS shall inform the QExA health plans of the members that are coming up on one year of a non-permanent disability status. The member must be re-evaluated within sixty (60) days for continued disability determination. If the member is found to no longer be disabled, the member shall be re-enrolled into QUEST, in accordance with Section 30.500, no later than on the first day of the second month following the date the ADRC is approved by DHS.

The DHS shall regularly review the appropriateness of ADRC referrals submitted for disability determinations. If ADRC referrals from the QUEST health plan are determined

to be not disabled for more than 20% of health plan's annual referrals, the health plan shall be required to reimburse DHS for the cost of disability determinations over the allowable threshold. The DHS shall provide updates of percent of referrals not found disabled on a quarterly basis.

31.100 Monitoring and Evaluation

The DHS has developed a Quality Strategy to guide the implementation of MQD's quality activities. It outlines the strategies to monitor and evaluate health plan compliance to standards for access to care, structure and operations, and quality measurement and improvement, according to 42 CFR Part 438, Subpart D.

As part of these monitoring responsibilities, the DHS shall:

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

31.110 Quality Assessment and Performance Improvement (QAPI) Program

See Section 50.730 for DHS' responsibilities for monitoring of the health plan's QAPI program.

31.120 External Quality Review/Monitoring

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

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

The health plan shall collaborate with the DHS contracted EQRO in the external quality review (EQR) activities

performed by the EQRO to assess the quality of care and services provided to members and to identify opportunities for health plan improvement. To facilitate this review process, the health plan shall provide all requested QAPI Program related documents and data to the EQRO.

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

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

- Administration, analysis, and reporting the results of the CAHPS® Consumer Survey. The survey shall be conducted annually, administered to an NCQA-certified sample of members enrolled in each health plan and analyzed using NCQA guidelines. Adult and child surveys are conducted in alternate years using the most current CAHPS® survey for managed care plans. DHS may modify this schedule based upon the needs of the Department. The EQRO shall provide an overall report of survey results to the DHS. The DHS and the health plan shall receive a copy of their health plan-specific raw data by island;
- Administration, analysis, and reporting of the results of the Provider Satisfaction Survey. This survey shall be conducted every other year within the broad parameters of CMS protocols for conducting Medicaid

EQR surveys (the DHS, CMS 2002, Final Protocol, Version 1.0 -- *Administering of Validating Surveys: Two Protocols for Use in Conducting Medicaid External Quality Review Activities*). DHS may modify this schedule based upon the needs of the Department. The EQRO shall assist the DHS in developing a survey tool to gauge PCPs' and specialists' satisfaction in areas such as: how providers feel about managed care, how satisfied providers are with reimbursement, and how providers perceive the impact of health plan utilization management on their ability to provide quality care. The EQRO shall provide the DHS with a report of findings, including the raw data broken down by island. Each health plan shall receive an electronic version of the report with its plan-specific raw data per island from the EQRO; 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 438.364, the EQRO must submit to DHS, an annual detailed technical report of all the EQR activities conducted. DHS submits a copy of the final report to CMS.

31.130 Case Study Interviews

The DHS or its designee may conduct case study interviews. These could require that key individuals

involved with the programs (including representatives of the health plans, association groups and consumer groups) identify what was expected of the program, changes needed to be made, effectiveness of outreach and enrollment, and adequacy of the health plans in meeting the needs of the populations served.

31.200 QUEST 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. The health plan shall acknowledge receipt of the memoranda through electronic mail.

All QUEST policy memorandum issued prior to the Commencement of Services to Members date identified in Section 20.100 are ineffective except for those that DHS has determined shall remain in effect. Health plans shall be advised of these memoranda by no less than thirty (30) days prior to the Commencement of Services to Members date identified in Section 20.100.

31.300 Readiness Review

Prior to the date of commencement as described in Section 20.100, the DHS or its agent shall 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 health plan's responsibilities in this readiness review are described in Section 51.700.

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

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

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

If the health plan is unable to demonstrate its ability to meet the requirements of the contract, as determined by the DHS, within the time frames specified by the DHS, the

DHS may terminate the contract in accordance with Section 71.600.

31.400 Information Systems

31.410 Hawaii Prepaid Medical Management Information Systems (HPMMIS)

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

- Receiving daily eligibility files from 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 Secure File Transfer (SFT) file server. The SFT file server allows the MQD and health plans to securely transfer member, provider, and encounter data via the internet.

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 agent, processes Medicaid fee-for-service payments in the Medicaid fee-for-service program utilizing HPMMIS.

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

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

SECTION 40 PROVISION OF SERVICES – HEALTH PLAN RESPONSIBILITIES

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

The QUEST programs 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 healthcare needs and provides/directs the services to meet the member’s needs. The health plan shall develop and maintain a provider network capable of providing the required individualized health services needed by the members.

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

40.200 Provider Network

40.210 General Provisions

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

The health plan needs to contract with enough providers for their members to have timely access to medically necessary covered services. The health plan is responsible for assuring that members have access to providers listed in Section 40.220. If the health plan's network is unable to provide medically necessary covered services to a particular member within its network or on the island of residence, the health plan shall adequately, and in a timely manner, provide these services out-of-network or transport the member to another island to access the covered services for as long as the health plan's network is unable to provide the member with medically necessary covered services on the island of residence as described in Section 41.100.

The health plan shall notify the out-of-network providers providing covered services to its members that payment

by the plan is considered as “payment-in-full” and that those providers cannot “balance bill” the members for the covered services. The health plan is prohibited from charging the member more than it would have if the covered services were furnished within the network.

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

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

In accordance with 45 CFR Section 162.410, the health plan shall require that each applicable provider have a national provider identifier (NPI).

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 U. S. Department of Health and Human Services, Office of Inspector General (OIG), or have been excluded by the DHS from participating in the Hawaii Medicaid program and all other state Medicaid programs. The health plan shall be responsible for checking with the MOD for those providers excluded from any Federal or State program at least annually and shall immediately terminate any provider(s) or affiliated provider(s) whose owners or managing employees are found to be excluded. As they occur, the health plan shall report provider application denials or terminations to the DHS attributable to those providers

appearing on any Federal or State exclusion lists. The health plan shall utilize the format provided by the DHS.

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

The health plan shall have written policies and procedures for the selection and retention of providers. The health plan shall submit these selection and retention of providers policies and procedures as required in Section 51.700, Readiness Review.

The health plan shall have an established provider network that meets the requirements of this RFP at the time of proposal submission.

40.220 Specific Minimum Requirements

The health plan is solely responsible for ensuring it: (1) has the network capacity to serve the expected enrollment in the service area: (2) offers an appropriate range of services and access to preventive, primary and behavioral health services: and (3) maintains a sufficient number, mix, and geographic distribution of providers of covered services. The following is a listing of the minimum required components of the provider network. This is not

meant to be an all-inclusive listing of the components of the network, rather the health plan may add provider types, or the DHS may require that the health plan add providers as required based on the needs of the members or due to changes in Federal or State law. At a minimum, the network shall include the following medical care providers:

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

- Pharmacies;
- Physical and occupational therapists, audiologists, and speech-language pathologists;
- Physician Assistants;
- Behavioral health providers, including psychologists, licensed mental health counselors, and substance abuse counselors;
- State licensed Special Treatment Facilities for the provision of adolescent substance abuse therapy/treatment;
- Home health agencies and hospices;
- Providers of lodging and meals associated with obtaining necessary medical care; and
- Sign language interpreters and interpreters for languages other than English.

At a minimum, the health plan shall have the following providers for adult members with serious and persistent mental illness (SPMI) in its network. These ratios shall be maintained across all islands where the health plan is providing services.

Statewide	
Provider Type	Number of Providers Required per Members with SPMI
Psychiatrists	1 per 150 members
Psychologists, Mental Health Counselors, and Social Workers	1 per 100 members
Case Management Services to include Intensive Case Management Services	1 per 30 members

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

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

Acute hospital with ability to treat acute psychiatric illness	2 for Oahu, 1 for Maui, 1 for Kauai, 2 for Hawaii*
Crisis response providers	1 per island (of those islands listed above)
Partial hospitalization or intensive outpatient hospitalization	1 per island (of those islands listed above)
Psychosocial Rehabilitation provider	4 for Oahu, 1 for Maui, 1 for Kauai, 2 for Hawaii*
Specialized Residential Treatment provider	2 for Oahu, 1 for Maui

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

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

The health plan may have contracts with physician specialists or pay for emergency services, urgent outpatient services, and inpatient acute services provided without prior authorization by non-participating physician

specialists. If the contracted specialist cannot provide twenty-four (24) hours/seven (7) days a week coverage for the specialty, the health plan must pay the non-participating physician specialists who provide emergency, urgent outpatient, sub-acute services, and inpatient acute services.

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 has written arrangements with another provider with admitting and treatment privileges with an acute care hospital within the health plan's network on the island of service. For the island of Hawaii, this requirement means that a provider in East Hawaii who does not have admission and treatment privileges shall have a written arrangement with another provider with admitting and treatment privileges in East Hawaii and that a provider in West Hawaii who does not have admission and treatment privileges shall have a written arrangement with another provider with admitting and treatment privileges in West Hawaii.

40.230 Availability of Providers

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

health services within the acceptable wait times. The acceptable wait times are:

- Emergency medical situations - Immediate care (twenty-four (24) hours a day, seven (7) days a week) and without prior authorization;
- Urgent care and PCP pediatric sick visits - Appointments within twenty-four (24) hours;
- PCP adult sick visits - Appointments within seventy-two (72) hours;
- PCP visits (routine visits for adults and children) - Appointments within twenty-one (21); and
- Visits with a specialist or Non-emergency hospital stays - Appointments within four (4) weeks or of sufficient timeliness to meet medical necessity.

The health plan shall ensure that:

- Network providers accept members for treatment unless the provider has requested a waiver from this provision and the health plan has received a waiver from the DHS;
- Network providers do not segregate members in any way from other persons receiving services, except for health and safety reasons;
- Members are provided services without regard to race, color, creed, ancestry, sex, including gender identity or expression, sexual orientation, religion, health status, income status, or physical or mental disability;

- Network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to hours offered to members under Medicaid fee-for-service, if the provider has no commercial members.

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

40.240 Geographic Access of Providers

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

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

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

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

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

40.250 Primary Care Providers (PCPs)

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

Each PCP shall be licensed in the State of 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 with prescriptive authority (APRN-Rx) who:
 - a. Is a registered professional nurse authorized by the State to practice as a nurse practitioner in accordance with State law;
 - b. Is certified as a nurse practitioner by a recognized national certifying body that has established standards for a nurse practitioner; and
 - c. Possesses a master's degree in nursing; or
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 member has selected a specialist with whom he or she has a historical relationship as his or her PCP;
- The health plan has confirmed that the specialist agrees to assume the responsibilities of the PCP.

Such confirmation may in writing, electronically or verbally; and

- The health plan submits to the DHS prior to implementation a plan for monitoring their performance as PCPs.

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

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

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

The health plan shall require that PCPs fulfill these responsibilities for all members. If the PCP is unable to fulfill their responsibilities to the member, the health plan shall transition the member to another PCP. The original PCP shall be responsible for continuing to provide services to the member until the other PCP has accepted the member except in situations where the PCP is terminated from either the health plan or Medicaid program.

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

- Not establish any limits on how frequently and for what reasons a member may choose a new PCP;
- Allow each member, to the extent possible and appropriate, to have freedom of choice in choosing his or her PCP;

- Describe the steps taken to assist and encourage members to select a PCP;
- Describe the process for informing members about available PCPs;
- Describe the process for selecting a PCP;
- Describe the process for auto-assigning a member to a PCP if one is not selected;
- Describe the process for changing PCPs; and
- Describe the process for monitoring PCPs, including specialists acting as PCPs, to ensure PCPs are fulfilling all required responsibilities described above.

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

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

If a PCP ceases participation in the health plan's provider network the health plan shall send written notice to the members who have chosen the provider as their PCP or

were seen on a regular basis by the provider. This notice shall be issued within fifteen (15) 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 is preserved until a new PCP has been selected.

40.260 Direct Access to Women's Health Specialists

The health plan shall provide female members with direct in-network access to a women's health specialist for covered care necessary to provide her routine and preventive healthcare services. Women's routine and preventive healthcare 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.

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

The health plan shall make FQHC and RHC services available and accessible in its network, unless the health plan can demonstrate to the DHS that it has both adequate capacity and an appropriate range of services for vulnerable populations.

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

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

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

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

40.290 Rural Exceptions

In areas in which there is only one health plan, any limitation the health plan imposes on the member's freedom to choose between PCPs may be no more restrictive than the limitation on disenrollment under 42 CFR Section 438.56(c) and Sections 30.520, 30.560 and 30.600 of this RFP. In this case, the member must have the freedom to:

- Choose from at least two (2) PCPs;
- Obtain services from any other provider under any of the following circumstances:
 - The service or type of provider (in terms of training, experience, and specialization) is not available within the health plan;
 - The provider is not part of the network but is the main source of a service to the member, is given the opportunity to become a participating provider under the same requirements for participation in the health plan, and chooses to join the network. If this provider chooses not to join the network, or does not meet the necessary qualifications to join, the health plan shall transition the member to an in-network provider within sixty (60) days. If the provider

is not appropriately licensed or is sanctioned, the health plan shall transition the member to another provider immediately;

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

40.300 Provider "Gag Rule" Prohibition

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

- The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;
- Any information the member needs in order to decide among all relevant treatment options;

- The risks, benefits and consequences of treatment or non-treatment; and
- The member's right to participate in decisions regarding his or her healthcare, including the right to refuse treatment, and to express preferences about future treatment decisions.

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

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

- The DHS within one-hundred twenty (120) days prior to adopting the policy with respect to any service;
- The DHS with the submission of its proposal to provide services under this RFP;

- Members within ninety (90) days of adopting the policy with respect to any service; and
- Members and potential members before and during enrollment.

40.400 Provider Credentialing, Recredentialing and Other Certification

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

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

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

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

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

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

40.500 Provider Contracts

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

1. Specify covered populations and specifically cite the QUEST programs;
2. Specify covered services;
3. Specify rates of payment;
4. Prohibit the provider from seeking payment from the member for any covered services provided to the member within the terms of the contract and require the provider to look solely to the health plan for compensation for services rendered, with the exception of cost sharing pursuant to the Hawaii Medicaid State Plan;
5. Prohibit the provider from imposing a no-show fee for QUEST program members who were scheduled to receive a Medicaid covered service;
6. Specify that in the case of newborns, the provider shall not look to any individual or entity other than the health plan for any payment owed to providers related to the newborn;
7. Require the provider to cooperate with the health plan's quality improvement activities;
8. Require that providers meet all applicable State and federal regulations, including but not limited to all applicable HAR sections, and Medicaid requirements for licensing, certification and recertification;
9. Require the provider to cooperate with the health plan's utilization review and management activities;
10. Not prohibit a provider from discussing treatment or non-treatment options with members that may not

reflect the health plan's position or may not be covered by the health plan;

11. Not prohibit, or otherwise restrict, a provider from acting within the lawful scope of practice, from advising or advocating on behalf of a member for the member's health status, medical care, or treatment or non-treatment options, including any alternative treatments that might be self-administered;
12. Not prohibit, or otherwise restrict, a provider from advocating on behalf of the member to obtain necessary healthcare services in any grievance system or utilization review process, or individual authorization process;
13. Require providers to meet appointment waiting time standards pursuant to the terms of this contract and as described in Section 40.230;
14. Provide for continuity of treatment in the event a provider's participation terminates during the course of a member's treatment by that provider except in the case of adverse reasons on the part of the provider;
15. Require that providers comply and maintain the confidentiality of member's information and records as required by law, including but not limited to privacy and security regulations adopted under HIPAA;
16. Keep any records necessary to disclose the extent of services the provider furnishes the members;

17. Specify that CMS, the State Medicaid Fraud Control Unit, and the DHS or their respective designee shall have the right to inspect, evaluate, and audit any pertinent books, financial records, medical records, documents, papers, and records of any provider involving financial transactions related to this contract and for the monitoring of quality of care being rendered without the specific consent of the member;
18. Require providers that are compensated by capitation payments submit complete and accurate encounter data on a monthly basis and any and all medical records to support encounter data upon request from the health plan without the specific consent of the member, DHS or its designee for the purpose of validating encounters;
19. Require provider to certify claim/encounter submissions to the plan as accurate and complete;
20. Require the provider to provide medical records or access to medical records to the health plan and the DHS or its designee, within sixty (60) days of a request. Refusal to provide medical records, access to medical records or inability to produce the medical records to support the claim/encounter shall result in recovery of payment;
21. Include the definition and standards for medical necessity, pursuant to the definition in Section 30.200 of this RFP;
22. Specify acceptable billing and coding requirements;

23. Require that providers comply with the health plan's cultural competency plan;
24. Require that the provider submit to the health plan any marketing materials developed and distributed by providers related to the QUEST programs;
25. Require that the provider maintain the confidentiality of members' information and records as required by the RFP and in federal and state law, including but not limited to:
 - a. The Administration Simplification (AS) provisions of HIPAA, Public Law 104-191 and the regulations promulgated thereunder, including but not limited to 45 CFR Parts 160, 162, 164, if the provider is a covered entity under HIPAA;
 - b. 42 CFR Part 431 Subpart F;
 - c. HAR Chapter 17-1702;
 - d. HRS Section 346-10;
 - e. 42 CFR Part 2;
 - f. HRS Section 334-5; and
 - g. HRS Chapter 577A.
26. Require that providers comply with 42 CFR Part 434 and 42 CFR Section 438.6, if applicable;
27. Require that providers not employ or subcontract with individuals or entities whose owner or managing employees are on the state or federal exclusions list;
28. Prohibit providers from making referrals for designated health services to healthcare entities with which the provider or a member of the provider's

family has a financial relationship as defined in Section 30.200;

29. Require providers of transitioning members to cooperate in all respects with providers of other health plans to assure maximum health outcomes for members;
30. Require the provider to comply with corrective action plans initiated by the health plan;
31. Specify the provider's responsibilities regarding third party liability;
32. Require the provider to comply with the health plan's compliance plan including all fraud and abuse requirements and activities;
33. Require that providers accept members for treatment, unless the provider applies to the health plan for a waiver of this requirement;
34. Require that the provider provide services without regard to race, color, creed, ancestry, sex, including gender identity or expression, sexual orientation, religion, health status, income status, or physical or mental disability;
35. Require that providers offer hours of operation that are no less than the hours of operation offered to commercial members or, if the provider has no commercial members, that the hours of operation are comparable to hours offered to recipients under Medicaid fee-for-service;
36. Require that providers offer access to interpretation services for members that have a Limited English

Proficiency (LEP) at no cost to the member, and to document the offer and provision of interpreter services to the same extent as the health plan under the Contract;

37. Include a statement that the State and the health plan members shall bear no liability for the health plan's failure or refusal to pay valid claims of subcontractors or providers for covered services;
38. Include a statement that the State and the health plan members shall bear no liability for services provided to a member for which the State does not pay the health plan;
39. Include a statement that the State and the health plan members shall bear no liability for services provided to a member for which the plan or State does not pay the individual or healthcare provider that furnishes the services under a contractual, referral, or other arrangement to the extent that the payments are in excess of the amount that the member would owe if the health plan provided the services directly;
40. Require the provider to secure all necessary liability and malpractice coverage as is necessary to protect the health plan's members and the health plan;
41. Require that the provider use the definition for emergency medical condition included in the provider manual;

42. Require that if the provider will be offering EPSDT services, the provider complies with all EPSDT requirements;
43. Require that the provider provides copies of medical records to requesting members and allows them to be amended as specified in 45 CFR Part 164;
44. Require that the provider provide record access to any authorized DHS personnel or personnel contracted by the DHS without member authorization so long as the access to the records is required to perform the duties of the contract with the State and to administer the QUEST programs;
45. Require that the provider complies with health plan standards that provide the DHS or its designee(s) prompt access to members' medical records whether electronic or paper;
46. Require that the provider coordinate with the health plan in transferring medical records (or copies) when a member changes PCPs;
47. Require that the provider comply with the advance directives requirements for hospitals , nursing facilities, providers of home and health care, hospices, and HMOs specified in 42 CFR Part 49, subpart I, and 42 CFR Section 417.436(d);
48. Require that medical records be retained in accordance with Sections 622-51 and 622-58, HRS, for a minimum of seven (7) years after the last date of entry in the records. For minors, records must be preserved and maintained during the period of

- minority plus a minimum of seven (7) years after the minor reaches the age of majority;
49. Require that the provider complies with all credentialing and re-credentialing activities;
 50. Require that the provider refund any payment received from a resident or family member (in excess of share of cost) for the prior coverage period;
 51. Require that the provider submit annual cost reports to the MQD, if applicable;
 52. Require that the provider comply with all requirements regarding when they may bill a member or assess charges as described in the provider manual;
 53. Require that the provider is licensed in good standing, in the State of Hawaii; and
 54. Require that providers (if they will be providing vaccines to children) enroll and complete appropriate forms for the Vaccines For Children program.

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

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

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

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

The health plan shall submit to the DHS for review and approval a model for each type of provider contract by the due date identified in Section 51.700, Readiness Review,

and at the DHS' request at any point during the contract period.

In addition, the health plan shall submit to the DHS, on the thirtieth (30th) of every month, starting with the month of Contract Award identified in Section 20.100 and concluding with the month prior to the date of Commencement of Services to Members, identified in Section 20.100 the signature page of all finalized and executed contracts that have not been previously submitted.

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

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

40.600 Provider Services

40.610 Provider Education

The health plan shall be responsible for educating the providers about managed care and all program requirements. The health plan shall conduct provider education sessions, either one-on-one or in a group setting, for all contracted providers during the two (2) month period prior to the Date of Commencement of Services to Members identified in Section 20.100. The health plan shall conduct education sessions at least every

six (6) months for their contracted providers after Date of Commencement of Services to Members identified in Section 20.100. In addition, the health plan shall provide one-on-one education to providers who are not fulfilling program requirements as outlined in the provider agreements and the provider manual.

Specifically, the health plan shall educate providers on:

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

- The provider grievance, complaints, and appeals process.

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

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

The health plan shall ensure that the providers are aware of their responsibilities for compliance with the Americans with Disabilities Act (ADA), including how to access interpreter and sign language services as described in Section 50.495.

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

40.620 Provider Grievance System

The health plan shall have policies and procedures for a provider grievance system that includes provider complaints, provider grievances and provider appeals. 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 51.100, 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 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 log all provider complaints and report to DHS in accordance with Section 51.520.7, Provider Complaint and Claims Report.

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

The health plan shall have provider grievance system policies and procedures. These policies and procedures shall be submitted to the DHS for review and approval by

the due date identified in Section 51.700, Readiness Review.

40.630 Provider Manual

The health plan shall develop a provider manual that shall be made available to all providers. The health plan may provide an electronic version only (via link to the health plan's web-site or on a CD-Rom or other appropriate storage disc) unless the provider requests a hard copy. If a provider requests a hard copy, the health plan shall provide it at no charge to the provider.

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

The health plan may utilize a developed provider manual if: (1) all QUEST provider manual requirements are included; (2) it is clear which requirements apply to the QUEST program; and (3) the requirements are clear and easy to understand.

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

- A table of contents;
- An introduction that explains the health plan's organization and administrative structure, including an overview of the health plan's provider services department, function, and how they may be reached;
- Provider responsibilities and the health plan's expectations of the provider;
- A listing and description of covered and non-covered services, requirements and limitations;
- Information about appropriate and inappropriate utilization of emergency room services as well as the definitions of emergency medical condition and emergency medical services as provided in Section 30.200;
- Health plan fraud and abuse activities, including how to report suspected fraud and/or abuse;
- QUEST appointment and waiting time standards as described in Section 40.230;
- Formulary information which shall be updated in advance of the change and sent to the providers;
- The description of the referral process which explains the services requiring referrals and how to obtain referrals;
- A description of the prior authorization (PA) process, including the services requiring PA and how to obtain PAs;
- A description of who may serve as a PCP as described in Section 40.250;

- Applicable criteria for specialists or other healthcare practitioners to serve as PCPs for members with chronic conditions as described in Section 40.250;
- The description of the roles and responsibilities of the PCP, including:
 - Serving as an ongoing source of primary care for the member, including supervising, coordinating, and providing all primary care to the member;
 - Being primarily responsible for coordinating other healthcare services furnished to the member, including:
 - Coordinating and initiating referrals to specialty care (both in-network and out-of-network);
 - Maintaining continuity of care; and
 - Maintaining the member's medical record (this includes documentation of services provided by the PCP as well as any specialty services);
- Information on the health plan's policies and procedures (P&P) for changing PCPs, including:
 - The process for changing PCPs, (e.g., whether the member may make the request by phone, etc.); and
 - When PCP changes are effective;
- Information on the availability of care coordination/case management and how to access these services;

- The description of the role of care coordinators;
- The description of members' rights and responsibilities as identified in Section 50.450;
- A description of reporting requirements, including encounter data requirements, if applicable;
- Reimbursement information, including reimbursement for members with other insurance;
- Explanation of remittance advices;
- A statement that if a provider fails to follow plan procedures which results in nonpayment, the provider may not bill the member;
- The description of when a provider may bill a member or assess charges or fees which shall include a provision that the provider may not bill a member or assesses charges or fees except:
 - If a member self-refers to a specialist or other provider within the network without following health plan procedures (e.g. without obtaining prior authorization) and the health plan denies payment to the provider, the provider may bill the member; and
 - If a provider bills the member for non-covered services or for self-referrals, the provider shall inform the member and obtain prior agreement from the member regarding the cost of the procedure and the payment terms at time of service;

- A description of the health plan's grievance system process and procedures for members which shall include, at a minimum:
 - The member's right to file grievances and appeals with requirements, and time frames for filing;
 - The member's right to a State administrative hearing, how to obtain a hearing and rules on representation at a hearing;
 - The availability of assistance in filing a grievance or an appeal;
 - The member's right to have a provider or authorized representative file a grievance and/or an appeal on his or her behalf, provided he or she has provided consent to do so;
 - The toll-free numbers to file a grievance or an appeal; and
 - When an appeal or hearing has been requested by the member, the right of a member to receive benefits while the appeal or hearing is pending and that the member may be held liable for the costs of those benefits if the health plan's adverse action is upheld;
- A description of the provider grievance system including how to file a complaint, grievance, or appeal;
- A description of how the provider can access language interpretation, sign language services, and

specialized communication (e.g., Braille, translation in a language other than English, etc.);

- A description of the provider's responsibility for continuity of treatment in the event a provider's participation with the health plan terminates during the course of a member's treatment by that provider;
- A description of credentialing and recredentialing requirements and activities;
- A description of the health plan's QAPI and the provider's responsibilities as it relates to the QAPI;
- Medical records standards and the provider's responsibilities regarding medical records;
- A description of confidentiality and HIPAA requirements with which the provider must comply;
- A statement that the health plan shall immediately transfer a member to another PCP, health plan, or provider if the member's health or safety is in jeopardy;
- Claims submission and adjudication procedures;
- Utilization review and management activities; and
- A description of the provider's role in the development of treatment plans for members, as applicable.

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

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

The health plan shall operate a toll-free provider call center to respond to provider questions, comments, inquiries and requests for prior authorizations. The toll-free provider call center shall be available and accessible to providers from all islands on which the health plan serves.

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

The provider call center shall be fully staffed between the hours of 7:45 a.m. (H.S.T.) and 4:30 p.m. (H.S.T.), Monday through Friday, excluding State holidays. The provider call center staff shall be trained to respond to provider questions in all areas.

The health plan shall meet the following call center standards:

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

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

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

40.650 Web-site for Providers

The health plan shall have a provider portal on its web-site that is accessible to providers. The portal shall include all pertinent information including, but not limited to, the provider manual, sample provider contracts, update newsletters and notifications, and information about how

to contact the health plan's provider services department. In addition, the web-site shall have the functionality to allow providers to make inquiries and receive responses from the health plan regarding care for the member, including real-time health plan eligibility and electronic prior authorization request and approval. In addition, the provider web-site shall have a real-time system to track utilization of limited member benefits.

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

The health plan shall submit screenshots of its provider web-site to the DHS for review and approval by the due date identified in Section 51.700, Readiness Review.

40.700 Covered Benefits and Services

General Overview

The health plan shall be responsible for providing all medically necessary covered services to all eligible members as defined in this section. These medically necessary covered services shall be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to recipients under Medicaid fee-for-service. The

health plan may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. The health plan may incorporate utilization controls as described in Section 50.800 as long as the services furnished to the member can be reasonably expected to achieve its purpose.

The health plan shall provide all preventive services as defined in Appendix F and all required EPSDT services defined in Section 40.753.

Included in the services to be provided to adults and children are the medical services required as part of a dental treatment. The health plan shall provide and be financially responsible for medical services related to the dental services and for certain dental procedures performed by both dentists (oral surgeons) and physicians (primarily plastic surgeons, otolaryngologists, and general surgeons), as defined in Section 40.740.1 and Appendix D.

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 or benefit limits. The health plan shall provide a description of any additional services it will provide to the DHS by the due date identified in Section 51.700, Readiness Review.

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

40.710 QUEST Programs

The QUEST Programs have two benefit packages: QUEST Adult and QUEST Keiki. These benefit packages are to be administered by the health plan. This section describes the services provided under each of these programs. Description of services provided in these benefit packages are found in Section 40.740.

40.710.1 QUEST: QUEST Adult Benefit Package

The health plans shall provide the following services to QUEST members that are twenty-one (21) of age and older, including those enrolled in the health plan during prior period coverage. Services shall be provided if medically necessary in the amount and duration listed below. The scope of services is defined in Section 40.740.1.

- Emergency medical services as defined in Section 40.740.1 to include medically necessary ground and air (fixed wing and air) ambulance;

- Ten (10) inpatient hospital days for medical and surgical care to include post-stabilization services, sterilization and hysterectomies or inpatient hospital psychiatric care;
- Twenty (20) outpatient medical or behavioral health visits. These visits include family planning, home health, medical services related to dental needs, other practitioner services, physician services, podiatry, preventative services, rehabilitation services, smoking cessation, urgent care, vision, and hearing services. Family planning services including family planning drugs, supplies and devices to include but not limited to generic birth control pills, medroxyprogesterone acetate (Depo-Provera), intrauterine device (IUD), and diaphragms. Behavioral health visits include alcohol and substance abuse treatment medication management, psychiatric or psychological evaluation and treatment, and methadone management.
- Diagnostic tests (laboratory tests, radiology services, diagnostic and therapeutic services) associated with the covered outpatient medical visits;
- Three (3) outpatient hospital or ambulatory surgical center procedures (including sleep laboratory services and surgeries performed in a free-standing ambulatory surgery center (ASC) and hospital ASC);
- Home Health Services;
- Long-term care and hospice services;

- Immunizations including influenza, pneumococcal, and diphtheria and tetanus vaccines;
- Prescription drugs;
- Diabetic supplies to include syringes, test strips, and lancets;
- Smoking Cessation;
- Non-emergency transportation;
- Interpreter Services/Translation Services;
- Additional behavioral health services as described in Section 40.740.2.c for those that meet diagnostic criteria defined in Section 40.740.2.c and Appendix G;
- Pregnancy-related services; and
- Cancer-related treatment (See Section 40.754).

The health plan shall provide the above identified medical and behavioral health services to all adult members. These services do not include case management, except for members that are identified as having a Special Health Care Need (SHCN) as described in Section 40.751. These services do not include outreach services. More specific rules for exclusions and other limitations on the benefit packages are available in the DHS Hawaii Administrative Rules.

Members may be billed directly by the rendering provider for any non-covered services and for covered services exceeding the established limits, as applicable. The health plans shall inform members that they may be billed

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

40.710.2 QUEST: QUEST Keiki Benefit Package

The health plans shall provide the following services to QUEST members who are younger than twenty-one (21) years of age, including those enrolled in the health plan during prior period coverage. Services shall be provided if medically necessary in the amount, duration, and scope as defined in Section 40.740.1.

- a. Cornea transplants and bone graft services;
- b. Durable medical equipment and medical supplies;
- c. Emergency and Post Stabilization services;
- d. Family planning services;
- e. Home health services;
- f. Hospice services;
- g. Inpatient hospital services for medical, surgical, psychiatric, and maternity/newborn care;
- h. Long-term care services;
- i. Medical services related to dental needs;
- j. Other practitioner services;
- k. Outpatient hospital services;
- l. Physician services;
- m. Podiatry services;

- n. Pregnancy-related services;
- o. Prescription drugs;
- p. Preventive services (See Appendix F for more details on preventive services);
- q. Radiology/laboratory/other diagnostic services;
- r. Rehabilitation services;
- s. Smoking Cessation services;
- t. Sterilizations and Hysterectomies;
- u. Sleep laboratory services;
- v. Transportation services;
- w. Urgent care services;
- x. Vaccinations; and
- y. Vision and hearing services.

40.720 Behavioral Health Services

The health plan shall provide the following services to members as part of their benefit package as described in Sections 40.710.1 and 40.710.2 including those enrolled in the health plan during prior period coverage. Details of coverage for each of these services are discussed in Section 40.740.2.

- a. Inpatient Psychiatric Hospitalizations;
- b. Ambulatory Mental Health Services and crisis management;
- c. Medications and Medication Management;
- d. Psychiatric or psychological evaluation and treatment;
- e. Medically necessary alcohol and chemical dependency services; and

- f. Methadone management services.

40.720.1 Additional Behavioral Health Services for Adults

Adult members age twenty-one (21) years of age or older with a diagnosis of serious and persistent mental illness (SPMI) are eligible for additional behavioral health services within the health plan including those enrolled in the health plan during prior period coverage. The additional behavioral health services that may be provided to these members include:

- a. Intensive Care Coordination/Case Management;
- b. Partial hospitalization or intensive outpatient hospitalization;
- c. Psychosocial Rehabilitation;
- d. Therapeutic Living Supports;
- e. Ten (10) inpatient psychiatric hospital days. If all ten (10) psychiatric hospital days are used, the member may use available inpatient days from the base benefit package (thereby giving the member a minimum of ten (10) and a maximum of twenty (20) inpatient psychiatric hospital days);
- f. Six (6) behavioral health outpatient visits (alcohol and substance abuse are included as part of behavioral health visits) to include but not limited to medication management, psychiatric or psychological evaluation and treatment, and methadone management. If all six (6) behavioral health outpatient visits are used, the member may use available outpatient visits from the base benefit package (thereby giving the member a

minimum of six (6) and a maximum of twenty-six (26) behavioral health outpatient visits).

40.730 Long-Term Care Services

The health plan shall provide these services to members as part of their benefit package as described in Sections 40.710.1 and 40.710.2 who meet appropriate level of care for a maximum of sixty (60) days. Details of coverage for each of the services are discussed in Section 40.740.1.

- a. Skilled Nursing Facility (SNF)/Intermediate Care Facility (ICF);
- b. Subacute facility; and
- c. Subacute bed in an acute hospital.

40.740 Coverage Provisions

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

40.740.1 *Coverage Provisions for Primary and Acute Care Services*

The health plan shall provide the following primary and acute care services in accordance with the prescribed parameters and limitations as part of their benefit package as described in Sections 40.710.1 and 40.710.2. The health plan shall comply with all State and Federal laws pertaining to the provision of such services.

a. Cornea Transplants and Bone Graft Services

Cornea (Keratoplasty) transplants shall be provided in accordance with the Hawaii Administrative Rules. Bone graft is an orthopedic procedure and not part of the transplant program.

b. Durable Medical Equipment and Medical Supplies

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

c. Emergency and Post Stabilization Services

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

members to receive non-emergent care outside of the emergency room.

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

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

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 not adequate time to effect a safe transfer to another hospital before delivery; or (2) that transfer may pose a threat to the health or safety of the woman or her unborn child.

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

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

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

pay for all emergency services that are medically necessary to be provided on an emergent basis until the member is stabilized. The health plan shall also pay any screening examination services to determine whether an emergency medical condition exists.

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

The emergency 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, which shall be responsible for coverage and payment. The health plan is responsible for coverage and payment of medically necessary emergency services. However, the health plan may deny reimbursement for any services provided on an

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

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

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

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

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

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

The health plan shall be responsible for providing post-stabilization care services twenty-four (24) hours a day, (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 Section 438.114, to improve or resolve the member's condition. Post-stabilization services include follow up outpatient specialist care.

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

- The health plan does not respond to the provider's request for pre-certification or prior authorization within one (1) hour;
- The health plan cannot be contacted; or
- The health plan's representative and the attending physician cannot reach an agreement concerning the member's care, and a health plan physician is not available for consultation. In this situation, the health plan shall give the treating physician the opportunity to consult with an in-network physician, and the treating physician may continue with the care of the member until a health plan physician is reached or one of the criteria outlined below are met.

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

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

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

d. 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; and
- Diagnosis and treatment of sexually transmitted diseases.

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

e. Home Health Services

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

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

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

f. Hospice Care

Hospice is a program that provides care to terminally ill patients who are not expected to live more than six (6) months. A participating hospice provider must meet Medicare requirements. Children under the age of

twenty-one (21) years can receive treatment to manage or cure their disease while concurrently receiving hospice services. Adults age twenty-one (21) years or older may receive hospice for up to sixty (60) days while awaiting transition into QExA.

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

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

h. Long-Term Care Services

i. Skilled Nursing Facility (SNF)/Intermediate Care Facility (ICF)

Nursing facility services are provided to members who need twenty-four (24) hours a day assistance with Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) and need care provided by licensed nursing personnel and paramedical personnel on a regular, long-term basis. Nursing facility services are provided in a free-standing or a distinct part of a facility that is licensed and certified as meeting the requirements of

participation to provide skilled nursing, health-related care and rehabilitative services on a regular basis in an inpatient facility in accordance with Section 11-94, HAR. The care that is provided in a nursing facility includes independent and group activities, meals and snacks, housekeeping and laundry services, nursing and social work services, nutritional monitoring and counseling, pharmaceutical services, and rehabilitative services.

ii. Subacute facility

A facility that is licensed in accordance with Section 11-94, HAR and provides the member with services that meet a level of care that is needed by the member not requiring acute care, but who needs more intensive skilled nursing care than is provided to the majority of members in a skilled nursing facility. The subacute services shall be provided in accordance with the Hawaii Administrative Rules.

iii. Subacute bed in an acute hospital

Provision of subacute services, as defined in accordance with the Hawaii Administrative Rules in a licensed and certified hospital for the care and treatment of inpatients.

Appropriate Level of Care

The health plan shall provide members with levels of care appropriate to their medical needs. For a member with documented medical needs that 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 H for a description of the process for obtaining level of care determination 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 referrals.

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 Hawaii Administrative Rules.

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

If the health plan identifies a member it believes may qualify for nursing facility level of care services, the health plan shall initiate the referral process by completing a Form DHS 1147 (Appendix H). The health plan shall complete the forms, which require a review by the health plan's Medical Director, a statement of need for long-term care, and the inclusion of additional documentation—especially related to the social supports available to the member. These forms shall be provided to the DHS or its designated agent.

If the DHS determines that the member meets nursing facility level of care, the health plan or facility shall also refer the member for an ADRC determination in accordance with Section 30.900. If determined disabled, the DHS or its agent shall notify the eligibility worker who shall disenroll the member from QUEST and transfer the member to the QExA program. The member's disenrollment shall become effective no later than the first day of the second month in which the individual or health plan files the request. The health plan shall

coordinate and pay for the member's care until the member is disenrolled from the health plan or if in a facility, up to sixty (60) days of waitlist care, whichever is earlier. As long as the health plan has the member enrolled, the health plan shall make all medical necessity decisions on the placement of the member. The health plan may decide to place the member in a waitlist bed, nursing home bed, or maintain the member at home with home care and other support.

The QExA health plan shall assume financial responsibility for the member when the member is disenrolled from the QUEST health plan and transferred to the QExA program. The former health plan shall notify the facility that the QExA health plan has assumed financial responsibility for the waitlisted recipient. If a member is either not approved for nursing facility level of care or is approved for nursing facility care but not determined permanently disabled through the ADRC process, the member shall remain in the QUEST health plan. If the health plan transfers the member to a nursing facility or places the member on a waitlist and the DHS' agent does not agree with the placement, the member shall remain in the QUEST health plan and the QUEST health plan shall remain responsible for the cost of the long-term care or waitlisted bed.

i. Medical Services Related to Dental Needs

Please refer to Section 30.730 for health plan responsibilities pertaining to Medical Services related to Dental Needs.

j. *Other Practitioner Services*

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

k. *Outpatient Hospital Services*

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

l. Physician Services

Physician services are provided within the scope of practice of medicine or osteopathy as defined by State law and in accordance with Section 17-1737-5, HAR. Services must be medically necessary and provided at locations including, but not limited to: physician's office; a clinic; a private home; a licensed hospital; a licensed skilled nursing or intermediate care facility; or a licensed or certified residential setting.

m. Podiatry Services

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

- Professional services, not involving surgery, provided in the office and clinic;
- Professional services, not involving surgery, related to diabetic foot care in the outpatient and inpatient hospital;
- Surgical procedures are limited to those involving the ankle and below;
- Diagnostic radiology procedures limited to the ankle and below;
- Foot and ankle care related to the treatment of infection or injury is covered in the office or an outpatient clinic setting; and

- Bunionectomies are covered only when the bunion is present with overlying skin ulceration or neuroma secondary to the bunion.

n. Pregnancy-related Services - Services for Pregnant Women and Expectant Parents

The following services are covered under pregnancy-related services: prenatal care; radiology, laboratory, and other diagnostic tests; treatment of missed, threatened, and incomplete abortions; delivery of the infant; postpartum care; prenatal vitamins; inpatient hospital services, physician services, other practitioner services, and outpatient hospital services that impact pregnancy outcomes.

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

The health plan is prohibited from:

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

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

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

o. Prescription Drugs

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

The health plan shall be permitted to develop a common formulary for its QUEST programs. In accordance with Section 346-59.9, HRS, a member shall not be denied access to, or have any limitations on, any medication that is required to be covered by statute, including antipsychotic medications and continuation of antidepressant and anti-anxiety medications prescribed by a licensed psychiatrist or physician duly licensed in the State for a U. S. Food and Drug Administration (FDA) approved indication as treatment of a mental or emotional disorder. Similarly, in accordance with Section 346-352, HRS, any physician licensed in the State who treats a member suffering from the human immunodeficiency virus, acquired immune deficiency syndrome, or hepatitis C, or a member in need of transplant immunosuppressives, shall be able to prescribe any medications approved by the FDA, that are eligible pursuant to the Omnibus Budget Reconciliation Rebates Act, and necessary to

treat the condition, without having to comply with the requirements of any preauthorization procedures.

The health plan shall inform its providers in writing, at least thirty (30) days in advance, of any drugs deleted from its formulary. The health plan shall establish and inform providers of the process for obtaining coverage of a drug not on the health plan's formulary. At a minimum, the health plan shall have a process to provide an emergency supply of medication to the member until the health plan can make a medically necessary determination regarding new drugs.

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

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

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

p. Preventive Services (See Appendix F for more details on preventive services)

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

q. Radiology/Laboratory Diagnostic and Therapeutic Services

These services include, but are not limited to: diagnostic and therapeutic radiology and imaging; screening and diagnostic laboratory tests; and other medically necessary diagnostic or therapeutic radiology or laboratory services.

r. Rehabilitation Services

This service includes physical and occupational therapy, audiology, and speech-language pathology.

s. Smoking Cessation Services

The health plan shall make available a comprehensive smoking cessation program, limited to two quit attempts per benefit period, for

all members who smoke. Services shall be accessible statewide and include medications and counseling, preferably in a combined approach. The health plan's smoking cessation program may be developed within the health plan, contracted to another entity, or a combination of both.

Smoking Cessation services shall include:

- Counseling: at least four (4) in-person sessions per quit attempt that may include any combination of low intensity (3-10 minutes), high intensity (>10 minutes), individual, or group. Two (2) effective components of counseling, practical counseling (problem-solving/skills training) and social support delivered as part of the treatment, shall be emphasized.
- Medications: those recommended in the most current Public Health Service guidelines as effective for smoking cessation to include both nicotine and non-nicotine agents. Effective combinations per the most current Public Health Service guidelines shall also be covered. At least the first three (3) months of generic smoking cessation medications (nicotine and non-nicotine) shall be provided without prior authorization.

t. *Sterilizations and Hysterectomies*

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

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

who is visually impaired, hearing impaired or otherwise disabled;

- The member is not institutionalized in a correctional facility, mental hospital or other rehabilitative facility; and
- Meets the requirements in accordance with Section 560:5-601-612, HRS.

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

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

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

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

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

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

u. Sleep Laboratory Services

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

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

v. *Transportation Services*

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

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

The health plan shall also provide transportation to members who are referred to a provider that is located on a different island or in a different service area. The health plan may use whatever modes of transportation that are available and can be safely utilized by the member. In cases where the member is a minor or requires assistance, the health plan shall provide for an attendant to accompany the member to and from medically necessary visits to providers. The health plan is responsible for the arrangement and payment of the travel costs for the member and the attendant as well as 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 specialty physicians), the health plan shall arrange to transport providers.

Should the member be disenrolled from the plan and enrolled into the Medicaid fee-for-service program or another health plan 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 or the other health plan.

w. Urgent Care Services

The health plan shall provide urgent care services as necessary. Such service may be subject to prior authorization or pre-certification.

x. Vaccinations

Refer to Section 30.820.3 for health plan responsibilities regarding the State's Vaccines for Children (VFC) Program.

y. Vision and Hearing Services

The health plan shall provide eye and vision services provided by qualified optometry/ophthalmology professionals once in a twelve (12) month period for members under age twenty-one (21) years. Visits done more frequently are payable when indicated by symptoms or medical condition. Emergency eye care, which meets the definition of an emergency medical condition, is covered for all members.

Vision examinations, prescription lenses, cataract removal, and prosthetic eyes are covered for all members. An ophthalmologic exam with refraction is also an included service. Excluded vision services include:

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

Visual aids prescribed by ophthalmologists or optometrists (eyeglasses, contact lenses and miscellaneous vision supplies) are covered by the health plan, if medically necessary. These include costs for the lens, frames, or other parts of the glasses, as well as

fittings and adjustments. New lenses are limited to once in a twelve (12) month period for individuals under the age of twenty-one (21) years. Replacement glasses and/or new glasses with significant changes in prescription are covered within the benefit periods for both adults and children. Contact lenses are not covered for cosmetic reasons. Dispensing of the lenses or contacts from the new prescription begins a new twelve (12) month period.

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

Hearing services include but are not limited to the following:

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

Hearing aid device coverage is for both analog and digital models. The coverage of hearing devices shall include a service/loss/damage warranty, a trial or rental period, and reasonable reimbursement as set forth by MQD in the most current hearing aid coverage policy memo. In addition, there should be consideration of

medically justified requests for services outside capped dollar amounts or frequency of replacement.

40.740.2 *Coverage Provisions for Behavioral Health Services*

40.740.2.a *Standard Behavioral Health Services*

The health plan shall be responsible for providing behavioral health services to all members that are in need of behavioral health services, including 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.

The health plan is not obligated to provide behavioral health services to those *adult* members for whom diagnostic, treatment or rehabilitative services are not determined medically necessary by the health plan.

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

The psychiatric evaluation and treatment of members who have been criminally committed to ambulatory mental health care settings (i.e., those *adults* on conditional release to the DOH) shall be the clinical and financial responsibility of the appropriate State agency. The health plan shall remain responsible for providing medical services to these criminally committed members.

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

i. *Inpatient Psychiatric Hospitalizations*

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

ii. *Ambulatory Mental Health Services*

Ambulatory Mental Health Services includes twenty-four (24) hour access line, mobile crisis response, crisis stabilization, crisis management, and crisis residential services. Health plans shall contract for these crisis

services with the Department of Health, Adult Mental Health Division at the Medicaid fee-for-service rate.

iii. Medications and Medication Management

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

iv. Psychiatric or psychological evaluation and treatment

The health plan may utilize a full array of effective interventions and qualified professionals such as psychiatrists, psychologists, licensed clinical social workers, licensed mental health counselors, licensed marriage family therapists, and behavioral health nurse practitioners to evaluate for and provide treatment of behavioral health services to include individual and group counseling and monitoring.

v. Medically necessary alcohol and chemical dependency services

Substance abuse services can only have limits or prior authorization requirements that are co-extensive with physical treatments. Substance abuse services shall be provided in a treatment setting accredited according to the standards established by the State of Hawaii Department of Health Alcohol and Drug Abuse Division (ADAD). The health plan is encouraged to utilize

currently existing publicly funded community-based substance abuse treatment programs, which have received ADAD oversight, through accreditation and monitoring. Substance abuse counselors shall be certified by ADAD.

vi. Methadone management services

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

40.740.2.b Additional Behavioral Health Services for Children

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

40.740.2.c Additional Intensive Interventions or Behavioral Health Services for Adults

Adult members age twenty-one (21) years or older with a diagnosis of serious and persistent mental illness (SPMI) are eligible for additional behavioral health services within the health plan. Health plans shall have

a process in place to identify adults with SPMI who are in need of additional behavioral health services based on the criteria listed below. Members may be eligible for additional behavioral health services if they meet the following criteria:

- The member is eligible for the QUEST program;
- The member falls under one of the qualifying diagnoses (see Appendix G); and
- The member demonstrates presence of qualifying diagnosis for at least twelve (12) months or is expected to demonstrate the qualifying diagnosis for the next twelve (12) months;
- The member meets at least one of the criteria below demonstrating instability and/or functional impairment:
 - Global Assessment of Functioning (GAF) < 50;
or
 - Clinical records demonstrate that the member is currently unstable under current treatment or plan of care (e.g., multiple hospitalizations in the last year and currently unstable, substantial history of crises and currently unstable to include but not limited to consistently noncompliant with medications and follow-up, unengaged with providers, significant and consistent isolation, resource deficit causing instability, significant co-occurring medical illness causing instability, poor coping/independent living/problem

solving skills causing instability, at risk for hospitalization); or

- The member is under Protective Services or requires intervention by housing or law enforcement officials; and
- Members that do not meet the requirements listed above, but are assessed by the health plan's medical director that additional services are medically necessary for the member's health and safety, shall be evaluated on a case-by-case basis for provisional eligibility.

The health plan shall have a process in place to regularly reassess adults with SPMI who are receiving additional behavioral health services and re-evaluate the continued need for additional services. Criteria to end or suspend additional behavioral health services are based on the member's stabilization and clinical indication to be able to be maintained by the behavioral health services available to all health plan members. The clinical criteria used to end or suspend additional behavioral health services include the following:

- The member is unable to engage or demonstrate benefit or maintenance of benefit from additional services despite maximum intervention for at least six (6) months, OR
- Completion of assessment by the health plan's medical director who determines that the additional

behavioral health services are no longer medically necessary for the member's health and safety, OR

- All of the following:
 - GAF > 50 (adults), and
 - Stable for at least 3 months with no anticipated change, and
 - Able to remain stable without additional intensive services.
- Members that meet criteria to end or suspend additional services, but are assessed by the health plan's medical director to need additional medically necessary services for the member's health and safety, shall be evaluated on a case-by-case basis for extension of additional services for a specified length of time.

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

If the health plan contracts with another entity to provide SPMI services for eligible members, the health plan is responsible for the regular assessments for continued stay or for discharge from the contracted entity.

The additional behavioral health services that may be provided to these members include:

i. Intensive Care Coordination/Case Management

Intensive care coordination/case management is case assessment, planning, outreach, ongoing monitoring and service coordination, including disease and self-management to promote illness management and recovery. The health plan shall identify and assign acuity levels for clients that shall correspond to the frequency and intensity of case management as identified below. The frequency of Case Management visits may be increased to more than is identified below if medically necessary. If the Case Manager identifies a significant change in the member, the Case Manager shall notify the psychiatrist of the significant change within twenty-four (24) hours.

Case Management Intensity Criteria

Service Level	IV. Highly Intensive	III. Intensive	II. Intermediate	I. Routine
Change in GAF	GAF has dropped at least 20 points below their baseline.	GAF has dropped at least 10-20 points below their baseline	GAF has dropped at least 10 points below their baseline.	GAF: at or near baseline for > more than 6 months
Course	Unable to remain stable in the community for more than 30 consecutive days.	Consistent progress Relative to TX goals for 3 months	Condition stable > 3 months	Condition stable > 6 months

Relapse	IP, Crisis, or more than 2 ER visits within the last 3 months	IP, Crisis or Residential Care within the last 3-6 months	Only Partial, IOP, or OP Care ≥ 3 months	No higher level of treatment for more than 6 months
Compliance	Poor participation. Requires support participation	Sporadic or progressive participation. Requires limited support	Consistent participation. Infrequent need for support	Established pattern of participation. Infrequent need for support.

Case Management Frequency Service Requirements

Service Level	Minimum Service Contact Requirement	Contact Description
IV. High Intensity	Two (2) times per week	Face-to-face one time per week Other contact may be telephonic
III. Intensive	One (1) time per week	Face-to-face two (2) times per month Other contact may be telephonic
II. Intermediate	Every other week	Face-to-face one time per month Other contact may be telephonic
I. Routine	One (1) time per month	Face-to-face

ii. Psychiatric or Psychological Evaluation and Treatment
 The description of this service is provided in Section 40.740.2.a.

iii. Partial Hospitalization or Intensive Outpatient Hospitalization

Partial hospitalization or intensive outpatient hospitalization is for the purpose of providing stabilization of psychiatric impairments as well as enabling the individual to reside in the community or to

return to the community from a more restrictive setting. The goals of the service are clearly articulated in each consumer's individualized plan of care. Treatment is time-limited, ambulatory and active, offering intensive, coordinated clinical service provided by a multi-disciplinary team. This service shall be used as a step-down from an acute psychiatric hospitalization.

iv. Psychosocial Rehabilitation (PSR)/Clubhouse

PSR/Clubhouse is therapeutic day rehab social skill building services, such as group skill building activities that focus on development of problem solving skills, medication education, and symptom management, that allows individuals to gain necessary social and communication skills necessary to enable them to remain in or return to naturally occurring community programs.

v. Therapeutic Living Supports

Therapeutic Living Supports are services covered in settings such as group living arrangements or therapeutic foster homes. Covered therapeutic supports are only available when the identified individual resides in a licensed group living arrangement or licensed therapeutic foster home. Although these group living arrangements and therapeutic foster homes may provide twenty-four (24) hours per day of residential care, only the therapeutic services provided are

covered. There is no reimbursement for room and board charges. Services provided in therapeutic group homes and therapeutic foster homes include: supervision, monitoring and developing independence of activities of daily living and behavioral management, medication monitoring, counseling and training (individual, group, family), directed at the amelioration of functional and behavioral deficits and based on the individual's plan of care developed by a team of licensed and qualified mental health professionals. Services are provided in a licensed facility and are provided by a qualified mental health professional or staff under the supervision of a qualified mental health professional with 24-hour on-call coverage by a licensed psychiatrist or psychologist.

In addition to services described above, the health plan shall provide integrated services for individuals with co-occurring substance abuse and mental illness.

The DHS may carve-out behavioral health services at a future date and would provide at least three (3) months notice.

40.740.2.d Adverse Events Policy/Reporting and other Behavioral Health Reporting

The health plan shall have policies and procedures in place to identify and address adverse events that occur to adult health plan members receiving additional behavioral health services. Adverse events include but are not limited to death, suicide attempts, altercations

with law enforcement personnel, involvement with Adult Protective Services, homicide or attempted harm to others, medication errors, and injuries requiring medical attention. The health plan shall submit to the DHS, for review and approval, policies and procedures relating to adverse events by the due date identified in Section 51.700, Readiness Review.

Other behavioral health reporting to monitor access to and quality of the behavioral health services provided to health plan members are described in Section 51.540.8, Behavioral Health Services Report.

40.750 Other Covered Services

40.751 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. The health plan shall develop policies and

procedures to identify the following groups of adults with SHCN:

- Adults whose use of prescription medication includes the use of atypical antipsychotics, the chronic use of opioids, the chronic use of polypharmacy, and other chronic usage of specific drugs that exceed the use by other adults in the health plan as identified by the health plan;
- Adults whose utilization of emergency room services is beyond that generally used by other adults in the health plan;
- Adults whose utilization of inpatient services have been used completely in accordance with Section 40.710.1; or
- Adults who have utilized either half of their allowable medical or behavioral health visits in the first six (6) months of the benefit period in accordance with Section 40.710.1, or have utilized twelve (12) outpatient medical or behavioral health visits.

A child with SHCNs is an individual under twenty-one (21) years of age who has a chronic physical, developmental, behavioral, or emotional condition and who requires health and related services of a type or amount beyond that generally required by children. 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 ensures that children with conditions such as asthma, diabetes, hypertension, chronic obstructive lung disease, and children who become pregnant are referred for care coordination/case management services. 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 at 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 members 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 assist 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 71.700.

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.

The health plan shall report to DHS on status of members identified as those with SHCN in accordance with the report described in Section 51.540.7.

40.752 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 Section 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 care for members; and
- Coordination and integration care for of members.

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 for meeting CC/CM standards as required in 42 CFR Section 438.208. 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., QExA health 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 or SHCN as defined in Section 40.751;

- 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 or QExA 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 71.700.

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 the member with 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 contract with, 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 and QExA.

The health plan shall identify its top one percent (1%) utilizers and develop a care coordination/case management plan. The health plan shall provide to DHS the identified members, expenditures over certain periods, and provided care coordination/case management activities to the identified members in accordance with reporting requirements identified in Section 51.560.3.

40.753 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services for Children

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

The health plan shall develop an EPSDT plan that includes written policies and procedures for outreach, informing, tracking, and following-up with members, families, and providers to ensure compliance with the periodicity schedules. The EPSDT plan shall emphasize outreach and compliance monitoring for members under age twenty-one (21) years, taking into account the multi-lingual, multi-cultural nature of the member population, as well as other unique characteristics of this population. The EPSDT plan shall include procedures for follow-up of missed appointments, including missed referral appointments for

problems identified through EPSDT screens and exams. The health plan shall also include procedures for referrals to the DHS contractor providing dental care coordination services for the Medicaid fee-for-service program for needed dental care. The health plan shall be responsible for medical services related to dental needs as described in Sections 30.730.

The health plan shall submit its EPSDT plan to the DHS for review and approval by the date specified in Section 51.700, Readiness Review.

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

The health plan shall require that all providers participating in a health plan utilize the most current EPSDT screening form prescribed by the DHS when performing an EPSDT exam on EPSDT eligible members.

The health plan's outreach and information process shall include:

- Notification to all newly enrolled families with EPSDT-aged members about the EPSDT program within sixty (60) days of enrollment. This requirement includes informing pregnant women and new

mothers either before or shortly after giving birth that EPSDT services are available; and

- Notification to EPSDT eligible members and their families about the benefits of preventive health care, about how to obtain timely EPSDT services (including translation and transportation services), and about receiving health education and anticipatory guidance. This includes informing pregnant women within twenty-one (21) days after confirmation of pregnancy and new mothers within fourteen (14) days after birth that EPSDT services are available.

The health plan's information shall:

- Be provided orally (on the telephone, face-to-face or films/tapes), or in writing. Information may be provided by health plan personnel or health care providers. The health plan shall follow-up with families with EPSDT-eligible members who, after six (6) months of enrollment, have failed to access EPSDT screens and services;
- Be provided in non-technical language at or below a 6th (6.9 grade level or below) grade reading level and use accepted methods for informing persons who are blind or deaf, or cannot read or understand the English language, in accordance with Section 50.430; and
- Stress the importance of preventive care; describe the periodicity schedule; provide information about

where and how to receive services; inform members that transportation and scheduling assistance is available upon request; describe how to access services; state that services are provided without cost; describe what resources are available for non-plan services; and describe the scope and breadth of the health services available. Annual informing by the health plan is required for EPSDT members who have not accessed services during the prior year.

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

- Complete periodic screens according to the EPSDT periodicity schedule in Appendix I 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;
- Inter-periodic screens; and
- Partial screens.

The health plan shall provide all medically necessary diagnostic and treatment services to correct or ameliorate a medical, dental (as defined in Section 30.730), or behavioral health problem discovered during an EPSDT screen (complete periodic, inter-periodic, or partial). This

includes, but is not limited to: initial or interval history; measurements; sensory screening; developmental assessments (including general developmental and autism screening); tuberculosis risk assessments and screening; lead risk assessments; psychosocial and behavioral assessments; alcohol and drug use assessments for adolescents; sexually transmitted infections and cervical dysplasia screening as appropriate; complete physical examinations; age appropriate surveillance; timely immunizations; procedures such as hemoglobin and lead level as appropriate; referral to a “dental home;” referral to state or specialty services; care coordination assistance if needed; age appropriate anticipatory guidance; diagnosis and treatment of any issues found in general developmental and autism screening; and diagnosis and treatment of acute and chronic medical, dental (as defined in Section 30.730), and behavioral health conditions. Screening for developmental delays, autism, and behavioral health conditions, shall be done using standardized, validated screening tools as recommended by current national guidelines and the State’s EPSDT program.

If it is determined at the time of the screening that immunization is needed and appropriate to provide at that time, the health plan shall insure that the provider administers the immunizations. With the exception of the services provided by the DOH, the health plan shall be responsible for providing all services listed in Sections

40.710 and 40.740.1 on Medical Services and Section 40.740.2 on Behavioral Health Services to EPSDT eligible members under EPSDT.

The health plan shall provide additional medical services determined as medically necessary to correct or ameliorate defects of physical, mental/emotional, or dental illness (as defined in Section 30.730) 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, and certain non-experimental medical and surgical procedures.

Health plans shall cover services under EPSDT if the services are determined to be medically necessary to treat a condition detected at an EPSDT screening visit.

The health plan is responsible for behavioral health services for all children with mental and behavioral conditions. Some children who meet criteria as identified in Section 40.740.2.b require more intensive services, which can be provided through CAMHD's Support for Emotional and Behavioral Development (SEBD) program. Children who are eligible for the SEBD program can obtain their behavioral health needs through CAMHD's SEBD program. See Section 30.820.1 and 40.740.2.b for details on Behavioral Health Benefits. These children are complex and often need the collaboration of multiple agencies for

effective intervention. The health plan must, along with CAMHD, have a process in place for collaboration with other agencies (DOE, DOH, and Child Welfare) to assure coordinated care for the member. The health plan is responsible for coordinating services for individuals determined to be eligible for the SEBD program by the health plan with the medically necessary outpatient behavioral health services that are required for the educational needs of the member provided by DOE and DOH.

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

The health plan is not responsible for providing health interventions that are not medically necessary or deemed experimental as per Section 432E.1-4, HRS.

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

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

In addition to the CMS 416 report, the health plan shall also submit to DHS, EPSDT data in an electronic format, to be specified by DHS. This data will be aggregated by DHS and generated reports provided to the health plan for purposes of targeted provider and client oversight, education, and outreach.

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

40.754 Treatment for Adults with Diagnosis of Cancer

If a health plan member is diagnosed with cancer, the member shall have access to any medically necessary service described in Section 40.740 for the treatment of cancer without limitation. Benefits may include but not limited to inpatient hospitalization, physician services, other practitioner services, outpatient hospital services including chemotherapy and radiation therapy, or hospice.

40.760 Other Coordination Activities

40.761 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.

40.762 Foster Care/Child Welfare Services (CWS) Children

In addition to providing all medically necessary services under EPSDT, the health plan shall be responsible for providing the pre-placement physicals (prior to placement) and comprehensive examinations (within forty-five (45) days after placement into a foster care home) including medication dispensed when a physical examination shows a medical need, for children with an active case with CWS. A comprehensive examination shall have all of the components of an EPSDT visit, including referrals for more in-depth developmental and behavioral assessment and management if needed, and the health plan shall reimburse the provider the same rate as for an EPSDT visit. The health plan shall have procedures in place to assist CWS workers in obtaining a necessary physical examination within the established timeframe through a provider in its network. Physical examinations may take place in either an emergency room or physician's office. A provider specializing in child protection, (e.g., provider from Kapi'olani Child Protection Center), may also perform the exams. The health plan shall be responsible for the pre-placement and the 45-day comprehensive exams regardless of whether the provider is the child's primary care physician and regardless of whether the provider is in or out-of-network provider. Any non-network provider must be a licensed provider and must understand and perform all the components of a comprehensive EPSDT examination, including referrals for more in-depth

developmental and behavioral assessment and management if needed.

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

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

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

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

- Providing assistance to members who wish to obtain a slot, either by helping them contact ADAD or its contractor or referring the member to a substance abuse residential treatment provider to arrange for the utilization of an ADAD slot;

- Providing appropriate medically necessary substance abuse treatment services while the member is awaiting an ADAD slot;
- Covering all medical costs for the member while the member is in an ADAD slot;
- Coordinating with the ADAD provider following the member's discharge from the residential treatment program; and
- Placing the member into other appropriate substance abuse treatment programs following discharge from the residential treatment program.

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

See Section 30.820.2 regarding health plan responsibilities for members with cleft and craniofacial disorders receiving care through the Kapi'olani Cleft and Craniofacial Clinic with DOH/CSHN Branch coordination.

40.800 Other Services to be provided

40.801 Cultural Competency

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

- Identify the health practices and behaviors of the members;
- Design programs, interventions, and services, which effectively address cultural and language barriers to

the delivery of appropriate and necessary health services;

- Describe how the health plan will ensure that services are provided in a culturally competent manner to all members so that all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, understand their condition(s), the recommended treatment(s), and the effect of the treatment on their condition, including side effects;
- Describe how the health plan will effectively provide services to people of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes, affirms and respects the worth of the individual members and protects and preserves the dignity of each; and
- Comply with, and ensure that providers participating in the health plan's provider network comply with, Title VI of the Civil Rights Act of 1964, 42 U.S.C. Section 2000d, 45 CFR Part 80 and 42 CFR Section 438.206(c)(2), 42 CFR Section 438.100(d), 42 CFR Sections 438.6(d)(4) and 438.6(f).

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

The health plan shall submit the cultural competency plan to the DHS for review and approval by the date specified in Section 51.700, Readiness Review.

40.802 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, hypertension, high-risk pregnancy, or obesity management. In addition, the health plan may request approval from DHS to change the two (2) other programs based upon member needs after providing services for the first year of the contract.

The health plan's disease management programs shall:

- Have a systematic method of identifying and enrolling members in each program;
- Utilize evidence-based clinical practice guidelines;
- Emphasize the prevention of exacerbation and complications of the diseases;
- Incorporate educational components for both members and providers;
- Utilize an integrated, comprehensive approach to patient care that extends beyond a focus on the prescription drug line item;
- Take a member-centered approach to providing care by addressing psychological aspects, caregiver issues and treatment of diseases using nationally recognized standards of care;

- Incorporate culturally appropriate interventions, including but not limited to taking into account the multi-lingual, multi-cultural nature of the member population;
- Focus interventions on the member through activities such as disease and dietary education, instruction in health self-management, and medical monitoring;
- Have established measurable benchmarks and goals which are specific to each disease and are used to evaluate the efficacy of the disease management programs; and
- Be analyzed to determine if costs have been lowered by reducing the use of unnecessary or redundant services or by avoiding costs associated with poor outcomes.

The health plan shall develop policies and procedures for its disease management programs. The health plan shall submit these policies and procedures to the DHS for review and approval by the date specified in Section 51.700, Readiness Review.

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

40.803 Certification of Physical/Mental Impairment

The health plan shall provide for all re-evaluations of disability (determinations of continued mental or physical impairment) for the public assistance program for TANF recipients and Medicaid (evaluations submitted to the ADRC). The DHS is responsible for the initial disability determination for all public financial assistance programs and the re-evaluations of disability for the financial assistance program entitled General Assistance.

40.900 Second Opinion

The health plan shall provide for a second opinion in any situation when there is a question concerning a diagnosis, the options for surgery or the treatment of a health condition when requested by the member, any member of the health care team, a parent(s) or legal guardian(s), or a DHS social worker exercising custodial responsibility. A qualified health care professional within the network shall provide the second opinion or the health plan shall arrange for the member to obtain a second opinion outside the provider network. The second opinion shall be provided at no cost to the member.

41.100 Out of State/Off Island Coverage

The health plan shall provide any medically necessary covered treatments or services that are required by the member. If these services are not available in the State or on the island in which the member resides, the health plan shall provide for these services whether off-island or out-

of-state. This includes referrals to an out-of-state or off-island specialist or facility, transportation to and from the referral destination for an off-island or out-of-state destination, lodging, and meals for the member and 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 as well as all out-of-state and off-island medically necessary EPSDT covered services to members under age twenty-one (21) years. The health plan may require prior authorization for non-emergency off-island 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 off-island or out-of-state facility when services were approved by the health plan or from an out-of-state or off-island facility when the services were emergent or post-stabilization services. Transportation costs for the return of the member to the island of residence shall be the health plan's responsibility even if the member is being or

has been disenrolled from the health plan during the out-of-state or off-island stay.

Medical services outside of the United States or in a foreign country are not covered for either children or adults.

41.200 Advanced Directives

The health plan shall maintain written policies and procedures for advance directives in compliance with 42 CFR Section 438.6(i)(1)-(2) and 42 CFR Section 422.128. For purposes of this section, the term "MA organization" in 42 CFR Section 422.128 shall refer to the health plan. Such advance directives shall be included in each member's medical record. The health plan shall provide these policies to all members eighteen (18) years of age or older and shall advise members of:

- Their rights under the law of the State of Hawaii, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives; 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 Section 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 the State of Hawaii law regarding advance directives.

The health plan shall educate its staff about its advance directive policies and procedures, situations in which advance directives may be of benefit to members, and the health plan's responsibility to educate and assist members who choose to make use of advance directives. The health plan shall educate members about their ability to direct their care using this mechanism and shall specifically designate which staff members or network providers are responsible for providing this education. The health plan shall provide these policies and procedures to its providers and upon request to CMS and DHS.

41.300 Transition of Care to and from the Health Plan

41.310 Transition to the Health Plan

In the event a member entering the health plan is receiving medically necessary covered services in addition

to or other than prenatal services (see below for members in the second and third trimester receiving prenatal services) the day before enrollment into the health plan, the health plan shall be responsible for the costs of continuation of such medically necessary services, without any form of prior approval and without regard to whether such services are being provided by contract or non-contract providers.

The health plan shall provide continuation of such services for at least forty-five (45) days or until the member's medical needs have been assessed or reassessed by the PCP. The health plan shall reimburse PCP services that the member may access during the forty-five (45) days prior to transition to their new PCP; even if the former PCP is not in the network of the new health plan.

In the event the member entering the health plan is in her second or third trimester of pregnancy and is receiving medically necessary covered prenatal services the day before enrollment, the health plan shall be responsible for providing continued access to the prenatal care provider (whether contract or non-contract) through the postpartum period.

41.320 Transition from the Health Plan

If the member moves to a different service area in the middle of the month and enrolls in a different health plan, the former health plan shall remain responsible for the care and the cost of the inpatient services (as provided in

Section 50.210) provided to the member, if hospitalized, until discharge or level of care changes, whichever occurs first. Otherwise, the new health plan shall be responsible for all services to the member as of member's date of enrollment. If the member moves to a different service area and remains with the same health plan, the health plan shall remain responsible for the care and cost of the services provided to the member.

The former health plan shall cooperate with the member and the new health plan when notified in transitioning the care of a member who is enrolling in a new health plan. The former health plan shall submit transition of care information to DHS utilizing a format specified by DHS for transition to the new health plan within five (5) business days of the former health plan being notified of the transition. The former health plan shall assure that the DHS or the new health plan has access to the member's medical records and any other vital information that the former health plan has to facilitate transition of care.

No health plan or its parent organization shall discriminate against any patient, who was a member of that health plan immediately prior to becoming age sixty-five (65) years, blind, or disabled, by denying access for that patient to his or her established provider(s) and disrupting continuity of care because that patient became age sixty-five (65) years, blind, or disabled.

41.330 Transition of Care Policies and Procedures

The health plan shall develop transition of care policies and procedures that address all transition of care requirements in this RFP and submit these policies and procedures for review and approval by the due date identified in Section 51.700, Readiness Review.

SECTION 50 HEALTH PLAN ADMINISTRATIVE REQUIREMENTS

50.100 Health Plan Eligibility Responsibilities

The health plan shall provide outreach to their members to help them maintain Medical Assistance eligibility on an annual basis. The DHS shall provide the health plan with each of their members' eligibility review dates on the health plan's monthly or daily enrollment/disenrollment rosters. The health plan shall develop processes to perform outreach to members to remind them of their annual eligibility review. The health plan shall submit these policies and procedures to the DHS for review and approval by the due date identified in Section 51.700, Readiness Review. In addition, the health plan shall describe their outreach processes.

50.200 Health Plan Enrollment Responsibilities

The health plan shall accept individuals enrolled into their plan by the DHS without restriction, unless otherwise authorized by the DHS. The health plan shall not discriminate against individuals enrolled, based upon health status or need for health care services, religion, race, color, creed, national origin, ancestry, sex, including gender identity or expression, sexual orientation, or income status. The health plan shall not use any policy or practice that has the effect of discriminating based upon race, religion, color, creed, national origin, ancestry, sex,

including gender identity or expression, sexual orientation, income status, or health care status.

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

- A confirmation of enrollment;
- A health plan membership card that includes the member number, which does not have to be the same as the Medicaid ID number which has been assigned by the DHS, and an expiration date which is the member's eligibility review date in the next calendar year;
- A Member Handbook as described in Section 50.440;
- A flyer or other handout that is separate from the member handbook that explains:
 - An explanation of the role of the PCP and the procedures to be followed to obtain needed services;
 - Information explaining that the health plan shall provide assistance in selecting a PCP and how the member can receive this assistance; and
 - Information explaining that the health plan shall auto-assign a member to a PCP if the member does not select a PCP within ten (10) days.

- A flyer or other handout that is separate from the member handbook that explains:
 - An explanation of the member's rights, including those related to the complaint and grievance procedures;
 - A description of member responsibilities, including an explanation of the information a member must provide to the health plan and the DHS upon changes in the status of the member including marriage, divorce, birth of a child, adoption of a child, death of a spouse or child, acceptance of a job, obtaining other health insurance, change in address and telephone number, etc.;
 - A copy of the written policies and procedures related to advance directives to members at the time of enrollment in accordance with 42 CFR Section 438.6(i); and
 - How to access assistance for those with limited English proficiency.
- A provider directory that includes the names, location, telephone numbers of, and non-English languages spoken by contracted providers in the member's service area including identification of providers that are not accepting new patients.

50.210 Health Plan Responsibilities Related to Enrollment Changes Occurring When a Member is Hospitalized

The health plan shall be responsible for all inpatient services, as well as any transportation, meals and lodging for one (1) attendant, if applicable, for all members who

are enrolled in its health plan on the date of admission to an acute care hospital. In the event a member transfers into a non-managed care MQD program, the QExA program, another health plan, or is otherwise disenrolled during an acute hospital stay, the health plan that the member was enrolled on admission, shall remain responsible for the inpatient services through change in level of care (subsequent to health plan change) or discharge, whichever comes first.

The new health plan is not responsible for providing inpatient services to members who are hospitalized at the time of enrollment under a non-managed care MQD program or another health plan.

The QUEST health plan, the QExA health plan, or the non-managed care MQD program into which the hospitalized member has been enrolled shall be responsible for professional fees, outpatient prescription drugs, and transportation, meals and lodging for an attendant, if applicable, from the date of enrollment into the health plan. QUEST Memo ADM-1009 describes scenarios related to this section found in Appendix J. Any updates to QUEST ADM-1009 shall be enacted as part of this section of the RFP.

50.220 PCP Selection

The health plan shall provide assistance in selecting a PCP and shall provide the member ten (10) calendar days from the date identified on enrollment packet described in Section 50.200 to select a PCP not including mail time. The standard number of days the health plan shall use for mail time is five (5) days. If a PCP is not selected within ten (10) days, excluding mail time, the health plan shall assign a PCP to the member based on the geographic area in which the member resides.

50.230 Member Status Change

The health plan shall forward to the DHS, in a timely manner, any information that affects the status of members in its health plan. The health plan shall complete the required form DHS 1179 for changes in member status and submit the information by fax, courier services, or mail to the appropriate MQD eligibility office. Change in address shall be communicated to the MQD on a monthly basis on the fifteenth (15) of the month or next business day utilizing the format provided by the DHS. In addition, the health plan shall notify the member that it is also his or her responsibility to provide the information to the DHS. Examples of changes in the member's status are provided in Section 30.580.

50.240 Enrollment for Newborns

The health plan shall notify the DHS of a member's birth of a newborn on form DHS 1179 when the health plan has access to the first name of the newborn or within thirty (30) days of birth, whichever is sooner. If the health plan submits the first name of the newborn as Baby Boy or Baby Girl at thirty (30) days, the health plan shall submit the first name of the child to DHS on form DHS 1179 as soon as they receive it.

50.250 Enforcement of Documentation Requirements

The health plan shall assist the DHS in meeting all citizenship, alien status, photo and identification documentation requirements prescribed in Section 6037 of the DRA and in other federal law.

50.260 Informational Brochure

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

50.300 Disenrollment

50.310 Acceptable Reasons for Health Plan Disenrollment Requests

The DHS is solely responsible for making all disenrollment determinations and decisions. The health plan shall notify

the DHS in the event it becomes aware of circumstances that might affect a member's eligibility or whether there has been a status change such that a member would be disenrolled from the health plan. The list of appropriate reasons for disenrollment is provided in Section 30.600.

50.320 Unacceptable Reasons for Health Plan Initiated Disenrollment Requests

The health plan shall not request disenrollment of a member for discriminating reasons, including:

- Pre-existing Medical Conditions;
- Missed appointments;
- Changes to the member's health status;
- Utilization of medical services;
- Diminished mental capacity; or
- Uncooperative or disruptive behavior resulting from the member's special needs (except where the member's continued enrollment in the health plan seriously impairs the health plan's ability to furnish services to either the member or other members).

50.330 Aid to Disabled Review Committee (ADRC)

Please refer to Section 30.900 on health plan responsibilities for the ADRC process.

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

Please refer to Section 30.710 for health plan administrative requirements for SHOTT.

50.400 Member Services

50.410 General Requirements

The health plan shall ensure that members are aware of their rights and responsibilities, the role of PCPs, how to obtain care, what to do in an emergency or urgent medical situation, how to file a grievance or appeal, how to report suspected fraud and abuse, and how to access language assistance services for individuals with limited English proficiency. The health plan shall convey this information via written materials and other methods that may include telephone, internet, or face-to-face communications that allow the members to ask questions and receive responses from the health plan.

When directed by the DHS, and whenever there has been a "significant" change as defined in Section 30.200, the health plan shall notify its members in writing of any change to the program information members receive. The health plan shall provide this information to members at least thirty (30) days prior to the intended effective date of the change.

The health plan shall develop member services policies and procedures that address all components of member services. The health plan shall submit these policies and procedures to the DHS for review and approval by the due date identified in Section 51.700, Readiness Review.

These policies and procedures must include, but are not limited to, policies and procedures on:

- Member call center staffing and monitoring;
- Member call center activities to ensure metrics as required in Section 50.480 are met;
- The availability and how to access interpretation services for non-English speakers, translation services, and services for individuals with visual and hearing impairments;
- Member rights and how they are protected;
- Up-dating and ensuring accuracy of information on the member portal of the web-site; and
- Methods to ensure member materials are mailed in a timely manner.

50.420 Member Education

The health plan shall educate its members on the importance of good health and how to achieve and maintain good health. Educational efforts shall emphasize the following but are not limited to: the availability and benefits of preventive health care; the importance and schedules for screenings for cancer, high blood pressure and diabetes; the importance of early prenatal care; and, the importance of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services including timely immunizations. The health plan shall also provide educational programs and activities that outline the risks

associated with the use of alcohol, tobacco and other substances.

The health plan shall educate its members on the concepts of managed care and the procedures that members need to follow such as informing the health plan and the DHS of any changes in member status, the use of the PCP as the primary source of medical care and the scope of services provided through the health plan. This includes education in the areas of member rights and responsibilities, availability and role of CC/CM services and how to access these services, the grievance and appeal process, identifying fraud and abuse by a provider and how the member can report fraud and abuse, and the circumstances/situations under which a member may be billed for services or assessed charges or fees including information that a member cannot be terminated from the program for non-payment of non-covered services and no-show fees.

As part of these educational programs, the health plan may use classes, individual or group sessions, videotapes, written material and media campaigns.

The DHS shall review and approve materials prior to the health plan distributing them or otherwise using them in educational programs. The health plan shall submit its member education materials including training plan and

curricula for review and approval by the due date identified in Section 51.700, Readiness Review.

50.430 Requirements for Written Materials

The health plan shall use easily understood language and formats for all member written materials.

The health plan shall make all written materials available in alternative formats and in a manner that takes into consideration the member's special needs, including those who are visually impaired or have limited reading proficiency. The health plan shall notify all members and potential members that information is available in alternative formats and provide information on how to access those formats.

The health plan shall make all written information for members available in English, Ilocano, Vietnamese, Chinese (Traditional) and Korean. When the health plan is aware that the member needs written information in an alternate language, the health plan shall send all written information in this language to that member. The health plan may provide information in other prevalent non-English languages based upon its member population as required in Title VI of the Civil Rights Act of 1964, 42 U.S.C. Section 2000d, 45 CFR Part 80.

All written materials distributed to members shall include a language block that informs the member that the

document contains important information and directs the member to call the health plan to request the document in an alternative language or to have it orally translated. The language block shall be printed, at a minimum, in the non-English languages identified in paragraph 3 of this section.

The health plan shall certify that a qualified individual has reviewed the translation of the information into the different languages for accuracy. The health plan shall submit certification and translation of information into different languages for review and approval by the due date identified in Section 51.700, Readiness Review.

All written materials shall be worded such that the materials are understandable to a member who reads at the 6th (6.9 or below) grade reading level. Suggested reference materials to determine whether this requirement is being met are the:

- Fry Readability Index;
- PROSE The Readability Analyst (software developed by Education Activities, Inc.);
- McLaughlin SMOG Index; or
- Flesch-Kincaid Index.

All written material including changes or revisions must be submitted to the DHS for prior approval before being distributed. The health plan shall also receive prior

approval for any changes in written materials provided to the members before distribution to members.

50.440 Member Handbook Requirements

The health plan shall mail to all newly enrolled members a Member Handbook within ten (10) days of receiving the notice of member enrollment from the DHS. The health plan shall mail to all enrolled members a Member Handbook every year.

Pursuant to the requirements set forth in 42 CFR Section 438.10, the Member Handbook shall include, but not be limited to:

- A table of contents;
- Information about the roles and responsibilities of the member;
- General information on managed care;
- Information about the role and selection of the PCP;
- Information on how to contact the toll-free call center both during and outside of business hours;
- Information about reporting changes in family status and family composition;
- Appointment procedures including the minimum appointment standards as identified in Section 40.230;
- Information that a provider cannot charge the member a “no-show” fee;

- Information on benefits and services that includes basic definitions;
- Information on how to access services, including EPSDT services, non-emergency transportation services and maternity and family planning services;
- An explanation of any service limitations or exclusions from coverage;
- Benefits provided by the health plan not covered under the contract;
- The health plan's responsibility to coordinate care;
- Information on services that are not provided by the health plan that the member may have access to (i.e., Early Intervention Program) and how to obtain these services;
- A notice stating that the health plan shall be liable only for those services authorized by the health plan;
- A description of all pre-certification, prior authorization or other requirements for treatments and services;
- The policy on referrals for specialty care and for other covered services not furnished by the member's PCP;
- Information on how to obtain services when the member is out-of-state or off-island;
- Information on cost-sharing and other fees and charges;
- A statement that failure to pay for non-covered services shall not result in a loss of Medicaid benefits;

- Notice of all appropriate mailing addresses and telephone numbers, to be utilized by members seeking information or authorization, including the health plan's toll-free telephone line;
- A description of member rights and responsibilities as described in Section 50.450;
- Information on advance directives;
- Information on how to access interpreter and sign language services, how to obtain information in alternative languages and formats, and that these services are available at no charge;
- Information on the extent to which, and how, after-hours and emergency services are provided, including the following:
 - What constitutes an urgent and emergency medical condition, emergency services, and post-stabilization services and availability of a twenty-four (24) hour triage nurse;
 - The fact that prior authorization is not required for emergency services;
 - The process and procedures for obtaining emergency services, including the use of the 911 telephone systems or its local equivalent;
 - The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered herein; and

- The fact that a member has a right to use any hospital or other appropriate health care setting for emergency services.
- Information on the member grievance system policies and procedures, as described in Section 51.100. This description must include the following:
 - The right to file a grievance and appeal with the health plan;
 - The requirements and timeframes for filing a grievance or appeal with the health plan;
 - The availability of assistance in filing a grievance or appeal with the health plan;
 - The toll-free numbers that the member can use to file a grievance or an appeal with the health plan by phone;
 - The right to a state administrative hearing, the method for obtaining a hearing, and the rules that govern representation at the hearing;
 - Notice that if the member files an appeal or a request for a state administrative hearing within the timeframes specified for filing, the member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member; and
 - Any appeal rights that the state chooses to make available to providers to challenge the failure of the health plan to cover a service.

- Additional information that is available upon request, including information on the structure and operation of the health plan and information on physician incentive plans as set forth in 42 CFR Section 438.6(h).

The Member Handbook shall be submitted to the DHS for review and approval by the due date identified in Section 51.700, Readiness Review.

50.450 Member Rights

The health plan shall have written policies and procedures regarding the rights of members and shall comply with any applicable federal and state laws and regulations that pertain to member rights. These rights shall be included in the Member Handbook. At a minimum, said policies and procedures shall specify the member's right to:

- Receive information pursuant to 42 CFR Section 438.100(a)(1)(2) and Sections 50.430 and 50.495 of this RFP;
- Be treated with respect and with due consideration for the member's dignity and privacy;
- Have all records and medical and personal information remain confidential;
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;

- Participate in decisions regarding his or her health care, including the right to refuse treatment;
- Be free from any form of restraint or seclusion as a means of coercion, discipline, convenience or retaliation, as specified in federal regulations on the use of restraints and seclusion;
- Request and receive a copy of his or her medical records pursuant to 45 CFR Parts 160 and 164, subparts A and E, and request to amend or correct the record as specified in 45 CFR Sections 164.524 and 164.526;
- Be furnished health care services in accordance with 42 CFR Sections 438.206 through 438.210;
- Freely exercise his or her rights, including those related to filing a grievance or appeal, and that the exercise of these rights shall not adversely affect the way the member is treated;
- Have direct access to a women's health specialist within the network;
- Receive a second opinion at no cost to the member;
- Receive services out-of-network if the health plan is unable to provide them in-network for as long as the health plan is unable to provide them in-network and not pay more than he or she would have if services were provided in-network;
- Receive services according to the appointment waiting time standards;
- Receive services in a culturally competent manner;
- Receive services in a coordinated manner;

- Have his or her privacy protected;
- Be included in treatment plan development, if applicable;
- Have direct access to specialists (if he or she has a special healthcare need);
- Not have services arbitrarily denied or reduced in amount, duration or scope solely because of diagnosis, type of illness, or condition;
- Not be held liable for:
 - The health plan's debts in the event of insolvency;
 - The covered services provided to the member by the health plan for which the DHS does not pay the health plan;
 - Covered services provided to the member for which the DHS or the health plan does not pay the healthcare provider that furnishes the services; and
 - Payments of covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount the member would owe if the health plan provided the services directly; and
- Only be responsible for cost sharing in accordance with 42 CFR Sections 447.50 through 447.60.

50.460 Provider Directory

The health plan shall produce a provider directory for the DHS to assist members in selecting a health plan. The

health plan shall organize the provider directory by island and then by provider type/specialty. The health plan shall include the following in the provider directory:

- The provider's complete name,
- All locations;
- Telephone numbers;
- Non-English languages spoken;
- Whether or not board certification has been attained;
- Web-site address (if available); and
- Whether the provider is accepting new patients.

The health plan shall maintain an updated provider directory on their web-site that includes all identified information above. This directory shall be updated at least monthly. Information on how to access this information shall be clearly stated in both the member and provider areas of the web-site. When the web-site is not accessible during business hours, (7:45 a.m. (H.S.T.) through 4:30 p.m. (H.S.T.)), the health plan shall have member and provider service representatives who can access provider directory information for its members, providers and the State.

The health plan shall send a hard copy of its provider directory to their members as part of the member handbook packet as described in Section 50.440. The health plan shall update its hard copy of the provider directory on at least a quarterly basis.

50.470 Member Identification (ID) Card

The health plan shall mail a member ID card to all new or renewing members within ten (10) days of their selecting a PCP or the health plan auto-assigning them to a PCP. The member ID card must, at a minimum, contain the following information:

- Member number;
- Member name;
- Effective date;
- Expiration date (the member's eligibility review date for the next calendar year);
- PCP name and telephone number;
- Benefit or other limits (for example, QUEST Keiki or QUEST Adult); and
- Third Party Liability (TPL) information.

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

The health plan shall reissue a member ID card within ten (10) days of notice if a member reports a lost card, there is a member name change, the PCP changes, for any other reason that results in a change to the information on the member ID card, or for renewal with continuing eligibility.

The health plan shall submit a front and back sample member ID card to the DHS for review and approval by the due date identified in Section 51.700, Readiness Review.

50.480 Member Toll-Free Call Center

The health plan shall operate a toll-free call center located in Hawaii to respond to member questions, comments and inquiries. The toll-free call center services shall be available and accessible to members from all islands the health plan serves.

The toll-free call center shall handle calls from non-English speaking callers, as well as calls from members who are hearing impaired. The health plan shall develop a process to handle non-English speaking callers.

The health plan's toll-free call center systems shall have the capability to track call center metrics identified by the DHS. The health plan's toll-free call center shall have the capacity for DHS to monitor remotely.

The call center shall be fully staffed between the hours of 7:45 a.m. (H.S.T.) and 4:30 p.m. (H.S.T.), Monday through Friday, excluding State holidays. The call center staff shall be trained to respond to member questions in all areas, including, but not limited to, covered services, the provider network, and non-emergency transportation (NET).

The health plan shall meet the following call center standards:

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

The health plan shall have an automated system or answering service available between the hours of 4:30 p.m. (H.S.T.) and 7:45 a.m. (H.S.T.), Monday through Friday and during all hours on weekends and holidays. This automated system or answering service shall provide callers with operating instructions on what to do in case of an emergency, shall provide an option to talk directly to a nurse or other clinician (as described below) and shall include a voice mailbox or other method for members to leave messages. The health plan shall ensure that the voice mailbox has adequate capacity to receive all messages. The health plan shall ensure that representatives return all calls by close of business the following business day.

In addition, the health plan shall have a twenty-four (24) hour, seven (7) day a week, toll-free nurse line available to members. The health plan may use the same number as is used for the call center or may develop a different

phone number. Staff on the toll-free nurse line must be a registered nurse (R.N.), physician's assistant, nurse practitioner, or medical doctor. The primary intent is through triage to decrease inappropriate utilization of emergency rooms and improve coordination and continuity of care with an individual's PCP. However, having the phone line staffed by someone who is also able to provide treatment as appropriate is encouraged.

The toll-free nurse line shall meet the following standards:

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

50.490 Internet Presence/Web-Site

The health plan shall have a member portal on its web-site that is available to all members which contains accurate, up-to-date information about the health plan, services provided, the provider network, FAQs, and contact phone numbers and e-mail addresses. This website shall incorporate a real-time system to track utilization of limited member benefits.

The section of the web-site relating to QUEST shall comply with the marketing policies and procedures and

requirements for written materials described in this contract and all applicable state and federal laws.

The health plan shall submit to the DHS, for review and prior approval, all screen shots relating to the QUEST program by the due date identified in Section 51.700, Readiness Review.

50.495 Interpretation Services

The health plan shall provide interpretation services of information to any member who requests the service regardless of whether a member speaks a language that meets the threshold of a prevalent non-English language. In addition, the health plan shall provide sign language and TDD services to members with hearing impairments. The health plan shall notify its members of the availability of interpretation services, sign language and TDD services and inform them of how to access these services. There shall be no charge to the member for any interpretation, sign language or TDD services.

50.500 Value-Driven Health Care

50.510 Background

Value-driven health care means aligning payment with quality and efficiency. This payment reform may include but not be limited to different reimbursement strategies such as fee for service with incentives for performance, capitation payment to providers with assigned responsibility for patient care, or a hybrid. Measures used

shall be evidence-based and validated. Value-driven health care can occur through reimbursement mechanisms for physicians, hospitals, and other health care providers.

50.520 Primary Care Providers

The medical home is a model to facilitate the provision of outpatient high quality and high efficient care. This model is based on the domains of patient-centered, accessible, comprehensive, coordinated, evidence-based, and performance measurement. Following are the elements for each of these domains:

Patient Centered:

- Include patient, and family as appropriate, in shared decision making
- Provide culturally sensitive and competent care including language access
- Provide processes to promote patient self-management
- Refer to community resources/supports as indicated

Accessible:

- Address patients' concerns in a timely manner
- Maintain open scheduling and/or expanded office hours
- Maintain after hours accessibility
- Develop and maintain multiple options for communication

Comprehensive:

- Maintain a whole person orientation
- Be first contact for undifferentiated problems
- Be responsible for addressing vast majority of physical and behavioral health care needs
- Provide preventive, acute, and chronic care

Coordinated:

- Provide or ensure provision of care across health care spectrum of services and settings
- Track and follow up tests and referrals
- Facilitate transition of care and reconcile care plan
- Identify high-risk patients

Evidence-Based:

- Adopt and implement evidence-based guidelines
- Utilize evidence-based clinical decision support tools
- Proactively manage evidence-based population health and disease management
- Implement effective practice organization and workflow processes

Performance Measurement

- Utilize electronic health record with registry functionality
- Utilize validated measures, particularly patient-oriented outcome measures when possible
- Report on performance

- Have continuous quality improvement process

Incentivizing increased quality and efficiency of care including proactive population management shall be based on outcomes. Payment reform is a quintessential component of enabling the medical home. The health plan may utilize a monthly patient management reimbursement to the provider that is reconciled with earned financial incentives based on performance.

A medical home shall receive increased reimbursement compared to a practice that does not meet the criteria to be a medical home, and there shall be two levels of medical homes with higher payment to the Platinum level compared to the Gold level:

- Platinum Level Medical Home: To be considered a first tier medical home, a provider/practice must meet all elements for each of the domains of patient centered, accessible, comprehensive, and coordinated; and must meet three elements for each for the domains of evidence-based and performance measurement; plus meet the Office of the National Coordinator requirements for meaningful use of an electronic health record.
- Gold Level Medical Home: To be considered a second tier medical home, a provider/practice must meet three elements for each of the domains of patient centered, accessible, comprehensive, and coordinated; and must

meet two elements for each for the domains of evidence-based and performance measurement. NCQA recognition for the patient-centered medical home shall deem a provider/practice as a second tier medical home.

50.530 Hospitals

To incentivize the provision of high quality highly efficient care, health plans shall not reimburse hospitals on a per diem basis, particularly where acuity adjusted diagnosis-based reimbursement methodologies have been well developed. However, the health plans may reimburse on a per diem basis for services for which such methodologies are not well developed and for specific situations such as wait-listed patients.

Financial incentives shall be based on validated measures including those adopted by the Centers for Medicare & Medicaid Services, developed by the National Committee for Quality Assurance, endorsed by the National Quality Forum, as well as the Agency for Healthcare Research and Quality inpatient quality and patient safety indicators. DHS recommends that health plans are sensitive to increasing hospital administrative burden and to the extent possible align measures with those already being reported.

50.540 Vertically Integrated Organizations

Health plans are encouraged to pursue a shared risk and shared savings program with integrated care organizations

if available. Such a health care delivery model may be provider led, and the organization assumes responsibility, i.e. becomes accountable for providing at a minimum primary, acute, and chronic care services. The contractual arrangement would be expected to include an element of capitation payment and may also include performance-based financial incentives and gain sharing.

50.550 Value-Driven Health Care Schedule

The health plan shall incorporate value-driven health care concepts as described in Section 50.500 and subsections for a minimum percentage of contracts with networked hospitals and primary care providers according to the following table:

Beginning of contract year:	Percentage of primary care providers and of hospitals
1	10%
2	20%
3	40%

The health plans shall incorporate the measures selected for financial incentives, as appropriate, into the provider contracts.

The health plan shall submit its value-driven health care plan to the DHS for review and approval at least ninety (90) days prior to implementation.

50.600 Marketing and Advertising

50.610 Allowable Activities

The health plan shall be permitted to perform the following marketing activities:

- Distributing general information through mass media (i.e., newspapers, magazines and other periodicals, radio, television, the Internet, public transportation advertising, and other media outlets);
- Distributing brochures and displaying posters at provider offices and clinics that inform patients that the clinic or provider is part of the health plan's provider network, provided that all health plans in which the provider participates have an equal opportunity to be represented; and
- Attending activities that benefit the entire community such as health fairs or other health education and promotion activities that have been previously approved by the DHS.

If the health plan performs an allowable activity, the health plan shall conduct these activities in the entire region in which it is operating.

All materials shall comply with the information requirements in 42 CFR Section 438.10 and as detailed in Section 50.430 of this RFP.

50.620 Prohibited Activities

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

- Directly or indirectly engaging in door-to-door, telephone, or other cold-call marketing activities to potential members;
- Offering any favors, inducements or gifts, promotions, or other insurance products that are designed to induce enrollment in the health plan, and that are not health related and worth more than ten dollars (\$10) cash;
- Distributing information and materials that contain statements that the DHS determines are inaccurate, false, or misleading. Statements considered false or misleading include, but are not limited to, any assertion or statement (whether written or oral) that the recipient must enroll in a specific health plan to obtain benefits, or to avoid losing benefits, or that any particular health plan is endorsed by the federal or state government, or similar entity; and
- Distributing materials that, according to the DHS, mislead or falsely describe the health plan's provider network, the participation or availability of network providers, the qualifications and skills of network providers (including their bilingual skills); or the hours and location of network services.

The State may impose financial sanctions, as described in Section 72.220, up to the federal limit, on the health plan for any violations of the marketing and advertising policies.

50.630 State Approval of Materials

All printed materials, advertisements, video presentations, and other information prepared by the health plan that pertain to or reference the programs or the health plan's program business shall be reviewed and approved by the DHS before use and distribution by the health plan. The health plan shall not advertise, distribute or provide any materials to its members or to any potential members that relate to QUEST that have not been approved by the DHS. All materials shall be submitted to the DHS for review and approval by the due date identified in Section 51.700, Readiness Review.

In addition, the health plan shall submit, to the DHS, any marketing materials it has received from a provider for review and prior approval.

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

50.700 Quality Improvement

50.710 Accreditation

The health plan shall be accredited by the National Committee for Quality Assurance (NCQA) for its QUEST program no later than when their current accreditation expires. For health plans undergoing accreditation for NCQA, health plans shall submit reports monitoring the accreditation process as required in Section 51.550.1.

50.720 General Provisions

The health plan shall provide for the delivery of quality care that is accessible and efficient, provided in the appropriate setting, according to professionally accepted standards, and in a coordinated and continuous rather than episodic manner.

The health plan shall provide quality care that includes, but is not limited to:

- Providing adequate capacity and service to ensure member's timely access to appropriate needs, services/care;
- Ensuring coordination and continuity of care;
- Ensuring that member's rights are upheld and services are provided in a manner that is sensitive to the cultural needs of members, pursuant to Section 40.801;

- Encouraging members to participate in decisions regarding their care and educating them on the importance of doing so;
- Placing emphasis on health promotion and prevention as well as early diagnosis, treatment and health maintenance;
- Ensuring appropriate utilization of medically necessary services; and
- Ensuring a continuous quality improvement approach.

The health plan shall execute processes to assess, plan, implement, evaluate and, as mandated, report quality management and performance improvement activities as specified by the State and that adhere to the requirements prescribed in 42 CFR Sections 438.240(a)(1) and (e)(2), including:

- Seeking input from, and working with, members, providers, MQD staff and its designees and community resources and agencies to actively improve the quality of care provided to members;
- Conducting Performance Improvement Projects (PIPs);
- Conducting QM monitoring and evaluation activities;
- Investigating, analyzing, tracking and trending quality of care issues, abuse and/or complaints that includes:

- Sending acknowledgement letter to the originator of the concern;
- Documenting all steps utilized during the investigation and resolution process;
- Following-up with the member to assist in ensuring immediate healthcare needs are met;
- Sending closure/resolution letter that provides sufficient detail to ensure that the member has an understanding of the resolution of his/her issue, any responsibilities he/she has in ensuring all covered, medically necessary care needs are met, and a contact name and telephone number to call for assistance or to express any unresolved concerns;
- Documenting implemented corrective action plan(s) or action(s) taken to resolve the concern; and
- Determining and evaluating evidence of the resolution implemented;
- Implementing the DHS mandated performance measures; and
- Establishing and implementing credentialing, recredentialing and provisional credentialing processes for providers and organizations according to 42 CFR Sections 438.206(b)(6) and 438.214.

The health plan shall submit a written Quality Assessment and Performance Improvement (QAPI) description that addresses its strategies for performance improvement and

conducting the quality management activities described in this section. In addition, the health plan shall submit an evaluation of the previous year's QAPI program.

50.730 Quality Assessment and Performance Improvement (QAPI) Program

The health plan shall have an ongoing QAPI Program for all services it provides to its members. The QAPI Program shall be comprehensive in range and scope. It shall cover all demographic groups, care settings, and types of services. It shall address clinical medical care, behavioral health care, member safety, and non-clinical aspects of service, including the availability, accessibility, coordination, and continuity of care. It shall consist of the systematic internal processes and mechanisms used by the health plan for its own monitoring and evaluation of the impact and effectiveness of the care/services it provides according to established standards. The principles of continuous quality improvement shall be applied throughout the process, from developing, implementing, monitoring, and evaluating the QAPI Program to identifying and addressing opportunities for improvement. The QAPI program designates and specifies the roles/responsibilities of a physician and behavioral health practitioner as well as the Quality Improvement Committee and all subcommittees.

The health plan shall submit its QAPI Program documentation for review to DHS with its RFP proposal. The health plan shall then submit its QAPI Program for

review and approval by DHS by the date specified in Section 51.700, Readiness Review. Upon request by the DHS, the health plan shall submit information on its QAPI program. The health plan also ensures that a QAPI program work plan is developed and evaluated on an annual basis and is updated as needed.

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

1. Conducting performance improvement projects (PIPs) described in 42 CFR Section 438.240(d);
2. Submitting performance measurement data (HEDIS measures) described in 42 CFR Section 438.240(c);
3. Establishing mechanisms for detecting both under-utilization and over-utilization of services; and
4. Establishing mechanisms for assessing the quality and appropriateness of care furnished to members with special health care needs.

When establishing its QAPI program standards, the health plan shall comply with applicable provisions of federal and state laws and current NCOA Standards/Guidelines for Accreditation of Managed Care Organizations.

The DHS reserves the right to require additional standards or revisions to established standards and their respective elements to ensure compliance with changes to federal or

state statutes, rules, and regulations as well as to clarify and to address identified needs for improvement.

Contingent upon approval from the DHS, the health plan may be permitted to delegate certain QAPI Program activities and functions. The health plan shall request to delegate QAPI Program activities and functions by the date specified in Section 51.700, Readiness Review. However, the health plan shall remain responsible for the QAPI Program, even if portions are delegated to other entities. Any delegation of functions requires:

- A written delegation agreement between the delegated organization and the health plan, describing the responsibilities of the delegation and the health plan; and
- Policies and procedures detailing the health plan's process for evaluating and monitoring the delegated organization's performance. At a minimum, the following shall be completed by the health plan:
 - Prior to execution of the delegation agreement there shall be provisions for a site visit and evaluation of the delegated organization's ability to perform the delegated activities; and
 - An annual on-site visit and/or documentation/record reviews to monitor/evaluate the quality of the delegated organization's assigned processes; and

- Evaluation of the content and frequency of reports from the delegated organization.

In accordance with 42 CFR Section 438.240(e), Program Review by the State, the DHS shall review, at least annually, the impact and effectiveness of each health plan's QAPI Program. The scope of the DHS review also includes monitoring of the systematic processes developed and implemented by the health plan to conduct its own internal evaluation of the impact and effectiveness of its QAPI program as well as to effect necessary improvements.

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

- Reviewing QAPI documents;
- Reviewing and evaluating the QAPI Program reports regularly required by the DHS (e.g. member grievances and appeals reports, provider complaints and claims reports, reports of suspected cases of fraud and abuse, the performance measures (HEDIS) report, performance improvement project (PIP) reports, QAPI Program Description Report, etc.);
- Reviewing, evaluating, or validating implementation of specific policies and procedures or special reports relating to areas such as:
 - Member rights and protections;

- Care/services provided to members with special health care needs;
- Utilization management (e.g. under-utilization and over-utilization of services);
- Access to care standards, including the:
 - Availability of services;
 - Adequate capacity and services;
 - Continuity and coordination of care;
 - Coverage and authorization of services;
- Structure and Operation Standards, including:
 - Provider selection;
 - Member information;
 - Confidentiality;
 - Enrollment and disenrollment;
 - Grievance systems;
 - Subcontractual relationships and delegation;
- Measurement and Improvement Standards;
- Practice guidelines;
- QAPI Program;
- Health information systems;
- Conducting on-site reviews to interview health plan staff for clarification, to review records, or to validate implementation of processes/procedures; and
- Reviewing medical records.

The DHS may elect to monitor the activities of the health plan using its own personnel or may contract with qualified personnel to perform functions specified by the DHS.

Upon completion of its review, the DHS or its designee shall submit a report of its findings to the health plan.

50.740 Medical Records Standards

As part of its QAPI Program, the health plan shall establish medical records standards as well as a record review system to assess and assure conformity with standards. These standards shall be consistent with the minimum standards established by the DHS identified below:

- Require that the medical record is maintained by the provider;
- Assure that DHS personnel or personnel contracted by the DHS shall have access to all records, as long as access to the records is needed to perform the duties of this contract and to administer the QUEST program for information released or exchanged pursuant to 42 CFR Section 431.300. The health plan shall be responsible for being in compliance with any and all State and Federal laws regarding confidentiality;
- Provide DHS or its designee(s) with prompt access to members' medical records;
- Provide members with the right to request and receive a copy of his or her medical records, and to request they be amended, as specified in 45 CFR Part 164; and
- Allow for paper or electronic record keeping.

As part of the record standards, the health plan shall require that providers adhere to the following requirements:

- All medical records are maintained in a detailed and comprehensive manner that conforms to good professional medical practice;
- All medical records are maintained in a manner that permits effective professional medical review and medical audit processes;
- All medical records are maintained in a manner that facilitates an adequate system for follow-up treatment;
- All medical records shall be legible, signed and dated;
- Each page of the paper or electronic record includes the patient's name or ID number;
- All medical records contain patient demographic information, including age, sex, address, home and work telephone numbers, marital status and employment, if applicable;
- All medical records contain information on any adverse drug reactions and/or food or other allergies, or the absence of known allergies, which are posted in a prominent area on the medical record;
- All forms or notes have a notation regarding follow-up care, calls or visits, when indicated;

- All medical records contain the patient's past medical history that is easily identified and includes serious accidents, hospitalizations, operations and illnesses. For children, past medical history including prenatal care and birth;
- All pediatric medical records include a completed immunization record or documentation that immunizations are up-to-date;
- All medical records include the provisional and confirmed diagnosis(es);
- All medical records contain medication information;
- All medical records contain information on the identification of current problems (i.e., significant illnesses, medical conditions and health maintenance concerns);
- All medical records contain information about consultations, referrals, and specialist reports;
- All medical records contain information about emergency care rendered with a discussion of requirements for physician follow-up;
- All medical records contain discharge summaries for: (1) all hospital admissions that occur while the member is enrolled; and (2) prior admissions as appropriate;
- All medical records for members eighteen (18) years of age or older include documentation as to whether or not the member has executed an advance directive, including an advance mental health care directive;

- All medical records shall contain written documentation of a rendered, ordered or prescribed service, including documentation of medical necessity; and
- All medical records shall contain documented patient visits, which includes, but is not limited to:
 - A history and physical exam;
 - Treatment plan, progress and changes in treatment plan;
 - Laboratory and other studies ordered, as appropriate;
 - Working diagnosis(es) consistent with findings;
 - Treatment, therapies, and other prescribed regimens;
 - Documentation concerning follow-up care, telephone calls or visits, when indicated;
 - Documentation reflecting that any unresolved concerns from previous visits are addressed in subsequent visits;
 - Documentation of any referrals and results thereof, including evidence that the ordering physician has reviewed consultation, lab, x-ray, and other diagnostic test results/reports filed in the medical records and evidence that consultations and significantly abnormal lab and imaging study results specifically note physician follow-up plans;

- Hospitalizations and/or emergency room visits, if applicable; and
- All other aspects of patient care, including ancillary services.

As part of its medical records standards, the health plan shall ensure that providers facilitate the transfer of the member's medical records (or copies) to the new PCP within seven (7) business days from receipt of the request.

As part of its medical records standards, the health plan shall comply with medical record retention requirements in Section 70.500.

The health plan shall submit its medical records standards to the State by the due date identified in Section 51.700, Readiness Review. If the health plan includes the medical records standards in the QAPI, it is permissible to submit a memo identifying where, in the QAPI program description, the medical records standards appear.

50.750 Performance Improvement Projects (PIPs)

As part of its QAPI Program, the health plan shall conduct two (2) PIPs in accordance with 42 CFR Section 438.240(d) that are designed to achieve, through ongoing measurements and interventions, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction. The PIPs shall include the following:

- A study topic identified by the health plan, CMS, or DHS;
- A clearly definable answerable study question;
- The use of objective, measurable, and clearly defined quality indicators to measure performance;
- A correctly identified study population;
- Valid sampling techniques;
- Accurate and complete data collection;
- The implementation of appropriate planned system interventions to achieve improvement in quality;
- An evaluation of the effectiveness of the intervention, including sufficient data and barrier analysis;
- An achievement of real improvement that is sustained; and
- A plan and activities that shall increase or sustain improvement.

The health plan shall report the status and results of each project to the State as requested. Each PIP must be completed in the time period determined by DHS so as to allow information on the progress of PIPs in aggregate to produce new information annually on quality of care according to 42 CFR Section 438.240(d)(2).

PIPs may be specified by the DHS and by CMS. All health plans shall have the same PIP topics and shall coordinate as appropriate when beneficial to members and providers. In these cases, the health plan shall meet the goals and objectives specified by the DHS and CMS. The health plan shall submit to the DHS and the EQRO any and all data necessary to enable validation of the health plan's performance under this section, including the status and results of each project.

The health plan shall submit its PIP topic suggestions to the State and its PIP standards and proposed PIPs for the selected topics to the State by the due date identified in Section 51.700, Readiness Review.

50.760 Practice Guidelines

The health plan shall include, as part of its QAPI Program, practice guidelines that meet the following requirements as stated in 42 CFR Section 438.236 and current NCQA standards. Each adopted practice guidelines shall be:

- Relevant to the health plan's membership;
- Based on valid and reliable clinical evidence or a consensus of health care professionals in a particular field;
- Adopted in consultation with in-network providers;
- Reviewed and updated periodically as appropriate; and
- Disseminated to all affected providers, and upon request, to members and potential members.

Additionally, in compliance with 42 CFR Section 438.236, the health plan shall ensure that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

The health plan shall develop at least two (2) clinical practice guidelines for medical conditions (such as asthma, diabetes, and pregnancy/high risk pregnancy) and at least two (2) for behavioral health conditions (such as depression, and ADHD), following current NCQA and BBA standards for adopting and disseminating guidelines. The health plan shall submit its policies and procedures addressing the stated requirements, a list of all current practice guidelines as well as the practice guidelines adopted specifically for two (2) medical conditions and two (2) behavioral health conditions by the date specified in Section 51.700, Readiness Review.

For each practice guideline adopted, and required, the health plan shall:

- Describe the clinical basis upon which the practice guideline is based;
- Describe how the practice takes into consideration the needs of the members;
- Describe how the health plan shall ensure that practice guidelines are reviewed in consultation with health care providers;

- Describe the process through which the practice guidelines are reviewed and updated periodically;
- Describe how the practice guidelines are disseminated to all relevant providers and, upon request, to potential members; and
- Describe how the health plan shall ensure that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

The health plan shall ensure that all decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply shall be consistent with the guidelines.

50.770 Performance Measures

The health plan shall comply with all the DHS quality management requirements to improve performance for DHS established performance measures. Performance measures may be based on CMS core measures or initiatives, State priorities, or areas of concern that arise from previous measurements. Both clinical (i.e., comprehensive diabetes care measures, cardiovascular disease measures) and utilization measures (i.e., emergency department visits, hospital readmissions) are included. The following include sets of performance measures that the health plan shall be required to provide:

- HEDIS measures - a set of HEDIS measures (both clinical and utilization measures) is required from the health plan each year. DHS shall provide a list of the HEDIS performance measures at the end of the calendar year for the next years required measures.
- Utilization dashboard - the health plan shall supply information that may include hospital admissions and readmissions, call center statistics, provider network, member demographics, etc. DHS shall provide a list of the measures and a format for submission.
- EPSDT data - the health plan shall report EPSDT information utilizing the CMS 416 format. This report includes information on EPSDT participation, percentage of children identified for referral, percentage of children receiving follow-up services in a timely manner, etc.

The health plan shall submit to the DHS and the EQRO any and all data necessary to enable validation of the health plan's performance under this section.

50.780 Performance Incentives

The health plan may be eligible for performance incentives as described in Section 60.200.

50.790 Non-duplication Strategy

The non-duplication regulation provides states the option to use information from a private accreditation review to avoid duplication with the review of select standards required under 42 CFR Section 438.204(g). The standards

that may be considered for this deemed compliance as referenced in 42 CFR Section 438.204(g) are those listed in Subpart D of the regulations for access to care, structure and operations, and measurement and improvement. The health plan may be eligible for consideration for 'deemed' compliant status for certain standards at the discretion of DHS as defined in DHS policies and as described in the State's approved Quality Strategy.

50.800 Utilization Management Program (UMP)

The health plan shall have in place a utilization management program (UMP) that is linked with and supports the health plan's QAPI Program. The UMP shall be developed to assist the health plan in objectively and systematically monitoring and evaluating the necessity, appropriateness, efficiency, timeliness and cost-effectiveness of care and services provided to members. The UMP shall be used by the health plan as a tool to continuously improve quality clinical care and services as well as maximize appropriate use of resources.

The health plan shall have a written UMP description, a corresponding workplan, UMP policies and procedures, and mechanisms to implement all UMP activities. The UMP description and workplan may be separate documents or may be integrated as part of the written QAPI Program description and workplan. The health plan's UMP shall include structured, systematic processes that employ

objective evidenced-based criteria to ensure that qualified licensed health care professionals make utilization decisions regarding medical necessity and appropriateness of medical and behavioral health services in a fair, impartial, and consistent manner. The health plan shall ensure that applicable evidence-based criteria are applied with consideration given to characteristics of the local delivery system available for specific members as well as member-specific factors, such as member's age, co-morbidities, complications, progress of treatment, psychosocial situation, and home environment. The health plan shall also have formal mechanisms to evaluate and address new developments in technology and new applications of existing technology for inclusion in the benefit package to keep pace with changes and to ensure equitable access to safe and effective care.

The health plan shall annually review and update all UMP criteria and application procedures in conjunction with review of the health plan's clinical practice guidelines, disease management programs, and evaluation of new technologies. Practitioners with appropriate clinical expertise shall be involved in developing, adopting, and reviewing the criteria used to make utilization decisions. The health plan shall provide UMP criteria to providers and shall ensure that members and providers seeking information about the UMP process and the authorization of care/services have access to UMP staff.

The health plan's utilization review/management activities shall include:

- Prior authorization/pre-certifications;
- Concurrent reviews;
- Retrospective reviews;
- Discharge planning;
- Case management; and
- Pharmacy Management.

The UMP shall include mechanisms to detect under-utilization, over-utilization, and inappropriate utilization as well as processes to address opportunities for improvement. The health plan shall perform:

- Routine, systematic monitoring of relevant utilization data;
- Routine analysis of all data collected to identify causes of inappropriate utilization patterns;
- Implementation of appropriate interventions to correct any patterns of potential or actual under-utilization or over-utilization; and
- Systematic measurement of the effectiveness of interventions aimed at achieving appropriate utilization.

The health plan shall evaluate and analyze practitioners' practice patterns, and at least on an annual basis, the health plan shall produce and distribute to providers,

profiles comparing the average medical care utilization rates of the members of each PCP to the average utilization rates of all health plan members. Additionally, feedback shall be provided to providers when specific utilization concerns are identified, and interventions to address utilization issues shall be systematically implemented.

The health plan shall ensure that pharmaceutical management activities promote the clinically appropriate use of pharmaceuticals. There shall be policies, procedures, and mechanisms to ensure that the health plan has criteria for adopting pharmaceutical management procedures and that there is clinical and scientifically-based evidence for all decisions. The policies must include an explanation of any limits or quotas and an explanation of how prescribing practitioners must provide information to support an exceptions request. The health plan shall ensure that it has processes for determining and evaluating classes of pharmaceuticals, pharmaceuticals within the classes, and criteria for coverage and prior authorization of pharmaceuticals. The health plan shall ensure that it has processes for generic substitution, therapeutic interchange, and step-therapy protocols.

The health plan shall not develop a compensation structure that creates incentives for the individuals or entities conducting UMP activities to deny, limit, or discontinue medically necessary services to any member.

The health plan shall submit its written UMP description, corresponding workplan, and UMP policies and procedures to the DHS for review and prior approval by the date identified in Section 51.700, Readiness Review. If the health plan includes the UMP in the QAPI, it is permissible to submit a memo identifying where, in the QAPI program description, the UMP information appears.

50.900 Authorization of Services

The health plan shall have in place written prior authorization/pre-certification policies and procedures for processing requests for initial and continuing authorization of services in a timely manner. As part of these prior authorization policies and procedures, the health plan shall have in effect mechanisms to: (1) ensure consistent application of review criteria for authorization decisions; and (2) consult with the requesting provider when appropriate. The health plan shall submit these policies and procedures to MQD for review and approval by the due date identified in Section 51.700, Readiness Review.

The health plan shall ensure that all prior authorization/pre-certification decisions, including but not limited to any decisions to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, shall be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease. Medical

necessity approvals may be made by licensed clinical staff or unlicensed staff under the supervision of licensed staff. Medical necessity denials must be made by licensed clinical staff.

The health plan shall not arbitrarily deny or reduce the required scope of services solely because of the diagnosis, type of illness, or condition. The health plan may place appropriate limits on a service based on criteria such as medical necessity or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose.

The health plan shall not require prior authorization of emergency services, but may require prior authorization of post-stabilization services and urgent care services as specified in Sections 40.740.1.c and 40.740.1.w.

The health plan shall notify the provider of prior authorization/pre-certification determinations in accordance with the following timeframes:

- For standard authorization decisions, the health plan shall provide notice as expeditiously as the member's health condition requires but no longer than fourteen (14) calendar days following the receipt of the written request for service. An extension may be granted for up to fourteen (14) additional calendar days if the member or the provider requests the

extension, or if the health plan justifies a need for additional information and the extension is in the member's interest. If the health plan extends the timeframe, it shall give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision. The health plan shall issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

- In the event a provider indicates, or the health plan determines that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the health plan shall make an expedited authorization determination and provide notice as expeditiously as the member's health condition requires but no later than three (3) business days after receipt of the request for service. The health plan may extend the three (3) business day timeframe by an additional fourteen (14) calendar days if the member requests an extension, or if the health plan justifies to the DHS a need for additional information and the extension is in the member's interest. If the health plan extends the timeframe, it shall give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a

grievance if he or she disagrees with that decision. The health plan shall issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

Service authorization decisions not reached within the timeframes specified above and in accordance with the DHS policy guidance shall constitute a denial and thus an adverse action.

51.100 Member Grievance System

51.105 General Requirements

The health plan shall have a formal grievance system that is consistent with the requirements of the State of Hawaii and 42 CFR Part 438, Subpart F. The member grievance system shall include an inquiry process, a grievance process and appeals process. In addition, the health plan's grievance system shall provide information to members on accessing to the State's administrative hearing system. The health plan shall require that members exhaust its internal grievance system prior to accessing the State's administrative hearing system.

The health plan shall develop policies and procedures for its grievance system and submit these to the DHS for review and approval by the due date identified in Section 51.700, Readiness Review. The health plan shall submit an updated copy of these policies and procedures within

thirty (30) days of any modification for review and approval.

The health plan shall address, log, track and trend all expressions of dissatisfaction, regardless of the degree of seriousness or regardless of whether the member or provider expressly requests filing the concern or requests remedial action. The formal grievance system must be utilized for any expression of dissatisfaction and any unresolved issue.

The health plan shall give members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

The health plan shall acknowledge receipt of each filed grievance and appeal in writing within five (5)¹ business days of receipt of the grievance or appeal. The health plan shall have procedures in place to notify all members in their primary language of grievance and appeal resolutions. These procedures may include written translation and oral interpretation activities.

¹ The first day shall be the day after the day of receipt of a grievance or appeal. For example, and assuming there are no intervening holidays, if an appeal is received on Monday, the five (5) business day period for acknowledgment of receipt of the appeal is counted from Tuesday. Therefore, the acknowledgment must be sent to the member by the following Monday.

The health plan shall ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made and reviewed by a healthcare professional that has appropriate medical knowledge and clinical expertise in treating the member's condition or disease.

The health plan shall ensure that individuals who make decisions on grievances and appeals were not involved in any previous level of review or decision-making and are healthcare professionals who have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease. This requirement applies specifically to reviewers of:

- An appeal of a denial that is based on a lack of medical necessity;
- A grievance regarding denial of expedited resolution of an appeal; or
- A grievance or appeal that involves clinical issues.

51.110 Recordkeeping

The health plan shall maintain records of its members' grievances and appeals in accordance with this RFP's requirements for recordkeeping and confidentiality of members' medical records.

51.115 Inquiry Process

The health plan shall have an inquiry process to address all inquiries as defined in Section 30.200. As part of this process, the health plan shall ensure that, if at any point during the contact, the member expresses a complaint of any kind, the inquiry becomes a grievance or appeal and the health plan shall give the member, or provider acting on behalf of the member, their grievance and appeal rights. The inquiry can be in writing or as a verbal request over the telephone.

51.120 Authorization of Representation (AOR)

The health plan shall have a process to obtain authorization of representation for members who cannot represent themselves in the grievance system processes. These processes shall include the ability for the member to provide verbal consent for the health plan to interact with the authorized representative. The health plan shall submit policies and procedures related to processing of authorization of representation as part of their Grievance System policies and procedures to MQD for review and approval by the due date identified in Section 51.700, Readiness Review to include but not limited to AOR form.

51.125 Grievance Process

A grievance may be filed about any matter other than an action, as defined in Section 30.200. Subjects for grievances include, but are not limited to:

- The quality of care of a provider;
- Rudeness of a provider or a provider's employee; or
- Failure to respect the member's rights.

A member or a member's representative may file a grievance orally or in writing. A provider may file a grievance on behalf of the member orally or in writing with written consent from the member or their authorized representative. The health plan shall have in place written policies and procedures for processing grievances in a timely manner to include if a grievance is filed by a provider on behalf of the member or member's authorized representative and there is no documentation of a written form of authorization, such as an AOR form.

As part of the grievance system policies and procedures, the health plan shall have in effect mechanisms to: (1) ensure reasonable attempts were made to obtain a written form of authorization; and (2) consult with the requesting provider when appropriate. The health plan shall submit these policies and procedures as part of their Grievance System policies and procedures to MQD for review and approval by the due date identified in Section 51.700, Readiness Review.

In addition to meeting all requirements detailed in Section 51.105, in fulfilling the grievance process requirements the health plan shall:

- Send a written acknowledgement of the grievance within five (5) business days of the member's expression of dissatisfaction;
- Convey a disposition, in writing, of the grievance resolution within thirty (30) days of the initial expression of dissatisfaction; and
- Include clear instructions as to how to access the State's grievance review process on the written disposition of the grievance.

The health plan's resolution of the grievance shall be final unless the member or member's representative wishes to file for a grievance review with the State.

51.130 State Grievance Review

As part of its grievance system, the health plan shall inform members of their rights to seek a grievance review from the State in the event the disposition of the grievance does not meet the satisfaction or expectations of the member. The health plan shall provide its members with the following information about the State grievance review process:

- Health plan members may request a State grievance review, within thirty (30) days of the member's

receipt of the grievance disposition from the health plan. A State grievance review may be made by contacting the MQD office at or mailing a request to:

Med-QUEST Division
Health Care Services Branch
PO Box 700190
Kapolei, HI 96709-0190
Telephone: 808-692-8094

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

51.135 Appeals Process

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

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

member, provider or authorized representative in this process.

In addition to meeting the general requirements detailed in Section 51.105, the health plan shall:

- Ensure that oral inquiries seeking to appeal an action are treated as appeals and confirmed in writing, unless the provider, member, or authorized representative requests expedited resolutions;
- As part of the grievance system policies and procedures, the health plan shall have in effect mechanisms to ensure reasonable attempts were made to obtain a written confirmation of the appeal;
- Send an acknowledgement of the receipt of the appeal within five (5) business days from the date of the receipt of the written or oral appeal;
- Provide the member or his or her representative a reasonable opportunity to present evidence, and evidence of allegations of fact or law, in person as well as in writing;
- Provide the member or his or her representative the opportunity, before and during the appeals process, to examine the member's case file, including medical records, and any other documents and records considered during the appeal process; and
- Include as parties to the appeal, the member and his or her representative, or the representative of a deceased member's estate.

For standard resolution of an appeal, the health plan shall resolve the appeal and provide a written notice of disposition to the parties as expeditiously as the member's health condition requires, but no more than thirty (30) days from the day the health plan receives the appeal.

The health plan may extend the resolution time frame by up to fourteen (14) additional days if the member requests the extension, or the health plan shows (to the satisfaction of MQD, upon its request for review) that there is need for additional information and how the delay shall not adversely affect the member. For any extension not requested by a member, the health plan shall give the member written notice of the reason for the delay.

The health plan shall include the following in the written notice of the resolution:

- The results of the appeal process and the date it was completed; and
- For appeals not resolved wholly in favor of the member:
 - The right to request a State administrative hearing, and clear instructions about how to access this process;
 - The right to request an expedited State administrative hearing, if applicable;

- o The right to request to receive benefits while the hearing is pending, and how to make the request; and
- o A statement that the member may be held liable for the cost of those benefits if the hearing decision upholds the health plan's action.

The health plan shall notify the provider in writing within thirty (30) days of the resolution.

51.140 Expedited Appeal Process

The health plan shall establish and maintain an expedited review process for appeals. The member, his or her representative or provider may file an expedited appeal either orally or in writing. No additional follow-up shall be required. An expedited appeal is only appropriate when the health plan determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function.

The health plan shall ensure that punitive action is not taken against a provider who requests an expedited resolution or who supports a member's appeal.

For expedited resolution of an appeal, the health plan shall resolve the appeal and provide written notice to the affected parties as expeditiously as the member's health

condition requires, but no more than three (3) business days from the time the health plan received the appeal. The health plan shall make reasonable efforts to also provide oral notice to the member with the appeal determination.

The health plan may extend the expedited appeal resolution time frame by up to fourteen additional (14) days if the member requests the extension or the health plan needs additional information and demonstrates to the MQD how the delay shall not adversely affect the member.

The health plan shall notify the MQD within twenty-four (24) hours, regarding expedited appeals if an expedited appeal has been granted by the health plan or if an expedited appeal time frame has been requested by the member or the health plan. The health plan shall provide the reason it is requesting a fourteen additional (14) day extension to the MQD. The health plan shall notify the MQD within twenty-four (24) hours (or sooner if possible) from the time the expedited appeal is lost. The DHS shall provide information on the method of notification to the MQD within sixty (60) days of contract award.

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

- Transfer the appeal to the time frame for standard resolution;
- Make reasonable efforts to give the member prompt oral notice of the denial;
- Follow-up within two (2) days of the written notice; and
- Inform the member orally and in writing that they may file a grievance for the denial of the expedited process with the State with the health plan.

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

51.145 State Administrative Hearing for Regular Appeals

If the member is not satisfied with the health plan's written notice of disposition of the appeal, he or she may file for a State administrative hearing within thirty (30) days of the receipt of the notice of disposition (denial) as part of the member's internal appeal procedure. At the time of the denied appeal determination, the health plan shall inform the member, the member's representative, the provider acting on behalf of the member, or the representative of a deceased member's estate that he or she may access the State administrative hearing process. The member, or his or her representative, may access the State administrative hearing process by submitting a letter

to the Administrative Appeals Office (AAO) within thirty (30) days from the receipt of the member's appeal determination.

The health plan shall provide the following address to the members:

State of Hawaii Department of Human Services
Administrative Appeals Office
PO Box 339
Honolulu, HI 96809

The State shall reach its decision within ninety (90) days of the date the member filed the request for an administrative hearing with the State.

51.150 Expedited State Administrative Hearings

The member may file for an expedited State administrative hearing only when the member requested or the health plan has provided an expedited appeal and the action of the appeal was determined to be adverse to the member (Action Denied). The member may file for an expedited State administrative hearing process by submitting a letter to the Administrative Appeals Office (AAO) within thirty (30) days from the receipt of the member's appeal determination.

The health plan shall provide the following address to the members:

State of Hawaii Department of Human Services
Administrative Appeals Office
PO Box 339
Honolulu, HI 96809

An expedited State administrative hearing must be heard and determined within three (3) business days after the date the member filed the request for an expedited State administrative hearing with no opportunity for extension on behalf of the State. The health plan shall collaborate with the State to ensure that the best results are provided for the member and to ensure that the procedures comply with state and federal regulations.

In the event of an expedited State administrative hearing the health plan shall submit information that was used to make the determination, (e.g. medical records, written documents to and from the member, provider notes, etc.). The health plan shall submit this information to the MQD within twenty-four (24) hours of the decision denying the expedited appeal.

51.155 Continuation of Benefits During an Appeal or State Administrative Hearing

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

- The member requests an extension of benefits;

- The appeal or request for State administrative hearing is filed in a timely manner, meaning on or before the later of the following:
 - Within ten (10) days of the health plan mailing the notice of adverse action; or
 - The intended effective date of the health plan's proposed adverse action.
- The appeal or request for State administrative hearing involves the termination, suspension, or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized provider; and
- The original authorization period has not expired.

If the health plan continues or reinstates the member's benefits while the appeal or State administrative hearing is pending, the health plan shall continue all benefits until one of following occurs:

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

If the final resolution of the State administrative hearing is adverse to the member, that is, upholds the health plan's adverse action, then the health plan may recover the cost of the services furnished to the member while the appeal was pending, to the extent that they were furnished solely because of the requirements of this section.

If the health plan or the State reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the health plan shall authorize or provide these disputed services promptly, and as expeditiously as the member's health condition requires.

If the health plan or the State reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the health plan shall pay for those services.

51.165 Notice of Action

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

- The action the health plan has taken or intends to take;
- The reasons for the action;
- The member's or provider's right to an appeal with the health plan;

- The member's or provider's right to request an appeal;
- Procedures for filing an appeal with the health plan;
- The circumstances under which an expedited resolution is available and how to request it; and
- The member's right to have benefits continue pending resolution of an appeal, how to request that the benefits be continued, and the circumstances under which a member may be required to pay the costs of these services.

The notice of action to the member shall be written pursuant to the requirements in Section 50.330 of this RFP.

The health plan shall mail the notice within the following time frames:

- For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least ten (10) days prior to the date the adverse action is to start except:
 - By the date of action for the following reasons:
 - The health plan has factual information confirming the death of a member;
 - The health plan receives a clear written statement signed by the member that he or she no longer wishes services or gives information that requires termination or

reduction of services and indicates that he or she understands that this must be the result of supplying that information;

- The member has been admitted to an institution that makes him or her ineligible for further services;
- The member's address is unknown and the post office returns health plan mail directed to the member indicating no forwarding address;
- The member has been accepted for Medicaid services by another local jurisdiction;
- The member's provider prescribes a change in the level of medical care;
- There has been an adverse determination made with regard to the preadmission screening requirements for nursing facility admissions on or after January 1, 1989; or
- In the case of adverse actions for nursing facility transfers, the safety or health of individuals in the facility would be endangered, the member's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the member's urgent medical needs, or the member has not resided in the nursing facility for thirty (30) days.

- The period of advanced notice is shortened to five (5) days if there is alleged fraud by the recipient and the facts have been verified, if possible, through secondary sources.
- For denial of payment: at the time of any action affecting the claim.
- For standard service authorization decisions that deny or limit services: as expeditiously as the member's health condition requires, but not more than fourteen (14) days following receipt of request for service, with a possible extension of up to fourteen (14) additional days (total time frame allowed with extension is twenty-eight (28) days from the date of the request for services) if: (1) the recipient or provider requests an extension; or (2) the health plan justifies a need for additional information and how the extension will not adversely affect the member. If the health plan extends the time frame, it must: (1) give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if he or she disagrees with that decision to extend the time frame; and (2) issue and carry out its determination as expeditiously as the member's health condition requires but no later than the date the extension expires.
- For expedited authorization decisions: as expeditiously as the member's health condition

requires but no later than three (3) business days after receipt of the request for service.

- For service authorization decisions not reached within the time frames specified above (which constitute a denial and, thus, an adverse action), on the date that the timeframes expire.

51.200 Information Technology

51.210 General Requirements

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

51.220 Expected Functionality

The DHS expects health plan information systems to facilitate and to integrate the following essential health plan case management and coordination of care functions: (1) member health status assessments; (2) determination of the optimal mix of health care services needed to improve the health status of said members; (3) coordination and oversight of the delivery of said services; and (4) the analysis and reporting of service utilization and outcomes data required to manage these functions effectively.

To achieve this objective, the health plan shall have a suite of properly interfaced, readily accessible yet secured information systems that enable the efficient execution of the aforementioned functions.

51.230 Method of Data Exchange with MQD

The MQD Secure File Transfer (SFT) server is the source of all file transfers between MQD and trading partners, including health plans. Specific technical specifications and instructions are provided in the HPMMIS Health Plan Manual available on the Med-QUEST web site. The SFT server allows the MQD and the health plan to securely transfer member, provider, and encounter data via the internet.

51.240 Compliance with the Health Insurance Portability and Accountability Act (HIPAA)

The health plan shall implement the electronic transaction and code set standards and other “Administrative Simplification” provisions, privacy and security provisions of HIPAA, Public Law 104-191, as specified by CMS.

51.250 Possible Audits of Health Plan Information Technology

The health plan shall institute processes to ensure the validity and completeness of the data submitted to the DHS. The DHS or its contractors may conduct general data validity and completeness audits using industry standard sampling techniques. The DHS reserves the right

to have access to the health plan's system at any time when deemed necessary under this contract.

51.260 Health Plan Information Technology Changes

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

51.270 Disaster Planning and Recovery Operations

The health plan shall have in place disaster planning and recovery operations appropriate for the health plan industry, and comply with all applicable federal and state laws relating to security and recovery of confidential information and electronic data. The health plan shall provide the DHS with a copy of its documentation describing its disaster planning and recovery operations by the due date identified in Section 51.700, Readiness Review.

51.300 Fraud & Abuse

51.310 General Requirements

The health plan shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud and abuse activities. In addition, as part of these internal controls and policies and procedures, the health plan shall have ways to verify services were actually provided using

random sampling of all members. The health plan shall have a compliance officer and sufficient staffing (as required in Section 51.400) and resources to investigate unusual incidents and develop and implement corrective action plans to assist the health plan in preventing and detecting potential fraud and abuse activities. The health plan's fraud and abuse activities shall comply with the program integrity requirements outlined in 42 CFR Section 438.608.

The health plan and all subcontractors shall cooperate fully with federal and state agencies in investigations and subsequent legal actions. Such cooperation shall include providing, upon request, information, access to records, and access to interview health plan employees and consultants, including but not limited to those with expertise in the administration of the program and/or medical or pharmaceutical questions or in any matter related to an investigation.

51.320 Reporting and Investigating Suspected Fraud and Abuse

Within thirty (30) calendar days of discovering instances of suspected fraud or abuse, the health plan shall report all instances of suspected fraud or abuse to the MQD and the State of Hawaii, Department of the Attorney General, Medicaid Fraud Control Unit (MFCU). The health plan shall use the report form to be provided by the DHS to report or refer suspected cases of Medicaid fraud or abuse. At a

minimum, this form shall require the following information for each case:

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

As part of its report, the health plan shall include the results of its preliminary investigation. This includes, but is not limited to, providing any evidence it has on the member's services or provider's billing practices (unusual billing patterns, services not rendered as billed and same services billed differently or separately).

Once the health plan has filed its report, it shall not contact the provider who is the subject of the investigation about any matters related to the investigation, enter into or attempt to negotiate any settlement or agreement, or accept any monetary or other thing of valuable consideration offered by the provider who is the subject of the investigation in connection with the incident.

If the provider is not billing appropriately, but the health plan has found no evidence of fraud or abuse, the health plan shall provide education and training to the provider in question. The health shall maintain documentation of the

education and training provided in addition to reporting the recovered amounts as income or revenues. A summary report shall be provided on a report form provided by the MQD.

51.330 Compliance Plan

The health plan shall have a written fraud and abuse compliance plan that shall have stated program goals and objectives, stated program scope, and stated methodology. Refer to CMS publications: "Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care", A product of the National Medical Fraud and Abuse Initiative, October 2000 as well as the CMS publication: "Guidelines for Constructing a Compliance Program for Medicaid and Prepaid Health Plans", a product of the Medicaid Alliance for Program Safeguards, May 2002 for reference regarding Compliance Plans. The health plan shall submit its compliance plan to the DHS for review and approval by the due date identified in Section 51.700, Readiness Review.

At a minimum, the health plan's fraud and abuse compliance plan shall:

- Require the reporting of suspected and/or confirmed fraud and abuse be done as required in Sections 51.320 and 51.570.1;
- Ensure that all of its officers, directors, managers and employees know and understand the provisions

of the health plan's fraud and abuse compliance plan;

- Require the designation of a compliance officer and a compliance committee that are accountable to senior management;
- Ensure and describe effective training and education for the compliance officer and the organization's employees;
- Ensure that providers and members are educated about fraud and abuse identification and reporting, and include information in the provider and member material;
- Ensure effective lines of communication between the compliance officer and the organization's employees;
- Ensure that enforcement of standards through well-publicized disciplinary guidelines;
- Ensure provision of internal monitoring and auditing with provisions for prompt response to potential offenses, and for the development of corrective action initiatives relating to the health plan's fraud and abuse efforts;
- Possess written policies, procedures and standards of conduct that articulate the organization's commitment to comply with all Federal and State standards related to Medicaid managed care organizations;
- Ensure that no individual who reports health plan violations or suspected fraud and abuse is retaliated against; and

- Include a monitoring program that is designed to prevent and detect potential or suspected fraud and abuse. This monitoring program shall include but not be limited to:
 - Monitoring the billings of its providers to ensure members receive services for which the health plan is billed;
 - Requiring the investigation of all reports of suspected fraud and over billings (upcoding, unbundling, billing for services furnished by others, and other overbilling practices);
 - Reviewing providers for over-utilization or under-utilization;
 - Verifying with members the delivery of services as claimed; and
 - Reviewing and trending consumer complaints on providers.

51.340 Employee Education About False Claims Recovery

The health plan shall comply with all provisions of Section 1902(a)(68) of the Social Security Act as it relates to establishing written policies for all employees (including management), and of any subcontractor or designee of the health plan, that includes the information required by Section 1902(a)(68) of the Social Security Act.

51.350 Child and Adult Abuse Reporting Requirements

The health plan shall report all cases of suspected child abuse to the Child Protective Services Section of the DHS, and all suspected dependent adult abuse to the Adult Protective Services Section of the DHS as required by state and federal statutes.

The health plan shall ensure that its network providers report all cases of suspected child abuse to the Child Protective Services Section of the DHS, and all suspected dependent adult abuse to the Adult Protective Services Section of the DHS as required by state and federal statutes.

51.400 Health Plan Personnel

51.410 General Requirements

The health plan shall have in place, either directly or indirectly, the organizational, management and administrative systems capable of fulfilling all contractual requirements.

For the purposes of this contract, the health plan shall not employ or contract with any individual that has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity or from participating in non-procurement activities under Section 103D-702, HRS.

The following table represents a listing of required staff. The health plan is responsible for operating its health plan in the State of Hawaii. Specifically, the health plan shall have all positions marked "Yes" in the "Hawaii" column in the table below filled by individuals residing and working full-time in the State of Hawaii. As part of this request, the health plan shall include a description of the processes in place that assure rapid responsiveness to effect changes for contract compliance. The health plan shall be solely responsible for any additional charges associated with on-site audits or other oversight activities that result when required systems and activities are located outside of the State of Hawaii.

If there is a "Yes" in the "report if person in position changes" column in the table below, the health plan shall notify the MQD in writing within seven (7) days of learning of an intended resignation or other change in the status of the position. The health plan shall include the name of the interim contact person in the notification. In addition, the health plan shall, upon DHS request, provide a written plan for filling the vacant position, including expected timelines. The name of the permanent employee shall be submitted as soon as the new hire has occurred.

The health plan shall submit a resume and job description for all positions marked "Yes" in the resume column. The job description shall identify the education and experience requirements as well as the requirements for fulfilling the

position requirements. For those positions not requiring a resume, the health plan shall submit job descriptions.

Some positions have the number of FTE that shall be required for this procurement. For example, a 1.0 FTE is a person that only performs work on this procurement. A 0.5 FTE can perform other work duties other than this procurement.

Positions	Resume (Y/N)	Hawaii (Y/N)	Report if person in position changes (Y/N)
Administrator/CEO/COO/Executive Director (1.0)	Yes	Yes	Yes
Medical Director (.5 FTE)	Yes	Yes	Yes
Financial Officer/CFO	Yes	Yes	Yes
Quality Management Coordinator (0.5)	Yes	Yes	Yes
Behavioral Health Coordinator	Yes	Yes	Yes
Pharmacy Coordinator/ Director/ Manager	Yes	Yes	Yes
Prior Authorization/Utilization Management/Medical Management Director	Yes	Yes	Yes
Prior Authorization/Utilization Management/Medical Management Staff	No	Not less than 2 positions	No
EPSDT Coordinator (0.5)	Yes	Yes	Yes
Member Services Director	Yes	Yes	Yes
Member Services' staff (to include call center staff)	No	Yes	No
Provider Services/Contract Manager	Yes	Yes	Yes
Provider Services/Contract staff	No	Yes	No
Claims Administrator/Manager*	No	No	Yes
Claims Processing Staff	No	No	No

Encounter processors	No	No	No
Grievance Coordinator	Yes	Yes	Yes
Credentialing Program Coordinator	Yes	No	Yes
Catastrophic Claims Coordinator (includes business continuity planning and recovery coordination)	Yes	No	Yes
Compliance Officer	Yes	Yes	Yes
Information Technology (IT) Director or Chief Information Officer (CIO)	Yes	No	Yes
IT Hawaii Manager	Yes	Yes	Yes
IT Staff	No	Not less than 2 positions	No

* The Claims Administrator/Manager does not need to reside in Hawaii as long as there is a manager in Hawaii (i.e., Provider Services Manager) who can address claims issues during Hawaii business hours.

The health plan shall ensure that all staff have the necessary qualifications (i.e., education, skills, and experience) to fulfill the requirements of their respective positions. The health plan shall conduct initial and ongoing training of all staff to ensure they have the education, knowledge and experience to fulfill the requirements of this contract.

Except as otherwise noted, a specific number of staff or FTEs are not required; the health plan shall only ensure that adequate staff is available and assigned to appropriate areas to fulfill the required functions specified in this contract.

The health plan shall submit both a staffing and training plan to the DHS for review and approval by the due date identified in Section 51.700, Readiness Review.

51.420 Specific Descriptions

The health plan shall have a dedicated employee (e.g., Administrator, Chief Executive Officer, Chief Operating Officer, Executive Director, etc.) who has clear authority over the general administration and day-to-day business activities of this RFP/contract.

The health plan shall have on staff a Medical Director licensed to practice medicine in the State of Hawaii. The Medical Director shall oversee the quality of care furnished by the health plan and ensure care is provided by qualified medical personnel. The Medical Director shall address any potential quality of care problems and direct QAPI activities. The Medical Director shall work closely with the MQD Medical Director and participate in quarterly DHS Medical Director meetings, Provider Advisory Board meetings and any committee meetings relating to the programs when requested by the DHS.

The health plan shall have a chief financial officer who is responsible for all accounting and finance operations, including all audits.

The health plan shall have a quality management coordinator or director who is responsible for all quality improvement activities. This person shall be a physician or registered nurse licensed in the State of Hawaii.

The behavioral health coordinator shall be responsible for all behavioral health services. This person shall be a physician, psychologist, registered nurse (may have additional training, e.g., advanced practice nurse practitioner), or licensed clinical social worker licensed in the State of Hawaii with experience related to the behavioral health population.

The health plan shall have an employed or contracted pharmacy coordinator/director/manager. This person shall be a licensed pharmacist in the State of Hawaii and shall serve as a contact for the health plan's providers, pharmacists, and members.

The health plan shall have a prior authorization/utilization management/medical management director. This person shall oversee all activities related to prior authorizations and concurrent and post-payment reviews, to include UM line personnel. In addition, this person shall be responsible for overseeing the hiring, training and work of all line personnel performing these functions.

The health plan shall have an EPSDT coordinator who is responsible for overseeing all EPSDT activities. This

person shall serve as the liaison to the State of Hawaii for these activities.

The health plan shall have a member services director who is responsible for all member services activities, including but not limited to call center staffing, member handbook updates, and translation activities. In addition, this person shall oversee the hiring, training and work of all line personnel performing member services functions.

The health plan shall have a provider services manager who is responsible for the provider network activities and provider education. This person shall oversee the hiring, training and work of all line personnel performing provider services functions.

The health plan shall have a grievance coordinator who oversees all member grievance system activities. This person shall also be responsible for the provider complaints, grievance and appeals system.

The health plan shall have a compliance officer who is responsible for all fraud and abuse detection activities, including the fraud and abuse compliance plan.

The health plan shall have an IT director who is responsible for all IT activities. This person need not be located in the State of Hawaii; however, if he or she is not,

the health plan shall have an IT Hawaii manager who is located in the State of Hawaii.

The health plan shall have a catastrophic claims coordinator who is responsible for monitoring all high dollar claims and communicating with the DHS financial staff concerning the DHS' catastrophic care program described in Section 60.500.

51.500 Reporting Requirements

51.510 General Requirements

The health plan shall submit to the DHS all requested reports identified below and in the time frames identified in this Section. In addition, the health plan shall comply with all additional requests from the DHS, or its designee, for additional data, information and reports. In the event the health plan is under a corrective action plan (CAP), the health plan may be required to submit certain reports more frequently than stated in this Section.

All reporting data shall be submitted to the DHS in electronic format of either Word 2010 or lower (.docx), or Excel 2010 or lower (.xlsx). Reporting data shall not be submitted with read only or protected formatting. All reporting data may be provided to the Health Care Services Branch (HCSB) within the Med-QUEST Division who will distribute internally as required.

As described in Section 51.610, the State may impose financial penalties for failure to produce accurate reports according to the time frames identified.

Data received from the health plan on quality, performance, patient satisfaction, or other measures shall be used for monitoring, public reporting, and financial incentives. DHS shall also share information among health plans to promote transparency and sharing of benchmarks/best practices. DHS shall publicly report measures in formats such as a consumer guide, public report, or otherwise, on MQD's website.

The health plan shall submit the following reports electronically to the DHS to the health plans File Transfer Protocol (FTP) site according to the specified schedule. The HCSB shall distribute the reports internally within the MQD to the required reviewer.

Category	Report	RFP Section	Due Dates	Reviewer
Provider Network/ Services	Provider Network Adequacy and Capacity Report	51.520.1	April 30 July 31 October 31 January 31	HealthCare Services Branch (HCSB)
Provider Network/ Services	GeoAccess or Similar Report	51.520.2	April 30 July 31 October 31 January 31	HCSB
Provider Network/ Services	PCP Assignment Report	51.520.3	The 15 th of each month	HCSB

Category	Report	RFP Section	Due Dates	Reviewer
Provider Network/ Services	Timely Access Report	51.520.4	April 30 July 31 October 31 January 31	HCSB
Provider Network/ Services	FQHC or RHC Services Rendered Report- Annual	51.520.5	January 31	HCSB
Provider Network/ Services	FQHC or RHC Services Rendered Report- Quarterly	51.520.5	April 30 July 31 October 31 January 31	HCSB
Provider Network/ Services	Provider Suspensions and Terminations	51.520.6	Within three business days of suspension or termination	Finance-Fiscal Integrity Staff (FIS)
Provider Network/ Services	Provider Suspensions and Terminations Report	51.520.6	April 30 July 31 October 31 January 31	HCSB
Provider Network/ Services	Provider Complaints and Claims Report	51.520.7	April 30 July 31 October 31 January 31	HCSB
Provider Network/ Services	Value-Driven Health Care	51.520.8	April 30 July 31 October 31 January 31	HCSB
Covered Benefits and Services	CMS 416 Report- EPSDT	51.530.1	February 1 August 1	HCSB

Category	Report	RFP Section	Due Dates	Reviewer
Member Services	Outreach for Medical Assistance Eligibility Renewal	51.540.1	April 30 July 31 October 31 January 31	HCSB
Member Services	Call Center Report	51.540.2	April 30 July 31 October 31 January 31	HCSB
Member Services	Interpretation Services Report	51.540.3	April 30 July 31 October 31 January 31	HCSB
Member Services	Requests for Documents in Alternate Languages Report	51.540.4	April 30 July 31 October 31 January 31	HCSB
Member Services	Member Grievance and Appeals Report	51.540.5	April 30 July 31 October 31 January 31	HCSB
Member Services	CAHPS® Consumer Survey	51.540.6	Annually, if applicable	HCSB
Member Services	Special Health Care Needs Report	51.540.7	April 30 July 31 October 31 January 31	HCSB
Member Services	Behavioral Health Services Report	51.540.8	Monthly at the end of the second month following the end of the reporting period	HCSB
Member Services	ADRC	51.540.9	April 30 July 31 October 31 January 31	Clinical Standards Office (CSO)

Category	Report	RFP Section	Due Dates	Reviewer
QAPI Program	Accreditation Update	51.550.1	April 30 July 31 October 31 January 31	HCSB
QAPI Program	QAPI Program Report	51.550.2	March 1	HCSB
QAPI Program	PIP Report	51.550.3	March 1	HCSB
QAPI Program	Health Plan Employer Data and Information Set (HEDIS) Report	51.550.4	June 15	HCSB
UM/PA	Prior Authorization Requests Denied/Deferred Report	51.560.1	April 30 July 31 October 31 January 31	HCSB
UM/PA	Report of Over-utilization and Under-Utilization of Drugs	51.560.2	April 30 July 31 October 31 January 31	CSO
UM/PA	Report of Over-utilization and Under-Utilization of Services	51.560.3	April 30 July 31 October 31 January 31	HCSB
Administration & Financial	Fraud and Abuse Summary Report	51.570.1	April 30 July 31 October 31 January 31	Finance
Administration & Financial	Provider Education & Training Report	51.570.2	April 30 July 31 October 31 January 31	Finance-FIS

Category	Report	RFP Section	Due Dates	Reviewer
Admin- stration & Financial	Employee Suspension and Termination Report	51.570.3	April 30 July 31 October 31 January 31	Finance- FIS
Admini- stration & Financial	QUEST Financial Reporting Guide	51.570.4	May 15 August 15 November 15 February 28 (shall also include information on the entire year)	Finance
Admini- stration & Financial	TPL Cost Avoidance Report	51.570.5	The 15 th of each month	Finance
Admini- stration & Financial	Disclosure of Info on Annual Business Transaction	51.570.6	Annually	Finance
Admini- stration & Financial	Encounter Data/Financial Summary Reconciliation Report	51.570.7	April 30 July 31 October 31 January 31	Finance
Admini- stration & Financial	Medicaid Contracting Report	51.570.8	December 31	HCSB
Admini- stration & Financial	QUEST Dashboard	51.570.9	The 15 th of each month	HCSB

Additional information about the contents of each report is provided below.

51.520 Provider Network and Service Reports

51.520.1 *Provider Network Adequacy and Capacity Report*

The health plan shall submit a *Provider Network Adequacy and Capacity Report* that demonstrates that the health plan offers an appropriate range of preventive, primary care and specialty services that is adequate for the anticipated number of members for the service and that the network of providers is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area.

The health plan shall submit these reports on electronic media in the format specified by the DHS. The information shall, at a minimum, include:

- A listing of all providers and include the specialty or type of practice of the provider;
- The provider's location;
- Mailing address including the zip code;
- Telephone number;
- Professional license number and expiration date;
- Number of members from its plan that are currently assigned to the provider (PCPs only);
- Indication as to whether the provider has a limit on the number of the program patients he/she will accept
- Indication as to whether the provider is accepting new patients;
- Foreign language spoken (if applicable);

- Verification of valid license for in-state and out-of-state providers; and
- Verification that provider or affiliated provider is not on the federal or state exclusions list.

The health plan shall provide a narrative that describes the health plan's strategy to maintain and develop their provider network to include but not limited to:

- Take into account the numbers of network providers who are not accepting new patients;
- Consider the geographic location of providers and members, considering distance, travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for members with disabilities;
- Current network gaps and the methodology used to identify them;
- Immediate short-term interventions when a gap occurs including expedited or temporary credentialing; and
- Interventions to fill network gaps and barriers to those interventions.

This report shall be provided in the format to be prescribed by the DHS.

51.520.2 *GeoAccess (Or Similar Program) Reports*

The health plan shall submit reports using GeoAccess or similar software that allow DHS to analyze, at a minimum, the following:

- The number of providers by specialty and by location with a comparison to the zip codes of members;
- Number of members from its plan that are currently assigned to the provider (PCPs only);
- Indication as to whether the provider has a limit on the number of QUEST program members he/she will accept;
- Indication as to whether the provider is accepting new patients; and
- Non-English language spoken (if applicable).

The health plan shall assure that the providers listed on the GeoAccess reports are the same providers that are described in the Provider Network Adequacy and Capacity Report.

In addition to the due date as identified in Section 51.510, these reports shall be submitted to the DHS at the following times:

- Upon the DHS request;
- Upon enrollment of a new population in the health plan;

- Upon changes in services, benefits, geographic service area or payments; and
- Any time there has been a significant change in the health plan's operations that would affect adequate provider capacity and services. A significant change is defined as any of the following:
 - A decrease in the total number of PCPs by more than five percent (5%) per island (for the island of Hawaii the health plan shall report on this for East Hawaii and West Hawaii);
 - A loss of providers in a specific specialty where another provider in that specialty is not available on the island; or
 - A loss of a hospital.

51.520.3 *PCP Report*

The health plan shall submit *PCP Reports* that provide the following information on activities from the previous month:

- The total number serving as a PCP to include the PCP to member ratio;
- The number and percent of members that chose or were auto-assigned to a PCP;
- The number of PCP change requests received and processed;
- The medical specialties with the largest number of PCP assignments; and
- Information on the highest utilized PCP.

This report shall be provided in the format to be prescribed by the DHS.

51.520.4 *Timely Access Report*

The health plan shall submit *Timely Access Reports* that monitor the time lapsed between a member's initial request for an appointment and the date of the appointment. The data may be collected using statistically valid sampling methods (including periodic member and provider surveys). Using data collected during the previous quarter, the report shall include the:

- Total number of appointment requests;
- Total number and percent of requests that meet the waiting time standards identified in Section 40.230 (for each provider type/class, e.g., specialists, PCP adult, PCP pediatric sick, etc.);
- Total number and percent of requests that exceed the waiting time standards (for each provider type/class);
- Average wait time for PCP routine visits; and
- Average wait time for requests that exceed the waiting time standards (for each provider type/class).

If the health plan is not meeting timely access in any one area (i.e., specialists), the DHS may require additional data collection (i.e., a report by specialty type).

This report shall be provided in the format to be prescribed by the DHS.

51.520.5 FQHC or RHC Services Rendered Report

The health plan shall submit *FQHC or RHC Services Rendered Report*. The report shall provide data on activities during the quarter or calendar year (January through December) and shall include the following information:

- The contract status of the FQHC/RHC (i.e., if the FQHC is participating or non-participating as a provider in the health plan's network);
- The total dollar amount of payments made to an FQHC/RHC, listed by FQHC/RHC;
- All visits and payments (including capitated payments) made to any FQHC/RHC, regardless of whether the FQHC/RHC is included in the health plan's contracted provider network; and
- The number of unduplicated visits provided to the health plan's members.

This report shall be provided in the format to be prescribed by the DHS.

51.520.6 *Provider Suspensions and Termination Report*

The health plan shall notify the MQD within three (3) business days of any provider suspensions and terminations, both voluntary and involuntary because of suspected or confirmed fraud or abuse. The immediate notification shall include provider's name, provider's specialty, reason for the action and the effective date of the suspension or termination. In addition, the health plan shall submit a summary *Provider Suspensions and Terminations Reports* that list by name, all provider suspensions or terminations. This report shall include all providers, each provider's specialty, their primary city and island of services, reason(s) for the action taken as well as the effective date of the suspension or termination. If the health plan has taken no action against providers during the quarter this shall be documented in the *Provider Suspensions and Terminations Report*. The health plan shall utilize the report format provided by the DHS.

51.520.7 *Provider Complaints and Claims Report*

The health plan shall submit *Provider Complaints Reports* that include the following information from the previous quarter:

- The total number of resolved complaints by category (benefits and limits; eligibility and enrollment; member issues; health plan issues);
- The total number of unresolved complaints by category (benefits and limits; eligibility and

enrollment; member issues; health plan issues) and the reason code explaining the status (i.e., complaint is expected to be resolved by the reporting date and complaint is unlikely to be resolved by the reporting date);

- Status of provider complaints that had been reported as unresolved in previous report(s);
- Status of delays in claims payment, denials of claims payment, and claims not paid correctly which includes the following:
 - The number of claims processed for each month in the reporting quarter;
 - The number of claims paid for each month in the reporting quarter;
 - The percentage of claims processed (at 14, 30, 60, and 90 days) after date of service for each month of the reporting quarter;
 - The number of claims denied for each month in the reporting quarter; and
 - The percentage of claims denied for each of the following reasons: (1) prior authorization/referral requirements were not met for each month in the reporting quarter; (2) submitted past the filing deadline for each month in the reporting quarter; (3) provider not eligible on date of service for each month in the reporting quarter; (4) member not eligible on date of service; and (5) member

has another health insurer which shall be billed first.

Reports shall be submitted using the format provided by the DHS.

51.520.8 Value-Driven Health Care Report

The health plan shall submit *Value-Driven Health Care Reports* that include information on the health plan's value-driven program in a format provided by the DHS.

51.530 Covered Benefits and Services Reports

51.530.1 CMS 416 Report – EPSDT

The health plan shall submit *CMS 416 Reports* that measure and document screening and participation rates in the EPSDT program. The health plan shall use the format provided by DHS. In addition to the requirements in the CMS 416 Report, the health plan shall report on any additional data that the DHS has determined is necessary for monitoring and compliance purposes.

The health plan's medical director shall review this report prior to submission to the DHS.

51.540 Member Services Reports

51.540.1 *Outreach for Medical Assistance Eligibility Renewal*

The health plan shall submit a report on their outreach that they performed during the previous quarter that shall include, at a minimum, the following:

- The name and member identification number for each member to whom outreach services was provided;
- The date provided;
- A description of the type of outreach services provided;
- The identification of who performed the outreach, if applicable, for health plans that utilize an agency other than themselves; and
- The final outcome of the outreach (i.e., if the member maintained their eligibility).

The health plan shall also report the number of members that were identified for eligibility review during the previous quarter and shall provide a percentage of the number of members that outreach occurred as well as a percentage of the number of members (of those that were identified for eligibility review) that lost eligibility during the previous quarter.

51.540.2 *Call Center Report*

The health plan shall submit a report on the utilization rate of the call center during the previous quarter that shall include, at a minimum, the following:

- Number of member calls (actual number and number reported per 100 members);
- Call abandonment rate;
- Average speed of answer;
- Average hold time;
- Blocked call rate;
- Longest wait in queue;
- Average talk time; and
- Type of call.

Reports shall be submitted using the format provided by the DHS.

51.540.3 Interpretation Services Report

The health plan shall submit the *Interpretation Services Reports* that include the following information on activities during the previous quarter:

- The name and Medicaid ID number for each member to whom interpretation services was provided;
- The date of the request;
- The date provided;
- The type of service including the language requested; and
- The identification of the interpreter.

Reports shall be submitted using the format provided by the DHS.

51.540.4 *Requests for Documents in Alternate Languages Report*

The health plan shall submit *Requests for Documents in Alternative Languages Reports* that include the following information on activities during the previous quarter:

- The name and Medicaid ID number for each member requesting documents in an alternative language;
- The language requested;
- The data of the request; and
- The date the documents were mailed or provided.

Reports shall be submitted using the format provided by the DHS.

51.540.5 *Member Grievance and Appeals Report*

The health plan shall submit *Member Grievance and Appeals Reports*. These reports shall be submitted in the format provided by the DHS. At a minimum, the reports shall include:

- The number of grievances and appeals by type;
- Type of assistance provided;
- Administrative disposition of the case;
- Overturn rates;
- Percentage of grievances and appeals that did not meet timeliness requirements;
- Ratio of grievances and appeals per 100 members; and
- Listing of unresolved appeals originally filed in previous quarters.

Reports shall be submitted using the format provided by the DHS.

51.540.6 CAHPS® Consumer Survey

The health plan shall report the results of any *CAHPS® Consumer Survey* conducted by the health plan on Medicaid members, if applicable. The health plan shall provide a copy of the overall report of survey results to the DHS. This report is separate from any *CAHPS® Consumer Survey* that is conducted by the DHS.

51.540.7 Special Health Care Needs (SHCN) Report

The health plan shall submit to the DHS a *Special Health Care Needs (SHCN) Report*. Reports shall include a list of all new members (both children and adults) who are identified as having a SHCN as

defined in Section 40.751. In addition, the health plan shall provide information on the SHCN identified, case management services, treatment plan, date identified as having a SHCN and date treatment plan was completed over the past quarter. In addition, the health plan shall provide information on members who were previously identified as having SHCN as well as those whose SHCNs have been resolved.

Reports shall be submitted using the format provided by the DHS.

51.540.8 Behavioral Health Services Report

The health plan shall submit to the DHS a *Behavioral Health Services report*. Reports shall be for members that are receiving additional behavioral health services as defined in Section 40.740.2.c. Reports shall include information on services provided by acuity of member as defined in Section 40.740.2.c, incident reporting related to SPMI diagnosis, and any other quality measures that the DHS deems necessary.

Reports shall be submitted using the format provided by the DHS.

51.540.9 *ADRC Report*

The health plan shall submit to the DHS an *Aid to Disabled Review Committee (ADRC) report*. Reports shall include information on number of ADRC referrals, number deemed “disabled” and number deemed “not disabled” as well as the percentage of referrals deemed “not disabled”. Health plans must maintain a standard of ten percent (10%) or less as deemed “not disabled”. Sanctions may be imposed if the health plan exceeds the ten percent (10%) standard.

Reports shall be submitted using the format provided by the DHS.

51.550 Quality Assessment and Performance Improvement (QAPI) Program Reports

51.550.1 *Accreditation Update*

The health plan shall submit *Accreditation Updates* in which it provides updates on its progress in achieving accreditation as required in Section 50.710. These updates shall detail activities undertaken and provide a synopsis of any issues that have arisen that may impede the accreditation process.

51.550.2 *QAPI Program Description*

The health plan shall provide an annual *QAPI Program Report*. The health plan's medical director shall review these reports prior to submittal to the DHS. The *QAPI Program Report* shall include the following:

- Any changes to the QAPI Program;
- A detailed set of QAPI Program goals and objectives that are developed annually and includes timetables for implementation and accomplishments;
- A copy of the health plan's organizational chart including vacancies of required staff, changes in scope of responsibilities, changes in delegated activities and additions or deletions of positions;
- A current list of the required staff as detailed in Section 51.410 including name, title, location, phone number and fax number;
- An executive summary outlining the changes from the prior QAPI;
- A copy of the current approved QAPI Program description, the QAPI Program work plan and, if issued as a separate document, the health plan's current utilization management program description with signatures and dates;
- A copy of the previous year's QAPI Program, if applicable, and utilization management program evaluation reports; and
- Written notification of any delegation of QAPI Program activities to contractors.

51.550.3 *Performance Improvement Projects (PIP) Report*

Annually, the health plan shall submit, on the DHS designated reporting form, two (2) *Performance Improvement Projects Reports* to the DHS and its EQRO. Each report shall document a clearly defined study question, and well-defined indicators (both of which may be selected by the DHS). The reports shall also address the following elements: a correctly identified study population, valid sampling techniques, accurate/complete data collection, appropriate improvements strategies, data analysis and interpretation, reported improvements, if any, and sustained improvement over time, if any. These reports shall be independently validated by the EQRO, on an annual basis, to ensure compliance with CMS protocols, and DHS policy, including timeline requirements. Status reports on performance improvement projects may be requested more frequently by the DHS.

51.550.4 *Health Plan Employer Data and Information Set (HEDIS) Report*

The health plan shall submit Health Plan Employer Data and Information Set (HEDIS) Reports in the format required by the DHS. This report shall cover the period from January 1 to December 31 and shall be reviewed by the health plan's Medical Director prior to submittal to the DHS.

The EQRO shall annually perform a HEDIS Report Validation to at least three (3) of the State-selected HEDIS

measures to ensure health plan compliance with HEDIS methodology.

51.560 Utilization Management Reports

51.560.1 *Prior Authorization Requests Denied/Deferred*

The health plan shall submit *Prior Authorization Requests that have been Denied or Deferred Reports*. The specific reporting period, types of services and due dates shall be designated by the DHS. The report shall include the following data:

- Date of the request;
- Name of the requesting provider;
- Member's name and ID number;
- Date of birth;
- Diagnoses and service/medication being requested;
- Justification given by the provider for the member's need for the service/medication;
- Justification of the health plan's denial or the reason(s) for deferral of the request; and
- The date and method of notification of the provider and the member of the health plan's determination.

Reports shall be submitted using the format provided by the DHS.

51.560.2 *Report of Over-Utilization and Under-Utilization of Drugs*

The health plan shall submit *Reports of Over-Utilization and Under-Utilization of Drugs* that include:

- Listing of the top fifty (50) high cost drugs and the top fifty (50) highly utilized drugs, the criteria that is used/developed to evaluate their appropriate, safe and effective use, and the outcomes/results of the evaluations;
- Listing of the top fifty (50) highest utilized non-formulary drugs paid for by the plan including the charges and allowances for each drug as well as the criteria used/developed to evaluate the appropriate, safe and effective use of these medications and the outcomes/results of the evaluations;
- Listing of members who are high users of controlled substances but have no medical condition (e.g., malignancies, acute injuries, etc.) which would justify the high usage. Additionally, the health plan shall submit: (1) its procedures for referring for monitoring and controlling their over-utilization; and (2) the results of the CC/CM services provided; and
- Results of pharmacy audits, including who performed the audits, what areas were audited, and if problems were found, the action(s) taken to address the issue(s), and the outcome of the corrective action(s).

Reports shall be submitted using the format provided by the DHS.

51.560.3 *Report of Over-Utilization and Under-Utilization of Services*

The health plan shall submit *Reports of Over-Utilization and Under-Utilization of Services*. The reports shall include information on the following measures.

- PCP Utilization: The number and percent of members that did not have access to a PCP who have a chronic disease or have over-utilization of narcotics or other pharmaceuticals;
- Hospital Utilization: The average length of stay (LOS) in hospitals by member type and the number and percentage of members by location and diagnosis who had a readmission within the past thirty (30) days;
- Emergency Room Utilization: The number and percent of members with ER use that were not admitted to a hospital by location and diagnosis;
- Increased utilization: The number and percent of adult members with utilization greater than twelve (12) outpatient visits and those that have fully utilized their inpatient benefits. The average cost spent for members with increased utilization;
- Top one percent (1%) by expenditures of adult members and top one percent (1%) of child members to include identified members, expenditures over certain periods, and provided care

coordination/case management activities to the identified members; and

- Health Care Acquired Conditions (HAC): Provide information on HAC as described in format provided by DHS.

Reports shall be submitted using the format provided by the DHS.

51.570 Administration and Financial Reports

51.570.1 *Fraud and Abuse Summary Reports*

The health plan shall submit *Fraud and Abuse Reports* that include, at a minimum, the following information on all alleged fraud and abuse cases:

- A summary of all fraud and abuse referrals made to the State during the quarter, including the total number, the administrative disposition of the case, any disciplinary action imposed both before the filing of the referral and after, the approximate dollars involved for each incident and the total approximate dollars involved for the quarter;
- A summary of the fraud and abuse detection and investigative activities undertaken during the quarter, including but not limited to the training provided, provider monitoring and profiling activities, review of providers' provision of services (under-utilization and over-utilization of services), verification with members that services were delivered, and suspected fraud and

- abuse cases that were ultimately not fraud or abuse and steps taken to remedy the situation; and
- Trending and analysis as it applies to: utilization management, claims management, post-processing review of claims, and provider profiling.

Reports shall be submitted using the format provided by the DHS.

51.570.2 Provider Education and Training Report

The Health Plans shall submit all provider education and training relating to correct/incorrect coding, proper/improper claims submission. The education/training can be to prevent fraud, waste and abuse or initiated by the Health Plan as a result of pre-payment or post-payment claims reviews. This report shall identify training/education at an individual provider level or as a group session.

This report shall be provided in the format to be prescribed by the DHS.

51.570.3 Employee Suspension and Termination Report

The Health Plans shall report if a subcontractor or employee resigns, is suspended, terminated or voluntarily withdraws from participation as a result of suspected or confirmed fraud and abuse.

This report shall be provided in the format to be prescribed by the DHS.

51.570.4 QUEST Financial Reporting Guide

The health plan shall submit financial information on a regular basis in accordance with the QUEST Financial Reporting Guide provided by the DHS.

The financial information shall be analyzed and compared to industry standards and standards established by the DHS to ensure the financial solvency of the health plan. The DHS may also monitor the financial performance of the health plan with on-site inspections and audits.

The health plan shall, in accordance with generally accepted accounting practices, prepare financial reports that adequately reflect all direct and indirect expenditures and management and fiscal practices related to the health plan's performance of services under this contract.

51.570.5 Third Party Liability (TPL) Cost Avoidance Report

The health plan shall submit *Third Party Liability (TPL) Cost Avoidance Reports*, using the format received by the DHS, which identifies all cost-avoided claims for members with third party coverage from private insurance carriers and other responsible third parties. In addition, on a quarterly basis, the health plan shall notify MQD of all of its QUEST members who have commercial insurance with the same or other health plan.

51.570.6 *Disclosure of Information on Annual Business Transaction Report*

The health plan shall submit *Disclosure of Information on Annual Business Transactions Reports* that disclose information on the following types of transactions:

- Any sale, exchange, or lease of any property between the health plan and a party in interest;
- Any lending of money or other extension of credit between the health plan and a party in interest; and
- Any furnishing for consideration of goods, services (including management services) or facilities between the health plan and the party in interest. This does not include salaries paid to employees for services provided in the normal course of their employment.

The health plan shall include the following information regarding the transactions listed above:

- The name of the party in interest for each transaction;
- A description of each transaction and the quantity or units involved;
- The accrued dollar value of each transaction during the fiscal year; and
- Justification of the reasonableness of each transaction.

For the purposes of this section, a party in interest, as defined in Section 1318(b) of the Public Health Service Act, is:

- Any director, officer, partner, or employee responsible for management or administration of an HMO; any person who is directly or indirectly the beneficial owner of more than five percent (5%) of the equity of the HMO; any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than five percent (5%) of the HMO; or, in the case of an HMO organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law;
- Any organization in which a person described above is director, officer or partner; has directly or indirectly a beneficial interest of more than five percent (5%) of the equity of the HMO; or has a mortgage, deed of trust, note, or other interest valuing more than five percent (5%) of the assets of the HMO;
- Any person directly or indirectly controlling, controlled by, or under common control with a HMO; or
- Any spouse, child, or parent of an individual described in the foregoing bullets.

51.570.7 *Encounter Data/Financial Summary Reconciliation Report*

The health plan shall submit *Encounter Data/Financial Summary Reconciliation Reports* using the instructions and format provided by the DHS.

51.570.8 *Medicaid Contracting Report*

The health plan shall submit an annual Medicaid contracting report to DHS, the State of Hawaii Department of Commerce and Consumer Affairs Insurance Division, and the Hawaii State Legislature, no later than one-hundred eighty (180) days following the end of the State Fiscal Year (SFY). The content of the Medicaid contracting report shall include the information required from the Section 103F-107, HRS. The health plan shall submit the report using the format provided by the DHS.

51.570.9 *QUEST Dashboard*

The health plan shall submit monthly a summary identified as the QUEST dashboard of QUEST health plan performance utilizing a format provided by the DHS. Information included on the QUEST Dashboard includes but is not limited to:

- Member demographics;
 - Provider demographics;
 - Call Center statistics;
 - Claims processing;
 - Complaints from both members and providers;
- and

- Utilization data.

The QUEST Dashboard shall be posted on the MQD website on a monthly basis.

51.580 Encounter Data Reporting

The health plan shall submit encounter data to MQD once per month in accordance with the requirements and specifications defined by the State and included in the Health Plan Manual. Encounters shall be certified and submitted by the health plan as required in 42 CFR Section 438.606 and as specified in Section 51.620.

51.580.1 Accuracy, Completeness and Timeliness of Encounter Data Submissions

The following encounter data submission requirements apply:

- Accuracy and Completeness – The data and information provided to the DHS shall be accurate and complete. Data and reports shall be mathematically correct and present accurate information. An accurate and complete encounter is one that reports a complete and accurate description of the service provided, and that passes the full edits/audits of the encounter processing cycle.
- Timeliness – sixty percent (60%) of the encounter data shall be received by the DHS no more than one-hundred twenty (120) days from the date that services were rendered. Health plans shall have the

goal of submitting one-hundred percent (100%) and shall submit no less than ninety-nine percent (99%) of encounter data within fifteen (15) months from the date of services. Adjustments and resubmitted encounters shall not be subject to the one-hundred twenty (120) day submission requirement. In addition, TPL related encounters shall not be subject to the one-hundred twenty (120) day submission deadline.

The health plan shall be notified by the DHS within thirty (30) days from the receipt date of the initial encounter submission of all encounters that have failed the accuracy and completeness edits. The health plan shall be granted a thirty (30) day error resolution period from the date of notification. If, at the end of the thirty (30) day error resolution period, fifteen percent (15%) of the initial encounter submission continues to fail the accuracy and completeness edits, a penalty amounting up to ten percent (10%) of the monthly (initial month's submission) capitation payment may be assessed against the health plan for failing to submit accurate and timely encounter data. In a case where the health plan contract is not continued, a penalty of up to ten percent (10%) may be assessed against all of the outstanding payments to the health plan for failing to submit accurate and timely encounter data.

51.600 Report Submission

51.610 Financial Penalties and Sanctions

The State may impose financial penalties or sanctions on the health plan for inaccurate, incomplete and late submissions of required data, information and reports. All requested data and information shall be accurate and complete with no material omissions. Encounter data is not accurate and complete if the data has missing or incomplete field information, or if the data does NOT pass the full edits/audits of the encounter processing cycle. The State may impose financial penalties on the health plan for failure to submit accurate encounter data on a timely basis. Any financial penalty imposed on the health plan shall be deducted from the subsequent month's capitation payment to the health plan. The amount of the total financial penalty for the month shall not exceed ten percent (10%) of the monthly capitation payment.

The health plan may file a written challenge to the financial penalty with the DHS not more than thirty (30) days after the health plan receives written notice of the financial penalty. Challenges shall be considered and decisions made by the DHS no more than sixty (60) days after the challenge is submitted.

Financial penalties are not refundable unless challenged and decided in favor of the health plan.

The health plan shall continue reporting encounter data once per month beyond the term of the contract as processing and reporting of the data is likely to continue due to lags in time in filing source documents by subcontractors and providers.

51.620 Health Plan Certification

The health plan shall certify the accuracy, completeness, and truthfulness of any data, including but not limited to, encounter data, data upon which payment is based, and other information required by the State, that may be submitted to determine the basis for payment from the State agency. The health plan shall certify that it is in substantial compliance with the contract and provide a letter of certification attesting to the accuracy, completeness, and truthfulness of the data submitted based on best knowledge, information, and belief. The health plan shall submit the letter of certification to its MQD plan liaison concurrent with the certified data and document submission. In the case of two (2) submissions in one month, the health plan shall submit two (2) letters of certification. The certifications are to be based on best knowledge, information, and belief of the following health plan personnel.

The data shall be certified by:

- The health plan's Chief Executive Officer (CEO);
- The health plan's Chief Financial Officer (CFO); or

- An individual who has delegated authority to sign for, and who reports directly to, the health plan's CEO or CFO.

The health plan shall require claim certification from each provider submitting data to the health plan.

51.630 Follow-Up by Health Plans/Corrective Action Plans/Policies and Procedures

The DHS shall provide a report of findings to the health plan after completion of each review, monitoring activity, etc.

Unless otherwise stated, the health plan shall have thirty (30) days from the date of receipt of a DHS report to respond to the MQD's request for follow-up, actions, information, etc. The health plan's response shall be in writing and address how the health plan resolved the issue(s). If the issue(s) has/have not been resolved, the health plan shall submit a corrective action plan including the timetable(s) for the correction of problems or issues to MQD. In certain circumstances (i.e., concerns or issues that remain unresolved or repeated from previous reviews or urgent quality issues), MQD may request a ten (10) day plan of correction as opposed to the thirty (30) day response time.

For all medical record reviews, the health plan shall submit information prior to the scheduled review and arrange for MQD and the EQRO to access medical records through on-

site review and provision of a copy of the requested records. The health plan shall submit this information within sixty (60) days of notification or sooner should circumstances dictate an expedited production of records.

The health plan shall submit the most current copy of any policies and procedures requested. In the event the health plan has previously submitted a copy of a specific policy or procedure and there have been no changes, the health plan shall state so in writing and include information as to when and to whom the policy and procedure was submitted. If there are no formal policies or procedures for a specific area, the health plan may submit other written documentation such as workflow charts or other documents that accurately document the actions the health plan has or shall take.

51.700 Readiness Review

51.710 Required Review Documents

The health plan shall comply with all readiness review activities required by the DHS. This includes, but is not limited to, submitting all required review documents identified in the table below by the required due date, participating in any on-site review activities conducted by the DHS, and submitting updates on implementation activities. The DHS reserves the right to request additional documents for review and approval during readiness review.

Document	RFP Reference Section	Due Date
Selection and retention of providers policies and procedures	40.210 General Provisions	30 days after contract award
Availability of providers policies and procedures	40.230 Availability of Providers	30 days after contract award
PCP policies and procedures	40.250 PCPs	30 days after contract award
Credentialing, recredentialing and other certification policies and procedures	40.400 Provider Credentialing, Recredentialing and Other Certifications	60 days after contract award
Model for each type of provider contract	40.500 Provider Contracts	10 days after contract award
The signature page of all finalized and executed contracts that have not been previously submitted	40.500 Provider Contracts	30 th day of every month from contract award to commencement of services
Provider education materials	40.610 Provider Education	At least 30 days prior to use of materials
Provider grievance, complaints and appeals system policies and procedures	40.620 Provider Grievance, Complaints and Appeals Process	75 days after contract award
Provider manual	40.630 Provider Manual	30 days after contract award
Provider call center policies and procedures	40.640 Provider Call Center/PA Line	90 days after contract award
Provider web-site screen shots	40.650 Web-site for Providers	60 days after contract award

Document	RFP Reference Section	Due Date
Web-site (member and provider portals) update policies and procedures	40.650 Web-site for Providers	60 days after contract award
Description of any additional services	40.700 Covered Benefits and Services – General Overview	30 days after contract award
Behavioral Health Adverse Events Policy and Procedure	40.740.2.d Adverse Events Policy/Reporting and other Behavioral Health Reporting	30 days after contract award
Cultural competency plan	40.801 Cultural Competency Plan	60 days after contract award
Disease management policies and procedures	40.802 Disease Management	90 days after Contract Award
EPSDT plan	40.753 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services for Children	60 days after contract award
Transition of care policies and procedures	41.330 Transition of Care Policies and Procedures	60 days after contract award
Member Outreach	50.100 Health Plan Eligibility Responsibilities	60 days after contract award
Member Services policies and procedures	50.410 Member Services, General Requirements	30 days after contract award
Member education materials, including the training plans and curricula	50.420 Member Education	90 days after contract award

Document	RFP Reference Section	Due Date
Translation Certification	50.430 Requirements for Written Materials	Within 30 days of DHS approval of English versions of documents
Member handbook	50.440 Member Handbook Requirements	30 days after contract award
Sample member ID card	50.470 Member ID Card	30 days after contract award
Member web-site screen shots	50.490 Internet Presence/Web-site	60 days after contract award
Marketing materials (including all printed materials, advertisements, video presentations, and other information prepared by the health plan that pertain to or reference the programs or the health plan's program business)	50.630 State Approval of Materials	30 days after contract award
QAPI Program	50.730 QAPI Program	60 days after contract award
Request for delegation of QAPI Program functions or activities (if applicable)	50.730 QAPI Program	90 days after contract award
Medical records standards	50.740 Medical Records Standards	60 days after contract award
Performance improvement projects	50.750 PIPs	60 days after contract award

Document	RFP Reference Section	Due Date
Practice guidelines policies and procedures, list of all current practice guidelines and practice guidelines adopted for two (2) medical conditions and two (2) behavioral health conditions	50.760 Practice guidelines	60 days after contract award
UMP description, corresponding workplan, and UMP policies and procedures	50.800 Utilization Management Program	60 days after contract award
Prior authorization/pre-certification policies and procedures	50.900 Authorization Services	60 days after contract award
Grievance system policies and procedures	51.100 Member Grievance System	60 days after contract award
Documentation describing its disaster planning and recovery operations	51.270 Disaster Planning and Recovery Operations	90 days after contract award
Compliance plan	51.330 Compliance Plan	60 days after contract award
Staffing and training plan (plus resumes, where applicable)	51.410 General Requirements	30 days after contract award
A GeoAccess (or comparable program) report	51.720 Updated GeoAccess Reports	30 days after contract award
Subcontractor agreements	70.400 Subcontractor Agreements	30 days after contract award

Document	RFP Reference Section	Due Date
Proof of License	80.230 Attachment, Other Documentation	Prior to contract signature

51.720 Updated GeoAccess Reports

The health plan shall submit, within thirty (30) days of the date of Contract Award identified in Section 20.100, updated GeoAccess reports (or reports generated by a similar program) that include all providers who have signed a provider agreement. The health plans shall submit additional reports to DHS every two (2) weeks thereafter until sixty days prior to the date of Commencement of Services to Members identified in Section 20.100.

51.730 Health Plan Provider Network

The health plans must meet provider network requirements outlined in Section 40.220 no later than sixty (60) days prior to date of Commencement of Services to Members as described in Section 20.100.

SECTION 60 FINANCIAL RESPONSIBILITIES

60.100 The DHS Responsibilities

60.110 Daily Rosters/Health Plan Reimbursement

The DHS shall enroll and disenroll members through daily files. All payments and recoveries shall be detailed on the daily file. The daily membership rosters identify the capitated fee amounts associated with mid-month enrollment and disenrollment transactions as well as prior period coverage transactions. The health plan agrees to accept daily and monthly transaction files from the DHS as the official enrollment record.

The DHS shall make capitation payments, with each payment being for a month's services, to the health plan for each enrolled member in the health plan beginning on the date of the Commencement of Services to Members identified in Section 20.100. Capitation payments shall be in the amounts listed in the health plan's contract with the DHS.

The DHS shall pay the established capitation rate to the health plan for members enrolled for the entire month. Capitation payment shall be paid on rate codes that reflect the risk factor adjustments. Capitation payments for members enrolled/disenrolled on dates other than the first or last day of the month shall be prorated on a daily basis based on the number of days in a month.

The DHS shall make additional capitation payments or recover capitation payments from the health plan as a result of retroactive enrollments, retroactive disenrollments and prior period coverage.

The DHS shall provide to the health plan a Monthly Payment Summary Report that summarizes capitation payments and recoveries made to the health plan.

The health plan shall not change any of the information provided by the DHS on the daily or monthly transaction files. Any inconsistencies between the health plan and the DHS information shall be reported to the DHS for investigation and resolution. All payments and recoveries shall be detailed on the daily file and summarized on the Monthly Payment Summary Report.

The DHS shall notify the health plan prior to making changes in the capitation amount/rate code.

60.120 Capitation Payments for Changes in Rate Codes

There are several situations in which a member may change eligibility categories, and therefore rate codes, that shall result in a different capitation payment amount or a disenrollment from the health plan.

Changes in the capitation payment amount/rate code paid shall become effective the next day after the enrollment change is processed.

60.130 Collection of Premium Shares for Members

The health plan shall be responsible for billing and collecting a members' premium share, for members with a required premium share, as stated in the HAR.

60.140 Gain Share Program

The DHS shall implement and manage a gain share arrangement and shall share in any significant savings. Additional information about the gain share program is available in Appendix C.

60.200 Incentives for Health Plan Performance

The health plan shall be eligible for financial performance incentives or Pay for Performance (P4P) as long as the health plan is fully compliant with all terms of the contract. All incentives shall be in compliance with the federal managed care incentive arrangement requirements set forth in 42 CFR Section 438.6 and the State Health Plan Manual.

To qualify for receipt of a financial incentive that uses either HEDIS or CAHPS measurements as a performance indicator demonstrating improvement, an NCQA licensed audit organization must have audited the reported HEDIS rate and an NCQA-certified survey vendor must have

administered the CAHPS survey. This is to ensure that both NCQA and CAHPS performance measures followed the CMS protocol for validation. The validation of HEDIS measures and CAHPS survey administration shall be performed by the DHS through the EQRO. The total of all payments paid to the health plan under this contract shall be pursuant to 42 CFR Section 438.6.

To receive the incentive payment, the health plan must meet a minimum threshold of achievement. Funding for the incentive payments would come from a \$2.00 per member per month (PMPM) withhold amount taken from the administrative allowance in the capitation rates starting on the date of the Commencement of Services to Members identified in Section 20.100. The health plans' rates are actuarially sound with or without the refund of the \$2.00 PMPM P4P withhold. The DHS shall weigh each of the five (5) measures as described in Sections 60.210 to 60.250. For the successful outcome of each of the five (5) measures, the indicated proportion of the withhold amount shall be returned to the health plan. The DHS shall not award partial incentives. If DHS fails to validate the HEDIS measures in accordance with timeframes established in 42 CFR Section 438.240(c) or conduct the CAHPS survey, the withhold amount for that measure shall be returned to the health plan.

The performance measures to be used for the calendar year are described in Sections 60.210 to 60.250. Earned

incentives shall be paid within ninety (90) days after the validated HEDIS and CAHPS results are available. The timeframe for validation of results shall be in accordance with timeframes established in 42 CFR section 438.240(c) for annual validation of performance measures. The minimum threshold of achievement is listed below for each of the measures; however, these measures and targets are subject to change in subsequent years. DHS shall inform the health plan of the specifications of each measure for incentive payment no less than fourteen (14) days prior to the beginning of the time period from which the data is being measured.

The source for the measures shall be the NCQA HEDIS data and CAHPS survey data as described above. For HEDIS measures, the percentile thresholds used shall be the HEDIS percentiles identified in the NCQA HEDIS Audit Means and Percentiles for Medicaid HMOs for the measurement year that NCQA publishes yearly in the spring. For CAHPS measures, the percentile thresholds used shall be the National Accreditation Benchmarks for Medicaid CAHPS measures. For HEDIS measures, NCQA specifications for the measures must have been followed. For the CAHPS measure, the CAHPS specification must have been followed.

60.210 Childhood Immunizations (20%)

A health plan shall be eligible for a performance incentive payment if the health plan's performance:

- Is at or exceeds the HEDIS Medicaid 75th percentile rate for the measure of Combination 2 under the Childhood Immunization Status measures.

60.220 Plan All-Cause Readmissions (30%)

A health plan shall be eligible for a performance incentive payment if the health plan's performance:

- Meets or exceeds the HEDIS 50th percentile rate in year one and 75th percentile rate in year two for the measure of Plan All-Cause Readmissions

60.230 Controlling High Blood Pressure (15%)

A health plan shall be eligible for a performance incentive payment if the health plan's performance:

- Meets or exceeds the HEDIS Medicaid 75th percentile rate for the measure of Controlling High Blood Pressure.

60.240 Comprehensive Diabetes Care (20%)

A health plan shall be eligible for a performance incentive payment if the health plan's performance:

- Meets or exceeds the HEDIS 50th percentile rate in year one and 75th percentile rate in year two for the measure of Comprehensive Diabetes Care

- Comprehensive Diabetes Care is defined as a combination of the three measures listed below equally weighted:
 - HBA1C Control (<8%);
 - LDL-C Control (<100 mg/dl); and
 - Systolic and Diastolic BP Levels (<130/ 80).

60.250 Getting Needed Care (15%)

A health plan shall be eligible for a performance incentive payment if the health plan's performance:

- Meets or exceeds the CAHPS Medicaid 75th percentile rate for the measure of 'Getting Needed Care' in the CAHPS Survey.

60.300 Health Plan Responsibilities

60.310 Provider and Subcontractor Reimbursement

With the exception of eligible services provided by hospice providers, FQHCs, and RHCs, the health plan may reimburse its providers and subcontractors in any manner, subject to federal rules. However, this does not preclude additional payments such as for a health home or financial incentives for performance. Health plans shall allow no less than a one-year filing deadline for providers to submit claims. Health plans shall have an incentive to promote electronic claims submission.

The reimbursement by the health plan to its providers and subcontractors, for example, may be a capitated rate or

discounted Medicaid fee-for-service amount. Regardless of the payment methodology, the health plan shall require that all providers submit detailed encounter data, if necessary.

Subject to CMS approval, the health plan may contract with FQHCs and RHCs using an alternative payment methodology in lieu of full PPS reimbursement. The alternative payment methodology would need to be mutually agreed upon by the health plan and provider and reviewed and approved by the Department. In such an arrangement, the FQHC/RHC chooses to assume risk and the Department shall not be required to reimburse the difference between the amount the FQHC receives from the health plan under the alternative payment methodology and the amount the health plan would have received under PPS.

The DHS shall calculate and reimburse FQHC/RHC's for any retroactive settlements involving a change in scope of services that result in an increased PPS rate that is not incorporated into the capitation rates. The DHS shall make reconciliation payments to FQHCs and RHCs that are not contracted with the health plan.

The health plan shall be able to differentiate members who are funded by Title XIX or XXI by contract type or rate code as specified by MQD as well as identify physician specialty. The health plan shall pay primary care providers

increased reimbursement for services provided to Title XIX members as instructed by MQD in accordance with the Affordable Care Act.

The health plan shall report this information to the DHS quarterly and in the format required by MQD.

The health plan shall pay hospice providers Medicare hospice rates as calculated by the DHS and CMS. The health plan shall implement these rates on October 1 of each year.

The health plan shall not pay out-of-network providers who deliver emergency services more than they would have been paid if the emergency services had been provided to an individual in the Medicaid fee-for-service program.

The health plan shall pay its subcontractors and providers on a timely basis, consistent with the claims payment procedures described in Section 1902(a)(37)(A) of the Social Security Act. The health plans shall allow providers at least one-hundred and eighty (180) days to submit claims for reimbursement.

This section requires that ninety percent (90%) of claims for payment (for which no further written information or substantiation is required in order to make payment) are paid within thirty (30) days of the date of receipt of such claims and that ninety-nine percent (99%) of claims are

paid within ninety (90) days of the date of receipt of such claims. The health plan and the provider may, however, agree to an alternative payment schedule provided this alternative payment schedule is reviewed and approved by the DHS.

In no event shall the health plan's subcontractors and providers look directly to the State for payment.

The State and the health plan's members shall bear no liability for the health plan's failure or refusal to pay valid claims of subcontractors or providers. The health plan shall include in all subcontractor and provider contracts a statement that the State and plan members bear no liability for the health plan's failure or refusal to pay valid claims of subcontractors or providers for covered services. Further, the State and health plan members shall bear no liability for services provided to a member for which the State does not pay the health plan; or for which the plan or State does not pay the individual or health care provider that furnishes the services under a contractual, referral, or other arrangement; or for payment for covered services furnished under a contract, referral, or other arrangement, to the extent that these payments are in excess of the amount that the member would owe if the health plan provided the services directly.

The health plan shall indemnify and hold the State and the members harmless from any and all liability arising from

such claims and shall bear all costs in defense of any action over such liability, including attorney's fees.

60.320 Non-Covered Services

The health plan may collect fees directly from members for non-covered services or for services from unauthorized non-plan providers. If a member self-refers to a specialist or other provider within the health plan's network without following procedures (i.e., obtaining prior authorization), the health plan may deny payment to the service provider.

The health plan shall educate providers about the processes that must be followed for billing a member when non-covered or unauthorized services are provided. This education shall include at a minimum the following:

- If a member self-refers to a specialist or other provider within the network without following health plan procedures (i.e., obtaining prior authorization) and the health plan does deny payment to the provider, the provider may bill the member;
- If a provider fails to follow plan procedures which results in nonpayment, the provider may not bill the member; and
- If a provider bills the member for non-covered services or for self-referrals, he or she shall inform the member and obtain prior agreement from the member regarding the cost of the procedure and the payment terms at time of service.

If the health plan later determines that a member has been billed and paid for health plan-covered services, the plan shall refund the member directly.

60.330 Physician Incentives

The health plan may establish physician incentive plans pursuant to federal and state regulations, including 42 CFR Sections 422.208, 422.210, and 438.6.

The health plan shall disclose any and all such arrangements to the DHS for review and approval prior to implementing physician incentives, and upon request, to members. Such disclosure shall include:

- Whether services not furnished by the physician or group are covered by the incentive plan;
- The type of incentive arrangement;
- The percent of withhold or bonus; and
- The panel size and if patients are pooled, the method used.

Upon request, the health plan shall report adequate information specified by applicable regulations to the DHS so that the DHS can adequately monitor the health plan.

If the health plan's physician incentive plan includes services not furnished by the physician/group, the health plan shall: (1) ensure adequate stop loss protection to

individual physicians, and must provide to the DHS proof of such stop loss coverage, including the amount and type of stop loss; and (2) conduct annual member surveys, with results disclosed to the DHS, and to members, upon request.

Such physician incentive plans may not provide for payment, directly or indirectly, either to a physician or to physician group as an inducement to reduce or limit medically necessary services furnished to an individual.

Aligning payment to incentivize high quality and high efficiency care is addressed in Section 50.500.

60.340 Payment for Health Care Acquired Conditions (HAC)

The health plan shall not pay for HAC identified by CMS by a date determined by the Department. DHS shall inform the health plans of the CMS required list as applicable.

60.350 Co-Payments

Health plans may be required to implement co-payments for members as determined by DHS. Services for which co-payments may be imposed include but are not limited to prescription drugs, emergency room visits for non-emergent visits or non-emergency transportation. Co-payments are subject to Federal regulations.

60.400 Third Party Liability (TPL)

60.410 Background

TPL refers to any other health insurance plan or carrier (i.e., individual, group, employer-related, self-insured or self-funded, or commercial carrier, automobile insurance and worker's compensation) or program, that is, or may be, liable to pay all or part of the health care expenses of the member.

Pursuant to Section 1902(a)(25) of the Social Security Act, the DHS authorizes the health plan as its agent to identify legally liable third parties and treat verified TPL as a resource of the member.

Reimbursement from the third party shall be sought unless the health plan determines that recovery would not be cost effective. For example, the health plan may determine that the amount it reasonably expects to recover will be less than the cost of recovery. In such situations, the health plan shall document the situation and provide adequate documentation to the DHS.

Each quarter, the health plan shall report to DHS in a format specified by DHS all TPLs known for its members, including any of its QUEST members that also have commercial insurance through the health plan.

60.420 Responsibilities of the DHS

The DHS shall:

- Be responsible for coordination and recovery of accident and workers' compensation subrogation benefits;
- Collect and provide member TPL information to the health plan. TPL information shall be provided to the health plan via the daily TPL roster; and
- Conduct TPL audits every six (6) months to ensure TPL responsibilities are being completed by the health plan.

60.430 Responsibilities of the Health Plan

The health plan shall coordinate health care benefits with other coverages, both public and private, which are or may be available to pay medical expenses on behalf of any member.

The health plan shall seek reimbursement from all other liable third parties to the limit of legal liability for the health services rendered. The health plan shall retain all health insurance benefits collected, including cost avoidance.

The health plan shall follow the mandatory pay and chase provisions described in 42 CFR Section 433.139(b)(3)(i)(ii).

In addition, the health plan shall:

- Continue cost avoidance of the health insurance plans accident and workers' compensation benefits;
- Report all accident cases incurring medical and medically related dental expenses in excess of five-hundred dollars (\$500) to the DHS;
- Provide a list of medical and medically related dental expenses, in the format requested by the DHS, for recovery purposes. "RUSH" requests shall be reported within three (3) business days of receipt and "ROUTINE" requests within seven (7) business days of receipt. Listings shall also include claims received but not processed for payments or rejected;
- Provide copies of claim forms with similar response time as the above;
- Provide listings of medical and medically related dental expenses (including adjustments, e.g., payment corrections, refunds, etc.) according to the payment period or "as of" date. Adjustments shall be recorded on the date of adjustment and not on the date of service;
- Inform the DHS of TPL information uncovered during the course of normal business operations;
- Provide the DHS with monthly reports of the total cost avoidance and amounts collected from TPLs within thirty (30) days of the end of the month;
- Develop procedures for determining when to pursue TPL recovery; and

- Provide health care services for members receiving motor vehicle insurance liability coverage at no cost through the Hawaii Joint Underwriting Plan (HJUP) in accordance with Section 431:10C-401 et. seq., HRS.

60.500 Catastrophic Care

60.510 Introduction

The State has contracted with a catastrophic claims manager that shall provide the participating health plan with reimbursement for eligible medical costs incurred by members beyond a specified dollar threshold. The purpose of this reimbursement program is to share the financial risks associated with catastrophic care and protect participating plans from significant, long-term, or unanticipated costs for specific cases.

The catastrophic reimbursement program is available to the health plan for QUEST members.

60.520 The DHS Responsibilities Regarding Catastrophic Care

The DHS or its designee (Catastrophic Claims Manager) shall manage, administer and provide reimbursement to the QUEST Plans for the State's share of eligible medical catastrophic medical expenses. Reimbursement for catastrophic care shall be for eligible members and services. Experimental or investigational services are excluded from catastrophic care.

The catastrophic claims manager shall provide a policy and procedure manual that outline the processes and requirements of the program, i.e. notification requirements, conducting concurrent reviews.

60.530 Health Plan Responsibilities Regarding Catastrophic Care

The health plan shall be held solely responsible for incurred costs for eligible services for each member up to three hundred thousand dollars (\$300,000) in a benefit year. The DHS shall reimburse for eligible costs according to the following:

	<u>Health Plan Share</u>	<u>State Share</u>
Up to \$300,000	100%	0%
\$300,000.01 - \$1,000,000.00	25%	75%
\$1,000,000.01 and up	0%	100%

Note: Amounts listed above are based upon the Medicaid FFS schedule, not the health plan's reimbursement structure.

All available TPL shall be exhausted before reimbursement through the DHS' catastrophic care program is initiated.

The health plan shall notify the Catastrophic Claims Manager within five (5) business days, whenever a case has incurred costs equal to sixty percent (60%) of the minimum or a member is expected to have the minimum cost or more. The health plan shall utilize the listing of the

diagnostic codes on which the catastrophic claims manager expects notification and the specific forms for transmittal of information provided by the catastrophic claims manager.

The following information shall be submitted to the Catastrophic Claims Manager after incurred costs have reached the threshold described above:

- Reports showing the charges and incurred costs of the services provided;
- All medical authorizations for services and level of care determinations, as requested;
- Pertinent information relative to the collection or cost avoidance due to other insurance coverage; and
- Case management reports or other relevant documentation.

In accordance with Section 346-10(a)(3), HRS the health plan shall release medical records to the catastrophic reinsurer.

The plan shall designate one individual within its organization to be responsible for the coordination and communication of catastrophic care information to the catastrophic claims manager.

If a health plan establishes a capitation payment methodology with a hospital, the catastrophic claims manager shall be notified of the payment arrangements.

SECTION 70 SPECIAL TERMS AND CONDITIONS

70.100 Contract Documents

The following documents form an integral part of the contract between the health plan and the DHS (hereafter collectively referred to as “the Contract”):

- Contract for Health and Human Services: Competitive Purchase of Service (AG Form 103F1 (10/08)) (see Appendix K), including General Conditions for Health & Human Services Contracts (AG Form 103F (10/08) (see Appendix K), any Special Conditions, attachments, and addenda;
- this RFP, appendices, attachments, and addenda, which shall be incorporated by reference; and
- the health plan’s technical proposal submitted in response to this RFP form, which shall be incorporated by reference.

References to “General Conditions” in this Section 70 are to the General Conditions for Health & Human Services Contracts attached as Appendix K.

70.200 Conflict Between Contract Documents, Statutes and Rules

Replace General Condition 7.5, Conflict between General Conditions and Procurement Rules, with the following:

- Contract Documents: In the event of a conflict among the contract documents, the order of

precedence shall be as follows: (1) Contract for Health and Human Services: Competitive Purchase of Service (AG Form 103F1), including all general conditions, special conditions, attachments, and addenda; (2) the RFP, including all attachments and addenda, as amended; and (3) applicant's proposal. In the event of a conflict between the General Conditions and the Special Conditions, the Special Conditions shall control.

- Contract and Statutes: In the event of a conflict between the language of the contract, and applicable statutes, the latter shall prevail.
- Contract and Procurement Rules/Directives: In the event of a conflict between the Contract and the Procurement Rules or a Procurement Directive, the Procurement Rules or any Procurement Directive in effect on the date this Contract became effective shall control and are hereby incorporated by reference.
- The sections of the rules and regulations cited in this RFP may change as the rules and regulations are amended for MQD. No changes shall be made to this RFP due to changes in the section numbers. The documents in the documentation library shall be changed as needed. The availability and extent of the materials in the documentation library shall have no effect on the requirements stated in this RFP.

70.300 Licensing and Accreditation

General Condition 1.2.2, Licensing and Accreditation, is amended to read as follows:

At the time of submission of the applicant's proposal, the health plan shall be properly licensed as a health plan in the State of Hawaii as described in chapters 431, 432, or 432D, HRS, and any other licenses and accreditations required under applicable federal, state, and county laws, ordinances, codes, rules, and regulations to provide the services under the contract. The health plan shall comply with all applicable requirements set forth in the above mentioned statutes, and shall include with its proposal proof of licensure and a certificate of good standing from the DCCA Insurance Division dated within 30 days of the date of the proposal (see Section 80.230). In the event of any conflict between the requirements of the contract and the requirements of any these licensure statutes, the statute shall prevail and the health plan shall not be deemed to be in default of compliance with any mandatory statutory requirement.

70.400 Subcontractor Agreements

Replace General Condition 3.2, Subcontracts and Assignments, with the following:

The health plan may negotiate and enter into contracts or agreements with subcontractors to the benefit of the health plan and the State. All such agreements shall be in

writing. No subcontract that the health plan enters into with respect to the performance under the contract shall in any way relieve the health plan of any responsibility for any performance required of it by the contract.

The health plan shall submit to the DHS for review and prior approval, all subcontractor agreements related to the provision of covered benefits and services and member services activities to members (e.g., call center) and provider services activities and payments to providers. The health plan shall submit these subcontractor agreements as required in Section 51.700, Readiness Review. In addition, the DHS reserves the right to inspect **all** subcontractor agreements at any time during the contract period.

The health plan shall notify the DHS at least fifteen (15) days prior to adding or deleting subcontractor agreements or making any change to any subcontractor agreements which may materially affect the health plan's ability to fulfill the terms of the contract.

The health plan shall provide the DHS with immediate notice in writing by registered or certified mail of any action or suit filed against it by any subcontractor, and prompt notice of any claim made against the health plan by any subcontractor that, in the opinion of the health plan, may result in litigation related in any way to the contract with the State of Hawaii.

Additionally, no assignment by the health plan of the health plan's right to compensation under the contract shall be effective unless and until the assignment is approved by the Comptroller of the State of Hawaii, as provided in Section 40-58, HRS, or its successor provision.

All subcontractor agreements must, at a minimum:

- Describe the activities, including reporting responsibilities, to be performed by the subcontractor and require that the subcontractor meet all established criteria prescribed and provide the services in a manner consistent with the minimum standards specified in the health plan's contract with the State;
- Require that the subcontractor fulfill the requirements of 42 CFR Section 438.6 that are appropriate to the service delegated under the subcontract;
- Include a provision that allows the health plan to:
 - Evaluate the subcontractor's ability to perform the activities to be delegated;
 - Monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule (the frequency shall be stated in the agreement) established by the DHS and consistent with industry standards or State laws and regulations;

- Identify deficiencies or areas for improvement; and
 - Take corrective action or impose other sanctions including, but not limited to, revoking delegation, if the subcontractor's performance is inadequate.
- Require that the subcontractor submits to the health plan a tax clearance certificate from the Director of the DOTAX, State of Hawaii, showing that all delinquent taxes, if any, levied or accrued under State law against the subcontractor have been paid;
- Fulfill the requirements of 42 CFR Section 434.6 that are appropriate to the service delegated under the subcontract;
- Include a provision that the health plan shall designate itself as the sole point of recovery for any subcontractor;
- Include a provision that neither the State nor the health plan members shall bear any liability of the health plan's failure or refusal to pay valid claims of subcontractors;
- Require that the subcontractor track and report complaints against them to the health plan;
- Require that the subcontractor fully adhere to the privacy, confidentiality and other related requirements stated in the RFP and in applicable federal and state law;
- Require that the subcontractor follow all audit requirements as outlined in Section 71.800 inclusive.

The actual requirements shall be detailed in the agreement;

- Require that the medical records be retained in compliance with Section 70.500. The actual requirements shall be detailed in the agreement;
- Require that the subcontractor comply with all requirements related to confidentiality of information as outlined in Section 71.700. The actual requirements found in this section shall be detailed in the agreement.
- Require that the subcontractor notify the health plan and the MQD of all breaches of confidential information relating to Medicaid applicants and recipients, as health plan members. The notice to the State shall be within two (2) business days of discovery of the breach and a written report of the investigation and resultant mitigation of the breach shall be provided to the State within thirty (30) business days of the discovery of the breach.

70.500 Retention of Medical Records

The following is added to the end of General Condition 2.3, Records Retention:

The health plan and its providers shall retain all medical records, in accordance with Section 622-58, HRS, for a minimum of seven (7) years from the last date of entry in the records. For minors, the health plan shall retain all

medical records during the period of minority plus a minimum of seven (7) years after the age of majority.

The health plan shall include in its subcontracts and provider agreements record retention requirements that are at least equivalent to those stated in this section.

During the period that records are retained under this section, the health plan and any subcontractor or provider shall allow the state and federal governments' full access to such records, to the extent allowed by law.

70.600 Responsibility For Taxes

In addition to the requirements of General Condition 3.4.4, PROVIDER's Responsibilities, subject to its corporate structure, licensure status, or other statutory exemptions, health plans may be liable for, or exempt from, other federal, state, and/or local taxes including, but not limited to, the insurance premium tax (chapter 431, Article 7, Part II, HRS). Each health plan is responsible for determining whether it is subject to, or exempt from, any such federal, state, or local taxes. The DHS makes no representations whatsoever as to the liability or exemption from liability of the health plan to any tax imposed by any governmental entity.

70.700 Full Disclosure

70.710 Business Relationships

The health plan warrants that it has fully disclosed all business relationships, joint ventures, subsidiaries, holding companies, or any other related entity in its proposal and that any new relationships shall be brought to the attention of the DHS as soon as such a relationship is consummated. The terms and conditions of CMS require full disclosure on the part of all contracting health plans and providers.

The health plan shall not knowingly have a director, officer, partner, or person with more than five percent (5%) of the health plan's equity, or have an employment, consulting, or other agreement with such a person for the provision of items and services that are significant and material to the entity's contractual obligation with the State, who has been debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. The health plan shall not, without prior approval of the DHS, lend money or extend credit to any related party. The health plan shall fully disclose such proposed transactions and submit a formal written request for review and approval.

The health plan shall include the provisions of this section in any subcontract or provider agreement.

70.720 Litigation

The health plan shall disclose any pending litigation to which they are a party, including the disclosure of any outstanding judgment. If applicable, please explain.

70.800 Conflict of Interest

The following is added to the end of General Condition 1.7, Conflicts of Interest:

No official or employee of the State of Hawaii or the federal government who exercises any function or responsibilities in the review or approval of the undertaking or carrying out of the programs shall, prior to the completion of the project, voluntarily acquire any personal interest, direct or indirect, in the contract. All officials or employees of the State of Hawaii shall be bound by Chapter 84, HRS, Standards of Conduct.

70.900 Employment of Department Personnel

The health plan shall not knowingly engage any persons who are or have been employed within the past twelve (12) months by the State of Hawaii to assist or represent the health plan for consideration in matters which he/she participated as an employee or on matters involving official

action by the State agency or subdivision, thereof, where the employee had served.

71.100 Fiscal Integrity

71.110 Warranty of Fiscal Integrity

The health plan warrants that it is of sufficient financial solvency to assure the DHS of its ability to perform the requirements of the contract. The health plan shall comply with the solvency standards established by the State Insurance Commissioner for private health maintenance organizations or health plans licensed in the State of Hawaii, and shall, upon request by the DHS, provide financial data and information to prove its financial solvency.

71.120 Performance Bond

The health plan shall obtain a performance bond issued by a reputable surety company authorized to do business in the State of Hawaii in the amount of one-million dollars (\$1,000,000) or more, conditioned upon the prompt, proper, and efficient performance of the contract, and shall submit the same to the DHS prior to or at the time of the execution of the contract. The performance bond shall be liable to forfeit by the health plan in the event the health plan is unable to properly, promptly and efficiently perform the contract terms and conditions or the contract is terminated by default or bankruptcy of the health plan.

The amount of the performance bond shall be adjusted at the time members begin enrolling in the plan. At that time, the amount of the performance bond shall approximate eighty percent (80%) of one month's capitation payments. The health plan shall update their performance bond annually. The health plans shall submit to DHS a revised performance bond no later than sixty (60) days after the start of the benefit period. The revised capitation payment shall be based upon the last capitation payment for the previous benefit period.

The health plan may, in place of the performance bond, provide the following in the same amount as the performance bond:

- Certificate of deposit, share certificate, or cashier's, treasurer's, teller's or official check, or a certified check made payable to the Department of Human Services, State of Hawaii, issued by a bank, a savings institution, or credit union that is insured by the Federal Deposit Insurance Corporation (FDIC) or the National Credit Union Administration, and payable at sight or unconditionally assigned to the procurement officer advertising for offers. These instruments may be utilized only to a maximum of one-hundred thousand dollars (\$100,000) each and must be issued by different financial institutions.

- Letter of credit with a bank insured by the FDIC with the Department of Human Services, State of Hawaii, designated as the sole payee.

Upon termination of the contract, for any reason, including expiration of the contract term, the health plan shall ensure that the performance bond is in place until such time that all of the terms of the contract have been satisfied. The performance bond shall be liable for, and the DHS shall have the authority to, retain funds for additional costs including, but not limited to:

- Any costs for a special plan change period necessitated by the termination of the contract;
- Any costs for services provided prior to the date of termination that are paid by MQD;
- Any additional costs incurred by the State due to the termination; and
- Any sanctions or penalties owed to the DHS.

71.200 Term of the Contract

This is a multi-term contract solicitation that has been deemed to be in the best interest of the State by the Director of the DHS in accordance with Section 3-149-302(c), HAR. The contract is for the initial term from the date of commencement of services to members as specified in Section 20.100 to December 31, 2013. Unless terminated, the contract shall be extended without the necessity of re-bidding, for not more than four (4)

additional twelve (12) month periods or parts thereof, only upon mutual agreement of the parties in writing, at least sixty (60) days prior to expiration of the contract term, provided that the contract price for the extended period shall remain the same or lower than the initial bid price or as adjusted in accordance with the contract price adjustment provision herein.

The State of Hawaii operates on a fiscal year basis, which runs from July 1 to June 30 of each year. Funds are available for only the first fiscal period of the contract ending June 30 in the first year of the initial term. The contractual obligation of both parties in each fiscal period succeeding the first fiscal period is subject to the appropriation and availability of funds to DHS.

The contract will be terminated only if funds are not appropriated or otherwise made available to support continuation of performance in any fiscal period succeeding the initial fiscal period of the contract; however this does not affect either the State's rights or the health plan's rights under any termination clause of the contract. The State shall notify the health plan, in writing, at least sixty (60) days prior to the expiration of the contract whether funds are available or not available for the continuation of the contract for each succeeding contract extension period. In the event of termination, as provided in this paragraph, the health plan shall be reimbursed for the unamortized, reasonably incurred, nonrecurring costs.

The health plan acknowledges that other unanticipated uncertainties may arise that may require an increase or decrease in the original scope of services to be performed, in which event the health plan agrees to enter into a supplemental agreement upon request by the State. The supplemental agreement may also include an extension of the period of performance and a respective modification of the compensation.

71.300 Insurance

71.310 Liability Insurance Requirements

The health plan shall maintain insurance acceptable to the DHS in full force and effect throughout the term of this contract, until the DHS certifies that the health plan's work has been completed satisfactorily.

Prior to or upon execution of the contract, the health plan shall provide to the DHS certificate(s) of insurance dated within thirty (30) days of the effective date of the contract necessary to satisfy the DHS that the insurance provisions of this contract have been complied with. Upon request by the DHS, health plan shall furnish a copy of the policy(ies) or endorsement(s) necessary for DHS to verify the coverages required by this section.

The policy or policies of insurance maintained by the health plan shall be written by insurance companies licensed to

do business in the State of Hawaii or meet the requirements of Section 431:8-301, et seq., HRS, if utilizing an insurance company not licensed by the State of Hawaii.

The policy(ies) shall provide at least the following limit(s) and coverage:

Coverage	Limits
Commercial General Liability	Per occurrence, not claims made <ul style="list-style-type: none"> • \$1 million per occurrence • \$2 million in the aggregate
Automobile	May be combined single limit: <ul style="list-style-type: none"> • Bodily Injury: \$1 million per person, \$1 million per accident • Property Damage: \$1 million per accident
Workers Compensation / Employers Liability (E.L.)	<ul style="list-style-type: none"> • Workers Comp: Statutory Limits • E.L. each accident: \$1,000,000 • E.L. disease: \$1,000,000 per employee, \$1,000,000 policy limit • E.L. \$1 million aggregate
Professional Liability, if applicable	May be claims made: <ul style="list-style-type: none"> • \$1 million per claim • \$2 million annual aggregate

Each insurance policy required by this contract shall contain the following clauses, which shall also be reflected on the certificate of insurance:

1. "The State of Hawaii is an additional insured with respect to operations performed for the State of Hawaii."

2. "Any insurance maintained by the State of Hawaii shall apply in excess of, and not contribute with, insurance provided by this policy."

Automobile liability insurance shall include excess coverage for the health plan's employees who use their own vehicles in the course of their employment.

The health plan shall immediately provide written notice to the DHS should any of the insurance policies required under the Contract be cancelled, limited in scope, or not be renewed upon expiration.

Failure of the health plan to provide and keep in force the insurance required under this section shall be regarded as a material default under this contract, entitling the DHS to exercise any or all of the remedies provided in this contract for a default of the health plan.

The procuring of such required policy or policies of insurance shall not be construed to limit health plan's liability hereunder nor to fulfill the indemnification provisions and requirements of this contract. Notwithstanding said policy or policies of insurance, health plan shall be liable for the full and total amount of any damage, injury, or loss caused by health plan in connection with this contract.

If the health plan is authorized by the DHS to subcontract, subcontractors are not excused from the indemnification and/or insurance provisions of this contract. In order to indemnify the State of Hawaii, the health plan agrees to require its subcontractors to obtain insurance in accordance with this section.

71.320 Reinsurance

The health plan may obtain reinsurance for its costs for program members.

71.400 Modification of Contract

The following is added as General Condition 4.1.4:

All modifications of the contract shall be negotiated and accompanying capitated rates established. If the parties reach an agreement, the contract terms shall be modified accordingly by a written amendment signed by the Director of the DHS and an authorized representative of the health plan. If the parties are unable to reach an agreement within thirty (30) days of the health plan's receipt of a contract change, the MQD Administrator shall make a determination as to the contract modifications and capitation rate, and the health plan shall proceed with the work according to a schedule approved by the DHS, subject to the health plan's right to appeal the MQD Administrator's determination of the contract modification and price under Section 72.100, Disputes.

71.500 Conformance with Federal Regulations

Any provision of the contract which is in conflict with federal Medicaid statutes, regulations, or CMS policy guidance is hereby amended to conform to the provisions of those laws, regulations, and federal policy. Such amendment of the contract shall be effective on the effective date of the statutes or regulations necessitating it, and shall be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

71.600 Termination of the Contract

The contract may terminate or may be terminated by DHS for any or all of the following reasons in addition to the General Conditions in Appendix K:

- Termination for Default;
- Termination for Expiration of the Programs by CMS;
- or
- Termination for Bankruptcy or Insolvency

71.610 Termination for Default

The failure of the health plan to comply with any term, condition, or provision of the contract shall constitute default by the health plan. In the event of default, the DHS shall notify the health plan by certified or registered mail, with return receipt requested, of the specific act or

omission of the health plan, which constitutes default. The health plan shall have fifteen (15) days from the date of receipt of such notification to cure such default. In the event of default, and during the above-specified grace period, performance under the contract shall continue as though the default had never occurred. In the event the default is not cured within fifteen (15) days, the DHS may, at its sole option, terminate the contract for default. Such termination shall be accomplished by written notice of termination forwarded to the health plan by certified or registered mail and shall be effective as of the date specified in the notice. If it is determined, after notice of termination for default, that the health plan's failure was due to causes beyond the control of and without error or negligence of the health plan, the termination shall be deemed a termination for convenience under General Condition 4.3 in Appendix K.

The DHS' decision not to declare default shall not be deemed a waiver of such default for the purpose of any other remedy the health plan may have.

71.620 Termination for Expiration or Modification of the Programs by CMS

The DHS may terminate performance of work under the contract in whole or in part whenever, for any reason, CMS terminates or modifies the programs. In the event that CMS elects to terminate its agreement with the DHS, the DHS shall so notify the health plan by certified or

registered mail, return receipt requested. The termination shall be effective as of the date specified in the notice.

71.630 Termination for Bankruptcy or Insolvency

In the event that the health plan shall cease conducting business in the normal course, become insolvent, make a general assignment for the benefit of creditors, suffer or permit the appointment of a receiver for its business or its assets or shall avail itself of, or become subject to, any proceeding under the Federal Bankruptcy Act or any other statute of any State relating to insolvency or the protection of the rights or creditors, the DHS may, at its option, terminate the contract. In the event the DHS elects to terminate the contract under this provision it shall do so by sending notice of termination to the health plan by registered or certified mail, return receipt requested. The termination shall be effective as of the date specified in the notice.

In the event of insolvency of the health plan, the health plan shall cover continuation of services to members for the duration of period for which payment has been made, as well as for inpatient admissions up until discharge. Members shall not be liable for the debts of the health plan. In addition, in the event of insolvency of the health plan, members may not be held liable for the covered services provided to the member, for which the State does not pay the health plan.

71.640 Procedure for Termination

In the event the State decides to terminate the contract, it shall provide the health plan with a pre-termination hearing. The State shall:

- Give the health plan written notice of its intent to terminate, the reason(s) for termination, and the time and place of the pre-termination hearing; and
- Give the health plan's members written notice of the intent to terminate the contract, notify members of the hearing, and allow them to disenroll immediately without cause.

Following the termination hearing, the State shall provide written notice to the health plan of the termination decision affirming or reversing the proposed termination. If the State decides to terminate the contract, the notice shall include the effective date of termination. In addition, if the contract is to be terminated, the State shall notify the health plan's members in writing of their options for receiving Medicaid services following the effective date of termination.

In the event of any termination, the health plan shall:

- Stop work under the contract on the date and to the extent specified in the notice of termination;

- Complete the performance of such part of the work as shall not have been terminated by the notice of the termination;
- Notify the members of the termination and arrange for the orderly transition to the new health plan(s), including timely provision of any and all records to the DHS that are necessary to transition the health plan's members to another health plan;
- Promptly supply all information necessary for the reimbursement of any outstanding Medicaid claims;
- Place no further orders or enter into subcontracts for materials, services, or facilities, except as may be necessary for completion of the work under the portion of the contract that is not terminated;
- Terminate all orders and subcontracts to the extent that they relate to the performance of work terminated by the notice of termination;
- Assign to the DHS in the manner and to the extent directed by the MQD Administrator of the right, title, and interest of the health plan under the orders or subcontracts so terminated, in which case the DHS shall have the right, in its discretion, to settle or pay any or all claims arising out of the termination of such orders and subcontracts;
- With the approval of the MQD Administrator, settle all outstanding liabilities and all claims arising out of such termination of orders and subcontracts, the cost of which would be reimbursable, in whole or in

part, in accordance with the provisions of the contract.

- Take such action as may be necessary, or as the MQD administrator may direct, for the protection and preservation of any and all property or information related to the contract which is in the possession of the health plan and in which the DHS has or may acquire an interest; and
- Within thirty (30) business days from the effective date of the termination, deliver to the DHS copies of all current data files, program documentation, and other documentation and procedures used in the performance of the contract at no cost to the DHS. The health plan agrees that the DHS or its designee shall have a non-exclusive, royalty-free right to the use of any such documentation.

The health plan shall create written procedures for the orderly termination of services to any members receiving the required services under the contract, and for the transition to services supplied by another health plan upon termination of the contract, regardless of the circumstances of such termination. These procedures shall include, at the minimum, timely notice to the health plan's members of the termination of the contract, and appropriate counseling. The health plan shall submit these procedures to the DHS for approval upon their completion, but no later than one-hundred eighty (180) days after the effective date of the contract.

71.650 Termination Claims

After receipt of a notice of termination, the health plan shall submit to the MQD Administrator any termination claim in the form and with the certification prescribed by the MQD Administrator. Such claim shall be submitted promptly but no later than six (6) months from the effective date of termination. Upon failure of the health plan to submit its termination claims within the time allowed, the MQD Administrator may, subject to any review required by the State procedures in effect as of the date of execution of the contract, determine, on the basis of information available to him/her, the amount, if any, due to the health plan by reason of the termination and shall thereupon cause to be paid to the health plan the amount to be determined.

Upon receipt of notice of termination, the health plan shall have no entitlement to receive any amount for lost revenues or anticipated profits or for expenditures associated with this or any other contract. The health plan shall be paid only the following upon termination:

- At the contract price(s) for the number of members enrolled in the health plan at the time of termination; and
- At a price mutually agreed to by the health plan and the DHS.

In the event the health plan and the DHS fail to agree, in whole or in part, on the amount of costs to be paid to the health plan in connection with the total or partial termination of work pursuant to this section, the MQD Administrator shall determine, on the basis of information available to the DHS, the amount, if any, due to the health plan by reason of the termination and shall pay to the health plan the amount so determined.

The health plan shall have the right to appeal any such determination made by the MQD Administrator as stated in Section 72.100, Disputes.

71.700 Confidentiality of Information

In addition to the requirements of General Condition 8, the health plan understands that the use and disclosure of information concerning applicants, recipients or members is restricted to purposes directly connected with the administration of the Hawaii Medicaid program, and agrees to guard the confidentiality of an applicant's, recipient's or member's information as required by law. The health plan shall not disclose confidential information to any individual or entity except in compliance with the following:

- 42 CFR Part 431, Subpart F;
- The Administrative Simplification provisions of HIPAA and the regulations promulgated thereunder, including but not limited to the Security and Privacy

requirements set forth in 45 CFR Parts 160, 162 and 164, (if applicable);

- Section 346-10, HRS; and
- All other applicable federal and State statutes and administrative rules, including but not limited to:
 - Section 325-101, HRS, relating to persons with HIV/AIDS;
 - Section 334-5, HRS, relating to persons receiving mental health services;
 - Chapter 577A, HRS relating to emergency and family planning services for minor females;
 - 42 CFR Part 2 relating to persons receiving substance abuse services;
 - Chapter 487J, HRS, relating to social security numbers
 - Chapter 487N, HRS, relating to personal information.

Access to member identifying information shall be limited by the health plan to persons or agencies that require the information in order to perform their duties in accordance with this contract, including the U.S. Department of Health and Human Services (DHHS), the DHS and other individuals or entities as may be required by the DHS. (See 42 CFR Section 431.300, et seq. and 45 CFR Parts 160 and 164.)

Any other party shall be granted access to confidential information only after complying with the requirements of

state and federal laws, including but not limited to HIPAA, and regulations pertaining to such access. The health plan is responsible for knowing and understanding the confidentiality laws listed above as well as any other applicable laws. The health plan, if it reports services to its members, shall comply with all applicable confidentiality laws. Nothing herein shall prohibit the disclosure of information in summary, statistical or other form that does not identify particular individuals, provided that de-identification of protected health information is performed in compliance with the HIPAA Privacy Rule.

Federal and State Medicaid rules, and some other Federal and State statutes and rules, including but not limited to those listed above, are often more stringent than the HIPAA regulations. Moreover, for purposes of this contract, the health plan agrees that the confidentiality provisions contained in Chapter 17-1702, HAR, shall apply to the health plan to the same extent as they apply to MQD.

The health plan shall implement a secure electronic mail (email) encryption solution to ensure confidentiality, integrity, and authenticity of email communications that contain information relating to members.

The health plan shall notify the State within two (2) business days of discovery of the breach of confidentiality. In addition, the health plan shall provide to the State a

written report of the investigation and resultant mitigation of the breach within thirty (30) business days of the discovery of the breach. All breaches of confidential information relating to Medicaid enrollees, as health plan members, shall be reported to the MQD. The actual requirements found in this section shall be detailed in all provider and subcontractor agreements.

71.800 Audit Requirements

The state and federal standards for audits of the DHS designees, contractors and programs conducted under contract are applicable to this subsection and are incorporated by reference into the contract. The DHS may inspect and audit any records of the health plan and its subcontractors or providers.

71.810 Accounting Records Requirements

The health plan shall, in accordance with generally accepted accounting practices, maintain fiscal records and supporting documents and related files, papers and reports that adequately reflect all direct and indirect expenditures and management and fiscal practices related to the health plan's performance of services under the contract.

The health plan's accounting procedures and practices shall conform to generally accepted accounting principles and the costs properly applicable to the contract shall be readily ascertainable from the records.

71.820 Inclusion of Audit Requirements in Subcontracts

The provisions of Section 71.800 and its associated subsections shall be incorporated in every subcontract/provider agreement.

71.900 Ongoing Inspection of Work Performed

In addition to the ongoing monitoring described in Section 31.100, the DHS, the State Auditor of Hawaii, the U.S. Department of Health and Human Services (DHHS), the General Accounting Office (GAO), the Comptroller General of the United States, the Office of the Inspector General (OIG), Medicaid Fraud Control Unit of the Department of the Attorney General, State of Hawaii, or their authorized representatives shall, during normal business hours, have the right to enter into the premises of the health plan, all subcontractors and providers, or such other places where duties under the contract are being performed, to inspect, monitor, or otherwise evaluate the work being performed. All inspections and evaluations shall be performed in such a manner to not unduly delay work. All records and files pertaining to the health plan shall be located in the State of Hawaii at the health plan's principal place of business or at a storage facility on Oahu that is accessible to the foregoing identified parties.

72.100 Disputes

Any dispute concerning a question of fact arising under the contract which is not disposed of by agreement shall be decided by the Director of the DHS or his/her duly authorized representative who shall reduce his/her decision to writing and mail or otherwise furnish a copy to the health plan within ninety (90) days after written request for a final decision by certified mail, return receipt requested. The decision shall be final and conclusive unless determined by a court of competent jurisdiction to have been fraudulent, or capricious or arbitrary, or so grossly erroneous as necessarily to imply bad faith. In connection with any dispute proceeding under this clause, the health plan shall be afforded an opportunity to be heard and to offer evidence in support of his/her dispute. The health plan shall proceed diligently with the performance of the contract in accordance with the disputed decision pending final resolution by a circuit court of this State.

Any legal proceedings against the State of Hawaii regarding this RFP or any resultant contract shall be brought in a court of competent jurisdiction in the City and County of Honolulu, State of Hawaii.

72.200 Liquidated Damages, Sanctions and Financial Penalties

72.210 Liquidated Damages

In the event of any breach of the terms of the contract by the health plan, liquidated damages shall be assessed against the health plan in an amount equal to the costs of obtaining alternative medical benefits for its members. The damages shall include, without limitation, the difference in the capitated rates paid to the health plan and the rates paid to a replacement health plan.

Notwithstanding the above, the health plan shall not be relieved of liability to the State for any damages sustained by the State due to the health plan's breach of the contract.

The DHS may withhold amounts for liquidated damages from payments to the health plan until such damages are paid in full.

72.220 Sanctions

The DHS may impose sanctions for non-performance or violations of contract requirements. Sanctions shall be determined by the State and may include:

- Imposing civil monetary penalties (as described below);
- Suspending enrollment of new members with the health plan;

- Suspending payment;
- Notifying and allowing members to change plans without cause;
- Appointment of temporary management (as described in Section 72.230); or
- Terminating the contract (as described in Section 71.600).

The State shall give the health plan timely written notice that explains the basis and nature of the sanction as outlined in 42 CFR Part 438, Subpart I. The health plan may follow DHS appeal procedures to contest the penalties or sanctions. The DHS shall provide these appeal procedures to the health plan prior to the Date of Commencement of Services identified in Section 20.100.

The civil or administrative monetary penalties imposed by the DHS shall not exceed the maximum amount established by federal statutes and regulations on the health plan.

The civil monetary penalties that may be imposed on the health plan by the State are as follows:

Number	Activity	Penalty
1	Misrepresentation of actions or falsification of information furnished to the CMS or the State	A maximum of one hundred thousand dollars (\$100,000) for each determination

Number	Activity	Penalty
2	Acts to discriminate among members on the basis of their health status or need for healthcare services	A maximum of one hundred thousand dollars (\$100,000) for each determination
3	Failure to implement requirements stated in the health plan's proposal, the RFP or the contract, or other material failures in the health plan's duties, including but not limited to failing to meet performance standards	A maximum of fifty thousand dollars (\$50,000) for each determination
4	Substantial failure to provide medically necessary services that are required under law or under contract, to an enrolled member	A maximum of twenty-five thousand dollars (\$25,000) for each determination
5	Imposition upon members premiums and charges that are in excess of the premiums or charges permitted under the program	A maximum of twenty-five thousand dollars (\$25,000) or double the amount of the excess charges (whichever is greater). The State shall deduct from the penalty the amount of overcharge and return it to the affected member(s)
6	Misrepresentation or false statements to members, potential members or providers	A maximum of twenty-five thousand dollars (\$25,000) for each determination
7	Violation of any of the other applicable	A maximum of twenty-five

Number	Activity	Penalty
	requirements of Sections 1903(m), 1905(t)(3) or 1932 of the Social Security Act and any implementing regulations	thousand dollars (\$25,000) for each determination
8	Failure to comply with the requirements for physician incentive plans, as set forth in 42 CFR Sections 422.208 and 422.210	A maximum of twenty-five thousand dollars (\$25,000) for each determination
9	Distribution, directly or indirectly through any agent or independent contractor, of marketing materials that have not been approved by the State or that contain false or materially misleading information	A maximum of twenty-five thousand dollars (\$25,000) for each determination
10	Not enrolling a member because of a discriminatory practice	A maximum of fifteen thousand dollars (\$15,000) for each member the State determines was not enrolled because of a discriminatory practice
11	Failure to resolve member appeals and grievances within the time frames specified in Section 51.100	A maximum of ten thousand dollars (\$10,000) for each determination of failure
12	Failure to comply with the claims processing standard required in Section 60.310	A maximum of five thousand dollars (\$5,000) for each determination of failure
13	Failure to meet minimum compliance of	A maximum of five thousand dollars

Number	Activity	Penalty
	provision of periodic screens to EPSDT eligible members as described in Section 40.753	(\$5,000) for each determination of failure
15	Failure to comply with staffing requirements as outlined in Section 51.400	A maximum of five thousand dollars (\$5,000) for each determination of failure
16	Failure to provide accurate information, data, reports and medical records, including behavioral health and substance abuse records to the DHS by the specified deadlines provided in Section 51.510	Two hundred dollars (\$200) per day until all required information, data, reports and medical records are received
17	Failure to report confidentiality breaches relating to Medicaid applicants and recipients to the DHS by the specific deadlines provided in Section 71.700	One hundred dollars (\$100) per day per applicant/recipient. A maximum of twenty-five thousands dollars (\$25,000) until the reports are received

Payments provided for under the contract shall be denied for new members when, and for so long as, payment for those members is denied by CMS in accordance with the requirements in 42 CFR section 438.730.

72.230 Special Rules for Temporary Management

The sanction of temporary management may be imposed by the State if it finds that:

- There is continued egregious behavior by the health plan, including, but not limited to, behavior that is described in 42 CFR Section 438.700, or that is contrary to any requirements of Sections 1903(m) and 1932 of the Social Security Act;
- There is substantial risk to the member's health; or
- The sanction is necessary to ensure the health of the health plan's members while improvements are made to remedy violations under 42 CFR Section 438.700 or until there is an orderly termination or reorganization of the health plan.

The State shall impose temporary management if it finds that the health plan has repeatedly failed to meet the substantive requirements in Sections 1903(m) and 1932 of the Social Security Act. The State shall not provide the health plan with a pre-termination hearing before the appointment of temporary management.

In the event the State imposes the sanction of temporary management, members shall be allowed to disenroll from the health plan without cause.

72.300 Compliance with Laws

In addition to the requirements of General Condition 1.3, Compliance with Laws, the health plan shall comply with the following:

72.310 Wages, Hours and Working Conditions of Employees Providing Services

Pursuant to Section 103-55, HRS, services to be performed by the health plan and its subcontractors or providers shall be performed by employees paid at wages or salaries not less than the wages paid to public officers and employees for similar work. Additionally, the health plan shall comply with all applicable federal and state laws relative to workers compensation, unemployment compensation, payment of wages, prepaid healthcare, and safety standards. Failure to comply with these requirements during the contract period shall result in cancellation of the contract unless such noncompliance is corrected within a reasonable period as determined by the DHS. Final payment under the contract shall not be made unless the DHS has determined that the noncompliance has been corrected. The health plan shall complete and submit the Wage Certification provided in Appendix L.

72.320 Compliance with other Federal and State Laws

The health plan shall agree to conform with the following federal and state laws as affect the delivery of services under the Contract including, but not limited to:

- Titles VI, VII, XIX, and XXI of the Social Security Act;
Title VI of the Civil Rights Act of 1964;
- the Age Discrimination Act of 1975;
- the Rehabilitation Act of 1973;
- the Americans with Disability Act;

- Chapter 489, HRS (Discrimination in Public Accommodations);
- applicable standards, orders or regulations issued pursuant to the Clean Air Act (42 U.S.C. Section 7401, et seq.) and the Federal Water Pollution Control Act, as amended (33 U.S.C. Section 1251, et seq.);
- the Byrd Anti-Lobbying Amendment (31 U.S.C. Section 1352); and
- E.O. 11246, "Equal Employment Opportunity," as amended by E.O. 11375 "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulations at 41 C.F.R. part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor".

The health plan shall recognize mandatory standards and policies relating to energy efficiency that are contained in any State energy conservation plan developed by the State in accordance with the Energy Policy and Conservation Act (Pub. L. 94-163, Title III, Part A).

The health plan shall include notice of grantor agency requirements and regulations pertaining to reporting and patient rights under any contracts involving research, developmental, experimental or demonstration work with respect to any discovery or invention which arises or is developed in the course of or under such contract, and of grantor agency requirements and regulations pertaining to copyrights and rights in data.

72.400 Miscellaneous Special Conditions

72.410 Use of Funds

The health plan shall not use any public funds for purposes of entertainment or perquisites and shall comply with any and all conditions applicable to the public funds to be paid under the contract, including those provisions of appropriate acts of the Hawaii State Legislature or by administrative rules adopted pursuant to law.

72.420 Prohibition of Gratuities

Neither the health plan nor any person, firm or corporation employed by the health plan in the performance of the contract shall offer or give, directly or indirectly, to any employee or designee of the State of Hawaii, any gift, money or anything of value, or any promise, obligation, or contract for future reward or compensation at any time during the term of the contract.

72.430 Publicity

General Condition 6.1 is amended to read as follows: Acknowledgment of State Support. The health plan shall not use the State's or the DHS's name, logo or other identifying marks on any materials produced or issued without the prior written consent of the DHS. The health plan also agrees not to represent that it was supported by or affiliated with the State of Hawaii without the prior written consent of the DHS.

72.440 Force Majeure

If the health plan is prevented from performing any of its obligations hereunder in whole or in part as a result of major epidemic, act of God, war, civil disturbance, court order or any other cause beyond its control, the health plan shall make a good faith effort to perform such obligations through its then-existing facilities and personnel; and such non-performance shall not be grounds for termination for default.

Neither party to the contract shall be responsible for delays or failures in performance resulting from acts beyond the control of such party.

Nothing in this section shall be construed to prevent the DHS from terminating the contract for reasons other than default during the period of events set forth above, or for default if such default occurred prior to such event.

72.450 Attorney's Fees

In addition to costs of litigation provided for under General Condition 5.2, in the event that the DHS shall prevail in any legal action arising out of the performance or non-performance of the contract, the health plan shall pay, in addition to any damages, all expenses of such action including reasonable attorney's fees and costs. The term 'legal action' shall be deemed to include administrative proceedings of all kinds, as well as all actions at law or in equity.

72.460 Time is of the Essence

Time is of the essence in the contract. As such, any reference to "days" shall be deemed calendar days unless otherwise specifically stated.

SECTION 80 MANDATORY AND TECHNICAL PROPOSAL

80.100 Introduction

The applicant shall comply with all content and format requirements for the technical proposal. The proposal shall be on standard 8 ½" by 11" paper, one and a half (1 ½) spaced, singled sided and with text no smaller than 11-point font. The pages must have at least one-inch margins. All proposal pages must be numbered and identified with the applicant's name.

Applicants shall answer all questions as part of the narrative in the order that they appear in each sub-section. The question must be restated above the response. The questions related to any attachment do not need to be restated as long as it is clear from the heading of the referenced attachment. Attachments may be placed, in the order in which they are requested, behind the narrative responses for that sub-section. Attachments do not count toward the maximum page limits.

Narratives in excess of the maximum page limits and any documentation not specifically requested shall not be reviewed. Likewise, providing actual policies and procedures in lieu of a narrative may result in the applicant receiving a non-responsive score for that question.

80.200 Mandatory Requirements

80.210 Attachment: Transmittal Letter

The transmittal letter shall be on official business letterhead and shall be signed by an individual authorized to legally bind the applicant. It shall include:

- A. A statement indicating that the applicant is a corporation or other legal entity and is a properly licensed health plan in the State of Hawaii at the time of proposal submission. All subcontractors shall be identified and a statement included indicating the percentage of work to be performed by the prime applicant and each subcontractor, as measured by percentage of total contract price;
- B. A statement that the applicant has an established provider network to serve Medicaid recipients in the State of Hawaii;
- C. A statement that the applicant is registered to do business in Hawaii and has a State of Hawaii General Excise Tax License, if applicable, and that this will be submitted to the DHS with the signed contracts (following the Contract Award date and prior to the Contract Effective Date identified in Section 20.100);
- D. The applicant's Hawaii excise tax number (if applicable);
- E. A statement identifying all amendments and addenda to this RFP issued by the issuing office. If no amendments or addenda have been issued, a statement to that effect shall be included;

- F. A statement of affirmative action that the applicant does not discriminate in its employment practices with regard to race, color, creed, ancestry, age, marital status, arrest and court records, sex, including gender identity or expression, sexual orientation, religion, national origin or mental or physical handicap, except as provided by law;
- G. A statement that no attempt has been made or will be made by the applicant to induce any other party to submit or refrain from submitting a proposal;
- H. A statement that the applicant has read, understands and agrees to all provisions of this RFP;
- I. A statement that it is understood that if awarded the contract, the applicant's organization shall deliver the goods and services meeting or exceeding the specifications in the RFP and amendments;
- J. A statement that the person signing this proposal certifies that he/she is the person in the applicant's organization responsible for, or authorized to make, decisions as to the prices quoted, that the offer is firm and binding, and that he/she has not participated and shall not participate in any action contrary to the above conditions; and
- K. A statement on whether the applicant is applying for Oahu and one other island, or Statewide. If less than two selected health plans applied to operate Statewide, the Department shall allow the other health plans to change to operate Statewide. If no

plan chooses to change, then the Department may require a completely new procurement.

80.220 Company Background Narrative

The applicant shall provide a description of its company that includes:

- A. The legal name and any names under which the applicant has done business;
- B. Address, telephone number and e-mail address of the applicant's headquarter office;
- C. Date company was established;
- D. Date company began operations;
- E. Names and addresses of officers and directors;
- F. The size and resources, including the gross revenues and total number of employees and current number of employees in Hawaii; and
- G. A description of any services it objects to based on moral or religious grounds as described in Section 40.300 including a description of the grounds for the objection and information on how it will provide the required services. If there are no services to which it objects, the applicant shall state that.

The information required above shall be supplied for each affiliated company that serves Medicaid members and any subcontractors the applicant intends to use.

80.230 Attachment: Other Documentation

The applicant shall attach, in the following order, completed forms provided in Appendix L:

- A. The Proposal Application Identification form (Form SPO-H-200);
- B. The State of Hawaii DHS Proposal Letter;
- C. The Certification for Contracts, Grants, Loans and Cooperative Agreements form;
- D. The Disclosure Statement (CMS required) form;
- E. Disclosure Statement;
- F. The Disclosure Statement (Ownership) form;
- G. The Organization Structure and Financial Planning form;
- H. The Financial Planning form;
- I. The Financial Performance form;
- J. The Controlling Interest form;
- K. The Background Check Information form;
- L. The Operational Certification Submission form;
- M. The Grievance System form;
- N. Applicant's Proof of Insurance;
- O. The Wage Certification form;
- P. The Standards of Conduct Declaration form;
- Q. The State and Federal Tax Clearance certificates from the prime applicant and, upon request from subcontractors, as assurance that all federal and state tax liabilities have been paid and that there are no significant outstanding balances owed (a statement shall be included if certificates are not available at time of submission of proposal that the

certificates will be submitted in compliance with Section 20.500.);

R. Proof of its current license to serve as a health plan in the State of Hawaii. A letter from the Insurance Division notifying the health plan of its license shall be acceptable "proof" for DHS; and

S. Certificate of Good Standing from the State of Hawaii, Department of Commerce and Consumer Affairs, Insurance Division.

80.240 Attachment: Risk Based Capital

The applicant shall provide the most recent completed risk based capital (RBC) amount. Where applicable, the applicant shall submit separate RBC amounts for all affiliated companies and companies with the same parent company as the applicant.

80.300 Technical Proposal

80.310 Experience and References (12 pages maximum not including attachments)

The applicant shall provide:

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

providing direct services and that the applicant intends to use in the QUEST program;

- B. A listing, in table format, of contracts for all Medicaid program clients (including those served by an affiliated company or a company with the same parent company as the applicant, and any subcontractors that are or have provided direct services and that the applicant intends to use in the QUEST program), past and present. This listing shall include the name, title, address, telephone number and e-mail address of the client and/or contract manager, the number of individuals the applicant has managed broken down by the type of membership (e.g. TANF and TANF related, foster children, aged, blind, disabled, etc.), and the number of years the applicant has been providing or had provided services for that program. In the interest of space, if the applicant has ten (10) or more contracts for the Medicaid programs that entail the provision of direct services, it is not necessary to include all contracts which do not entail direct service provision (e.g., administrative service arrangements);
- C. Letters of recommendation that support the health plan's proposal. The health plan shall submit no more than ten (10) letters of recommendation. Letters of recommendation may be provided from: (1) member advocacy groups in the State or service region; (2) provider organizations in the State or service region; or (3) other persons or organizations

that have had an opportunity to work with the health plan and can recommend their work in the QUEST program;

- D. Information on: (1) whether or not any applicant contract (including those for an affiliate of the company, a company with the same parent company as the applicant, or any subcontractor that the applicant intends to use in the QUEST program to provide direct services) has been terminated or not renewed for non-performance or poor performance within the past five (5) years; and (2) whether the applicant (including an affiliate of the company, a company with the same parent company as the applicant or any subcontractor providing direct services) failed to complete a full contract term or self-terminated mid-contract. Please include information on the details of the termination, non-renewal, failure to complete a full contract term or self-termination;
- E. Its most recent EQRO evaluations (July 2011) from the State of Hawaii. If the applicant is not currently providing services to Medical Assistance clients in the State of Hawaii, the applicant shall submit its most recent EQRO evaluation from at least two other states in which it has previously been or is currently operating. Note: this shall be cross-checked with references to ensure all EQROs have been submitted. The EQRO evaluations do not count towards the page limit; and

F. EPSDT measures for the last twelve (12) month period from the State of Hawaii. If the applicant is not currently providing services to Medical Assistance clients in the State of Hawaii, the applicant shall submit its most recent EPSDT measures from at least two other states that it has previously or is currently operating. Please provide reference to the population reporting on and include geographic location and member demographics. The applicant shall indicate that measures were validated by an EQRO and provide the EQRO validation reports. Note: neither the EPSDT measures nor the EQRO validation reports count towards the page limit.

This section shall be scored based upon:

1. The relevance of the experience in providing services to Medicaid enrollees in the State of Hawaii (experience in Hawaii shall be worth more points than experience providing services to Medicaid enrollees in another state);
2. The relevance of the duration of the experience per Item #1 above (a longer duration of the experience shall be worth more points);
3. Whether or not a contract has been terminated or was not renewed due to non-performance or for poor performance; and
4. The EQRO evaluations and EPSDT measures.

80.315 Provider Network and Services (30 pages maximum not including attachments)

80.315.1 *Provider Network Narrative (included in page maximum)*

The applicant shall provide a narrative describing how it maintains its provider network serving Medicaid recipients in order to assure that all services are available to members. As part of this narrative, the applicant shall describe:

- A. In detail, how it will maintain its network to meets **all** required access standards required under this RFP, including, but not limited to, capacity standards (for acute care, primary care, and behavioral health) and geographic access requirements;
- B. How it monitors the provider network to ensure that access and availability standards are being met. As part of this description, please specifically address how the applicant ensures that acceptable appointment wait times are met and steps taken in the past, if any, in the past to address deficiencies in this area;
- C. How it will provide services when there are either no contracted providers or the number of providers fails to meet the minimum requirement;
- D. How it will recruit, retain, and incentivize providers in rural and other historically under-served areas to ensure access to care and services in these areas;
- E. Provide a summary of its PCP policies and procedures that includes information on choosing and selecting a

PCP (including the PCP assignment process), describes who may serve as a PCP, referral to specialists, and describes who may serve as a PCP to members with chronic conditions;

F. The provider network analysis for its Medicaid business in Hawaii. This analysis shall include:

1. The percent of PCPs who are Board certified;
and
2. The percent of specialists who are Board certified in the specialty of their predominant practice.

80.315.2 Attachment: Required Providers (not included in page maximum)

The applicant shall provide a separate listing of its providers for each island for which it is bidding. Use the format listed below for these listings. Applicants shall include in this listing only providers who have signed a contract. DHS may request from the applicant a sampling of provider contract signature pages for contract verification.

Examples of completed rows are provided as examples.

Provider Type	Island/County (for Oahu include the city)	Provider Name (Last name, First name, Middle Initial)	Accepting new QUEST members (Y/N)?	Any limit on QUEST members (Y/N)?
PCP – Family practitioners, General Practitioners and General Internists	Honolulu, Oahu	Last Name, First Name, MI		
PCP – OB/GYN	Kapolei, Oahu	Last Name, First Name, MI		
Specialist – Cardiologist	Maui County	Last Name, First Name, MI		
Hospital	Kauai	Hospital Name		
Home Health Agency	Hawaii- East	Agency Name		

The applicant shall separate the providers by provider type and listed alphabetically within the different provider type by last name as follows:

- A. PCP providers (PCPs include pediatricians, family practitioners, general practitioners, internists, OB/GYN, and clinics. Nurse midwives, pediatric nurse practitioners, and family nurse practitioners shall be listed separately);
- B. Certified nurse midwives, pediatric nurse practitioners, and family nurse practitioners;
- C. Specialists;
- D. Hospitals (the DHS shall assume the hospital is on contract for acute services, outpatient and

emergency room unless otherwise noted in the specialty column);

- E. Urgent care providers;
- F. Emergency transport (including ground and air ambulance) providers;
- G. Pharmacies;
- H. Laboratories;
- I. Radiology providers;
- J. Physical, occupational, audiology and speech and language therapy providers;
- K. Behavioral health providers;
- L. Home health agencies and hospices;
- M. Durable medical equipment and medical suppliers;
- N. Non-Emergency transportation providers; and
- O. Interpretation/translation service providers.

The applicant shall list each provider once. For example, if an OB/GYN is serving both as a PCP and as a specialist, he or she shall be listed as either a PCP or a specialist, not both.

For provider types that may include a variety of providers the provider listing shall be ordered by specialty. As an example, for the PCP matrix, sort providers by pediatricians, physician assistants, family practitioners, general practitioners, internists, and OB/GYNs.

List nurse midwives, pediatric nurse practitioners, family nurse practitioners and behavioral health practitioners who

are in independent practice separately. If the nurse midwife, pediatric nurse practitioner or family nurse practitioner practice in a physician's office or clinic, he/she shall be listed under the clinic or physician's office as described below.

For clinics serving in the capacity of a PCP, list the clinic and under the clinic name, identify each specific provider (e.g., physician, nurse practitioner, etc.). Clinics may be listed on different provider type network matrices, but the individual provider of the service is listed only once. As an example, the clinic may be listed as a PCP with the clinic's pediatrician. Other physicians serving as specialists shall be listed on the specialty care matrix with the clinic's name. If the clinic also provides interpretation, it shall be listed on the interpretation services matrix.

The specialists list shall include all physicians (e.g. cardiologists, neurologists, ophthalmologists, pulmonologists, etc.) and non-physician services (e.g. optometrists, opticians, podiatrists, etc.), that provide medical services, but are not in the behavioral health service providers.

All behavioral health providers shall be listed on the behavioral health service provider lists and not the specialists list. This includes psychiatrists, psychologists, licensed social workers, case management agencies, residential treatment providers, etc.

In addition to a hard copy of the provider listings, the applicant shall include with its proposal an electronic file of providers in Excel 2010 or lower.

80.315.3 Attachment: Maps of Providers (not included in page maximum)

The applicant shall include in its proposal maps of the State by island indicating the locations of the following contracted health care providers: PCPs, acute care hospitals, pharmacies, specialists, and behavioral health providers. The applicant shall submit a separate map of their providers Statewide for each of the health care provider groups listed above.

80.315.4 Availability of Providers Narrative (included in page maximum)

The applicant shall describe how it will ensure that PCPs fulfill their responsibilities for supervising and coordinating care for all assigned members and include assurances that no PCP has too many members to fulfill their responsibilities. As part of this, the applicant shall describe how it will monitor the performance of specialists or other health care providers who are permitted to serve as a PCP to members with chronic conditions.

80.315.5 *Provider Services Narrative – General Requirements
(included in page maximum)*

The applicant shall provide a comprehensive explanation of how it intends to meet provider services requirements described below to include:

- A. A description of how the applicant will meet the timeframes associated with prior authorizations as described in Section 50.900;
- B. A description of how it will communicate fraud and abuse requirements to providers;
- C. A description of how it will process claims in a timely manner, as described in Section 60.310, as well as work with providers to assure that claims are processed timely; and
- D. A description of how it will assure that providers meet medically necessary requirements including, but not limited to, EPSDT screening and HEDIS measures.

80.320 Covered Benefits and Services (30 pages maximum)

80.320.1 *Covered Benefits and Services Narrative*

The applicant shall describe:

- A. Its experience providing, on a capitated basis, the primary, acute care, and behavioral health covered benefits and services as described in Section 40.700.
This description shall indicate:

1. The extent to which this experience is for a population comparable to that in the programs;
 2. Which covered benefits and services the applicant does not have experience providing and how they intend to obtain the experience to provide these services; and
 3. The proposal for providing the covered benefits and services required in this RFP, including whether or not the applicant intends to use a subcontractor and, if so, how the subcontractor will be monitored.
- B. Whether the applicant intends to provide additional services not required but allowed for in Section 40.700 and how it intends to provide these services;
- C. Its experience in providing services to members with special health care needs, including how it has identified such individuals and how it has provided needed services. In addition, the applicant shall describe how it intends to provide these services to its members in Hawaii; and
- D. Its competency serving the cultures in Hawaii and understanding the population served by the State's Medical Assistance program.

80.320.2 Behavioral Health Narrative

The applicant shall describe its planned approach to providing behavioral health and substance abuse services

as required in Section 40.740.2. Specifically describe how the following requirement will be implemented:

- A. Assessment of behavioral health needs;
- B. Assurance of case management within acuity levels;
- C. Assurance of medication refills for psychotropic medications;
- D. Prevention of unnecessary emergency room utilization and acute psychiatric hospitalizations; and
- E. Follow-up after acute psychiatric hospitalizations.

80.320.3 Prescription Drug Narrative

The applicant shall detail how it intends to maximize generic prescribing, minimize use of brand-name prescriptions, manage prescription drug costs, and implement Section 346-59.9, HRS, Psychotropic medication law.

80.320.4 Early and Periodic Screening Diagnosis and Treatment (EPSDT) Narrative

The applicant shall describe:

- A. Its interactions with community partners including, but not limited to, The American Academy of Pediatrics - Hawaii Chapter or Hilopa'a Family to Family Health Information Center, to promote ESPDT awareness;
- B. The procedures it will follow to address the following situations:
 - 1. A parent who is not adhering to periodicity schedules; and

2. A parent who is not following up with the children's referrals for diagnostic treatment services; and
- C. The applicant shall provide specific data from its largest Medicaid contract with documentation to verify the statistics on the:
1. Percentage of children who receive all screenings pursuant to the pediatric periodicity schedule;
 2. Percentage of children identified for referral to follow-up services; and
 3. Percentage of children so identified who actually receive follow-up services.

80.320.5 Care Coordination/Case Management (CC/CM) System/Services Narrative

The applicant shall provide a comprehensive description of its CC/CM system/services (either in Hawaii, another state, or its proposed CC/CM system/services for Hawaii), including policies and procedures as well as mechanisms developed for providing CC/CM system/services. The applicant shall describe how it shall meet the requirements in RFP Section 40.752 - Care Coordination/Case Management System, and RFP Section 40.751 - Services for Members with Special Health Care Needs (SHCNs).

At a minimum, the applicant shall describe and address:

- A. The organizational structure of its CC/CM system and services including the staff to member caseload ratios;

- B. How the CC/CM system ensures that members, family/designated representatives, providers and health plan staff are informed about the availability of CC/CM services, how to make a referral for services, and how to access services during and after regular working hours;
- C. The needs assessment process including the criteria used to screen/identify members in need of CC/CM services;
- D. If the applicant elects to develop differing levels of CC/CM services, a description of the levels of services, the criteria to be used in determining what level of service a member will receive and how cases are prioritized;
- E. How the CC/CM system addresses coordination and follow-up of outpatient and inpatient care/service needs as well as referrals to, and coordination with, community-based resources/services that provide services that are not covered by the programs;
- F. The processes for monitoring emergency room utilization and informing members of options for urgent care, after-hours care, and twenty-four hour nurse line;
- G. The processes for receiving and sharing pertinent information, and interfacing with the member, the member's PCP and other relevant providers, and as appropriate, the member's family, and applicant departments, to promote continuity of care and coordination of services. In addition, discuss how

- the member and/or the member's family are involved in the process for decisions regarding care;
- H. The mechanisms to ensure that the implementation of the member's treatment plan is monitored/evaluated for effectiveness, and is revised as frequently as the member's condition warrants;
 - I. The requirements for documentation of all CC/CM activities;
 - J. The criteria for discontinuing CC/CM services;
 - K. How the CC/CM system is linked to the applicant's information system. This description shall include how the information system tracks CC/CM activities, support evaluation of the CC/CM system and generate reports;
 - L. How the applicant will identify and manage its highest risk (top 1%) members; and
 - M. How applicant CC/CM activities will be coordinated with and may be delegated to providers.

80.320.6 Transition of Care Narrative

The applicant shall describe how it will ensure that members transitioning into its health plan receive appropriate care, including how it will honor prior authorizations from a different QUEST health plan or a QExA health plan. The applicant shall also describe how it will coordinate with a new health plan when one of its member's transitions out of its health plan and into a

different QUEST health plan or a QExA health plan. As part of this narrative, please provide specific examples.

80.325 Member Services (18 pages maximum)

80.325.1 *Member Services Narrative - General Member Services*

The applicant shall describe:

- A. How it will review and update members' annually on changes to their member handbook;
- B. How it will ensure that all member information provided or sent to members is written at a grade school level of 6.9 or lower as described in Section 50.430;
- C. How it will assure interpretation services are available to members that speak a language other than English as their primary language; and
- D. How it will notify members of the availability of oral interpretation services as required in Section 50.495.

80.325.2 *Member Services Narrative - Toll-free Call Center and Twenty-Four Hour Nurse Line*

The applicant shall provide a comprehensive description explaining how it will operate the required toll-free call center and nurse line. At a minimum, the applicant shall describe for both the call center and the nurse line:

- A. Its training curricula and schedule for training call center staff for both the call center and the nurse

- line, including ongoing training and training when program changes occur;
- B. How it will route calls among staff to ensure timely and accurate response to member inquiries, including procedures for referring calls to supervisors or managers;
 - C. How it will ensure that the telephone call center and nurse line staff can handle calls from non-English speaking callers and from members who are hearing impaired, including the number of hotline staff that are fluent in one of the State-identified prevalent non-English languages; and
 - D. How it will monitor compliance with performance standards outlined in Section 50.480 and what it shall do in the event those standards are not being met.

80.325.3 Member Grievance System Narrative

The applicant shall provide a narrative describing the member grievance system it is currently using in Hawaii or another state. In your narrative, please provide:

- A. A description of how the applicant determines a grievance to include but not limited to customer service calls or calls to other health plan personnel;
- B. An explanation of how member grievances and appeals are tracked and trended;

- C. A description of the training provided to staff who handle member grievances and appeals;
- D. A description of how staff performance and operational processes are monitored and adapted to ensure compliance with member grievance system requirements to include but not limited to meeting required timeframes identified in Section 51.100.

80.330 Quality Assessment and Performance Improvement (QAPI)
(36 pages maximum)

80.330.1 *QAPI Narrative – QAPI Program*

The applicant shall provide the following information relative to its QAPI program:

- A. The governing body accountable for providing organizational governance of the applicant's QAPI Program, a description of the governing body's responsibilities, a description of how it exercises these responsibilities, and the frequency of meetings;
- B. The committee/group responsible for developing, implementing and overseeing QAPI Program activities/operations including:
 - 1. A description of the committee's specific functions/responsibilities, how it exercises these responsibilities, and the frequency of its meetings;
 - 2. A description of the composition/membership of this committee, including information on:

- The chairperson(s) – including title(s), and for physicians, provide specialty;
 - Physician membership - including the total number and types of specialties represented;
 - The physician designated to have substantial involvement in the QAPI Program; and
 - The licensed behavioral health care practitioner designated to be involved in the behavioral health care aspects of the QAPI Program.
3. The applicant's staff membership – including names and position titles.

C. A description of how the applicant ensures that practitioners participate in the QAPI Program through planning, design, implementation and/or review; and

D. A description of how the applicant makes information about the QAPI program available to its practitioners and members, including a description of the QAPI program and a report on the organization's progress in meeting its goals.

80.330.2 *QAPI Narrative – General Provisions*

The applicant shall describe:

- A. How it will address, evaluate, and review both the quality of clinical care and the quality of non-clinical aspects of service such as availability, accessibility, coordination and continuity of care;
- B. The methodology to review the entire range of care provided to all demographic groups, care settings (inpatient, ambulatory, home) and types of services (preventive, primary, specialty care, including behavioral health care) to ensure quality, member safety, and appropriateness of care/services in pursuit of opportunities for improvement on an ongoing basis; and
- C. The methodology and mechanisms to implement corrective actions as well as monitor and evaluate the effectiveness of corrective action plans.

80.330.3 *QAPI Narrative – Value-Based Purchasing*

- A. The applicant shall describe its experience with value-based purchasing (VBP) to incentivize quality and efficiency of care and improve overall health outcomes; and
- B. The applicant shall describe how it will implement VBP in the QUEST program, to include supporting the health home model.

80.330.4 *QAPI Narrative - Performance Measures*

The applicant shall:

- A. Describe its policies and procedures relating to meeting HEDIS performance measures requirements; and
- B. Provide HEDIS measures for the last two (2), twelve (12) month periods from the State of Hawaii. If the applicant is not currently providing services to Medical Assistance clients in the State of Hawaii, the applicant shall submit its most recent HEDIS measures from at least two other states that it has previously or is currently operating. Please provide reference to the population reporting on to include geographic location and member demographics. The applicant shall indicate which measures were validated by an EQRO or NCOA certified compliance auditor and provide the validation reports. Note: the HEDIS measures and the validation reports do not count towards the page limit.

80.330.5 *QAPI Narrative - Delegation of QAPI Program Activities*

The applicant shall provide a narrative describing the functions of all activities it intends to delegate, a list of proposed delegates and its plan to monitor the delegated functions.

80.330.6 QAPI Narrative - Medical Records Standards

The applicant shall provide a narrative explaining how it maintains medical records and assures appropriate record retention and how it monitors provider compliance with its policies.

80.330.7 QAPI Narrative – Practice Guidelines

The applicant shall indicate the practice guidelines it will select for use as part of its QAPI program. For each guideline, also include:

- A. The rationale for its relevance to the QUEST population;
- B. The measures the applicant will take to increase compliance with practice guidelines and how compliance with practice guidelines will be monitored; and
- C. The process for developing, updating and disseminating practice guidelines to providers.

80.330.8 Disease Management (DM) Programs Narrative

The applicant shall provide:

- A. A description of its disease management program policies and procedures and mechanisms to assist members and practitioners in managing chronic conditions;
- B. A description of how the applicant will administer the required disease management programs for two of the conditions listed in Section 40.802; and

C. Quantitative data on health improvement of members in two disease management programs the applicant is currently operating in Hawaii or another state.

80.335 Utilization Management Program and Authorization of Services (8 pages maximum)

80.335.1 *Utilization Management Program (UMP) Narrative*

The applicant shall provide a narrative describing its:

A. Utilization Management Program (UMP) including:

1. A description of the committee responsible for the UMP as well as its functions and responsibilities, and how it exercises these responsibilities;
2. A description of how it detects, monitors and evaluates under-utilization, over-utilization and inappropriate utilization of services as well as the processes to address opportunities for improvement;
3. A discussion of strategies to improve health care quality and reduce cost by preventing unnecessary hospital readmissions and by decreasing inappropriate emergency department utilization; and
4. A discussion of any special issues in applying UM guidelines for behavioral health services; and

B. UMP and Authorization of Services – Prior Authorization (PA) including:

1. A description of the PA process, including how PAs will be applied for members requiring out-of-network, including out-of-state, services or services for conditions that threaten the member’s life or health;
2. A description of how it will ensure that services are not arbitrarily or inappropriately denied or reduced in amount, duration or scope; and
3. A description of how it will ensure consistent application of review criteria.

80.340 Health Plan Administrative Requirements (18 pages maximum)

80.340.1 *Health Plan Administrative Requirements Narrative - Fraud and Abuse*

The applicant shall:

- A. Provide a comprehensive description of how it shall detect, investigate, and communicate fraud and abuse to DHS as described in Section 51.300; and
- B. Continually improve and modify their fraud and abuse detection processes.

80.340.2 Health Plan Administrative Requirements Attachment and Narrative - Organization Charts (Attachment) and Narrative on Organization Charts

The applicant shall provide organization chart(s) and a brief narrative explaining its organizational structure, including: (1) whether it intends to use subcontractors for activities and functions and, if so, how it will manage and monitor them; and (2) how it will ensure coordination and collaboration among staff located in the State of Hawaii and those in the Continental United States.

80.340.3 Health Plan Administrative Requirements Narrative - Organization and Staffing Table

In a table format, the applicant shall describe its current or proposed staffing that includes the number of full-time equivalents (FTEs) for all positions described in the table in Section 51.410. Adequacy of proposed staff shall be judged based on an enrollment of approximately 20,000 members.

80.340.4 Health Plan Administrative Requirements Narrative - Reporting Requirements

The applicant shall describe its internal systems or processes to:

- A. Gather data to meet reporting requirements;
- B. Compile and review data for consistency and accuracy prior to submitting to DHS;
- C. Submit reports to DHS in a timely manner; and
- D. Develop corrective action plans (CAP), as needed, to improve health plan processes.

80.340.5 Health Plan Administrative Requirements Narrative – Encounter Data Reporting Requirements

- A. The applicant shall describe how it will ensure that all encounter data requirements are met and that encounter data is submitted to the State in a timely and accurate manner as described in Section 51.580. As part of this description, please provide a narrative of how you prepare encounter data reports and how you assure accuracy.
- B. Please provide a narrative on what trend analysis you perform on your encounter data.

80.340.6 Health Plan Administrative Requirements Narrative-Information Technology

The applicant shall provide:

- A. A description of its information systems environment including:
 - 1. Details on the systems that will be used to perform the key functions (“key production systems”) noted in Sections 51.220, 51.300, 51.580, 60.110 and 60.310. At a minimum include:
 - System name and version;
 - Number of users;
 - Who maintains the system and from what location;
 - The location of the data center where the system is housed;
 - Whether the system is currently in use or being implemented (if the system is

being implemented, please indicate the expected go-live date);

- Its ability to receive different rate codes and contract types; and
- Major system functionality.

2. How these key production systems are designed to *interoperate*: (a) how identical or closely related data elements in different systems are named, formatted and maintained; (b) data element update/refresh methods and frequency/periodicity; and (c) how data is exchanged between key production systems (i.e. how these systems are “interfaced” to facilitate work processes within your organization).
3. How these systems can be accessed by health plan users (for instance, can field-based case managers access case management information via portable devices such as laptops) to facilitate work, promote efficiencies and deliver services at the point of care, including how it will make available to providers in real time members’ utilization of limited benefits.
4. An explanation of how it will ensure that its systems can interface with the DHS systems and how it will institute processes to insure

the validity and completeness of the data submitted to the DHS.

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

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

80.340.7 Financial Responsibilities Narrative - Third Party Liability

The applicant shall describe how it will coordinate health care benefits with other coverages, its methods for obtaining reimbursement from other liable third parties, and how it will fulfill all requirements as detailed in Section 60.400.

SECTION 90 RATE STRUCTURE

90.100 Introduction

This section describes the rate structure and the guidelines for future rate setting.

90.200 Overview of the Rate Structure

For any given QUEST program managed care member, the DHS shall pay a capitation rate computed as a base rate (with rating categories specific to aid category and island of residence) multiplied by an age/gender factor (specific to aid category) and with certain other adjustments described in the next section. Aid categories for base rates include the following:

- AFDC/TANF
- CHIP
- Foster Care
- General Assistance
- Immigrant Pregnant Woman
- QUEST, QUEST-Net, QUEST-ACE, and Basic Health Hawaii Adults

The capitation rates shall assume an administrative load of no more than 10%, inclusive of administrative expenses, risk margin and care management expenses but excluding premium tax.

90.300 Rate Development

The DHS shall provide all applicants with proposed capitation rates with supporting documentation by the date identified in Section 20.100. The DHS shall conduct an orientation of proposed capitation rates as described in Sections 20.100 and 20.200. During this orientation, DHS shall describe the process used to generate the proposed capitation rates and receive input from the applicants regarding the proposed capitation rates. In addition, DHS shall receive written questions and comments from the applicants regarding the proposed capitation rates by the date identified in Section 20.100.

DHS shall have a second meeting with applicants on the date specified in Section 20.100 via meeting in person, via teleconference, or by another method deemed appropriate by DHS after reviewing written questions and comments to discuss the final capitation rates and changes resulting from applicant comments, if any.

The DHS shall provide final actuarially sound capitation rates to all selected applicants as part of the contracted award on the date specified in Section 20.100. All selected applicants shall receive the same base capitation rates as described in Section 90.200. The allowed administrative expenditures shall be increased to an amount not exceeding 10% for those that serve Statewide over those that serve only Oahu and one other island.

The capitation rates shall have three components of risk adjustment to the base rates. Across all health plans, two of the adjustments shall be in the form of enhanced payments and one of the adjustments shall be revenue neutral. Each of these adjustments shall be made after the initial enrollment period as described in Section 30.530.

The first part of the enhanced payment is based on FQHC and RHC use rates for enrolled members. The enhancement is intended to provide for the additional cost for services at these facilities due to the requirement that they be reimbursed at the PPS rate. Rates for health plans shall be increased to cover this additional cost based on historical use rates at these facilities for members enrolled in each plan. This enhancement shall vary by health plan, aid category, island and age/gender cohort.

The second part of the enhanced payment is based on SMI members enrolled in the health plan and receiving additional behavioral health services as described in Section 40.740.2.c. Rates shall be enhanced based on the severity and number of these individuals enrolled in each health plan. This enhancement shall vary by plan, aid category, island and age/gender cohort. This enhancement is set at the time of rate setting and DHS does not anticipate adjusting this until the time of the next rate setting.

In addition, in order to account for risk selection between health plans, DHS may perform a diagnosis or pharmacy based, or other risk adjustment. This rate adjustment shall be performed in a budget neutral manner for each applicable rate category. That is, the result of the application of risk factors for each rate category shall be expected to shift revenue between the health plans, with no impact on aggregate state funding. Risk adjustment factors shall be applied as early as possible at program startup, with the expectation of being no later than the second month of enrollment. If the risk adjustment is delayed beyond the initial month of enrollment, no retroactive adjustments shall be made. Each year, the risk adjustment process shall be refreshed with the target implementation for the next calendar year.

90.400 Future Rate Setting

Subject to limitations imposed by CMS, legislative direction or other outside influence for which the DHS shall comply, it is the intent of the DHS to publish revised rates each calendar year throughout the term of the contract. The DHS specifically does not commit to any particular methodology or formula, or to any particular benchmark or objective, for rate revisions.

SECTION 100 EVALUATION AND SELECTION

100.100 Introduction

The DHS shall conduct a comprehensive, fair and impartial evaluation of proposals received in response to this RFP. The DHS shall be the sole judge in the selection of the applicant(s). The evaluation of the proposals shall be conducted as follows:

- Review of the proposals to ensure that all mandatory requirements detailed in Section 80.200 are met;
- Review and evaluation of the technical proposals for proposals that meet all mandatory requirements to determine whether the applicant meets the minimum technical criteria and requirements detailed in Section 80.300; and
- Award of the contract to the selected applicants.

Failure of the applicant to comply with the instructions of this RFP or failure to submit a complete proposal shall be grounds for deeming the proposal non-responsive to the RFP. However, the DHS reserves the right to waive minor irregularities in proposals provided such action is in the best interest of the State. Where the DHS may waive minor irregularities, such waiver shall in no way modify the RFP requirements or excuse the applicant from full compliance with the RFP specifications and other contract requirements if the applicant is awarded the contract.

Proposals deemed by the evaluation committee(s) to be incomplete or not in accordance with the specified requirements shall be disqualified. Applicants may retrieve their proposal as described in Section 20.860.

100.200 Evaluation Committee(s)

The DHS shall establish evaluation committee(s) that shall evaluate designated sections of the proposal. The committee(s) shall consist of members who are familiar with the programs and the minimum standards or criteria for the particular area. Additionally, the DHS may, at its discretion, designate additional representatives to assist in the evaluation process. The committee(s) shall evaluate the assigned section of each qualifying proposal and document their comments, concerns and questions.

100.300 Mandatory Proposal Evaluation

Each proposal shall be evaluated to determine whether the requirements as specified in this RFP have been met. The proposal shall first be evaluated against the following criteria:

- Proposal was submitted within the closing date and time for proposals as required in Section 20.100;
- The proper number of separately bound copies are in sealed envelopes as required in Section 21.200;

- All information required in Section 80.200 has been submitted; and
- Proposal contains the necessary information in the proper order.

A proposal must meet all mandatory requirements prior to the technical evaluation. Any proposal that does not meet all mandatory requirements shall not have the technical proposal opened; the technical proposal shall be returned to the applicant.

100.400 Technical Proposal Evaluation

The technical proposals that have met the minimum mandatory requirements shall be evaluated in order to identify those applicants that meet the minimum technical requirements detailed in Section 80.300. Each applicant must obtain a minimum of seventy-five percent (75%) of the total points for each of the required review sections in the technical proposal.

The listing of criteria is not all-inclusive and the DHS reserves the right to add, delete or modify any criteria.

Section/Title	Total Points Possible	Points Needed to Pass
80.310 - Experience and References	160	120
80.315 - Provider Network and Services	200	150
80.320 - Covered Benefits and Services	180	135
80.325 - Member Services	200	150
80.330 - Quality Assessment and	160	120

Section/Title	Total Points Possible	Points Needed to Pass
Performance Improvement and Utilization Management		
80.340 - Health Plan Administrative Requirements	100	75
Total	1,000	750

Those proposals that do not meet the minimum points to pass each of the required criteria shall be returned to the applicant with a letter of explanation.

100.500 Selection of Applicants

Upon completion of the Technical Proposal evaluations, the DHS shall sum the scores from the evaluation to determine the applicants that shall be awarded contracts from the State. The DHS shall select all applicants/health plans that pass the technical proposal for provision of services.

100.600 Contract Award

Upon selection of the applicants that will be awarded contracts, the DHS shall initiate the contracting process. The applicant shall be notified in writing that the RFP proposal has been accepted and that the DHS intends to award a contract to the applicant. This letter shall serve as notification that the applicant should begin to develop its programs, materials, policies and procedures for the programs.

The contracts shall be awarded no later than the Contract Award date identified in Section 20.100. If an awarded

applicant requests to withdraw its bid without incurring penalties, it must be requested in writing to the MQD before the close of business (4:30 p.m. H.S.T.) on the Contract Award date identified in Section 20.100. After that date, the State expects to enter into a contract with the applicant.

This RFP and the applicant's technical proposal shall become part of the contract.