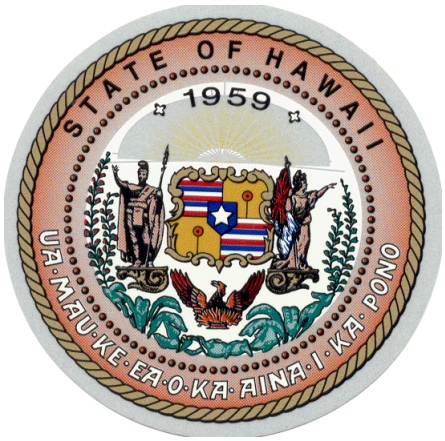


STATE OF HAWAII

Department of Human Services

REQUEST FOR PROPOSALS (RFP)

QUEST Integration (QI)

Managed Care to Cover Medicaid and Other Eligible Individuals

RFP-MQD-2021-008

State of Hawaii

Department of Human Services

Med-QUEST Division

Health Care Services Branch

Request for Proposals

RFP-MQD-2021-008

QUEST Integration (QI)

Managed Care to Cover Medicaid and Other Eligible Individuals

December 8, 2020

Note: It is the Health Plan's responsibility to check the public procurement notice website for any addenda issued to this RFP. The State shall not be responsible for any incomplete proposal submitted as a result of missing addenda, attachments or other information regarding the RFP.

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SECTION 1 – Administrative Overview and Request for Proposal (RFP) Requirements

1.1 Purpose of the RFP

A. The State of Hawaii, Department of Human Services (DHS or State), has issued this RFP with the intent of securing contracts with up to five (5) Health Plans for the provision of Covered Services to eligible Medicaid and Children's Health Insurance Program (CHIP) Members for medical, behavioral health, and LTSS in a fully risk-based managed care environment.

B. DHS prefers that the Health Plan provides services statewide; however, the Health Plan may propose to provide services on one (1) or more islands. If the Health Plan's proposal results in an island(s) not having the choice of two (2) Health Plans, then DHS may allow the other Health Plans an opportunity to change to operate on this island(s). If no Health Plan chooses to change, then DHS may cancel this RFP.

C. DHS reserves the right to add new eligibility groups and benefits and to negotiate different or new rates including any such changes. Services to health plan Members under the contracts awarded shall commence on the date identified in §1.5.

D. Health Plans are advised that the entire RFP, any addenda, and the corresponding proposal shall be part of the contract with the awarded Health Plans.

1.2 Authority for Issuance of RFP

A. This RFP is issued under the authority of Title XIX of the Social Security Act, 42 United States Code (USC) Section 1396, et. seq. as amended, the implementing regulations issued under the authority thereof, Hawaii Revised Statutes (HRS) §346-14, and the provisions

of the HRS §103F.

B. All Health Plans are charged with presumptive knowledge of all requirements cited by these authorities, and submission of a valid executed proposal by any Health Plan shall constitute admission of such knowledge on the part of such Health Plan. Failure to comply with any requirement may result in the rejection of the proposal. DHS reserves the right to reject any or all proposals received or to cancel this RFP, according to the best interest of the State.

1.3 RFP Organization

A. This RFP is composed of 16 sections plus appendices:

1. Section 1 – Administrative Overview and RFP Requirements: 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. Provides information on the rules and schedules for procurement.

2. Section 2 – Background and Scope: Describes the current populations receiving medical assistance, definitions, and the background and scope of the RFP.

3. Section 3 – Care Delivery and Health Coordination: Describes advanced primary care, stepped care approach to behavioral health, the health coordination program, and Medicare alignment requirements.

4. Section 4 – Covered Benefits and Services: Provides information on the medical, behavioral health, community integration, and LTSS to be provided under the RFP.

5. Section 5 – Quality, Utilization Management, and Administrative Requirements: Provides information on the

Med-QUEST Division (MQD) Quality Strategy, the Quality Assurance and Performance Improvement (QAPI) Program, External Quality Review Organization (EQRO) requirements, and other issues surrounding quality and utilization management.

6. Section 6 – Health Plan Reporting and Encounter Data Responsibilities: Provides information on Health Plan reporting requirements, submission requirements, and encounter data submission requirements.

7. Section 7 – DHS and Health Plan Financial Responsibilities: Provides information on Health Plan reimbursement, provider reimbursement, incentives, and third party liability (TPL).

8. Section 8 – Responsibilities and Requirements of DHS and Health Plans: Provider Networks, Provider Credentialing, Provider Contracts, and Other Functions for Providers: Provides information on provider network, credentialing, contracting, and provider services requirements.

9. Section 9 – Responsibilities and Requirements of DHS and Health Plans: Eligibility, Enrollment, Disenrollment, Continuity of Care, and Grievance and Appeals: Provides information on the enrollment and disenrollment of beneficiaries, Member services, grievances, and marketing and advertising.

10. Section 10 – Information Systems and Information Technology: Provides information on information systems requirements.

11. Section 11 – Health Plan Personnel: Provides information on Health Plan personnel requirements.

12. Section 12 – Program Integrity: Provides information on

fraud, waste, and abuse policies, and verification of services (VOS).

13. Section 13 – Readiness Review and Contract Implementation: Provides information on readiness review requirements.

14. Section 14 – Special Terms and Conditions: Describes the terms and conditions under which the work shall be performed, including penalties for non-compliance and poor performance.

15. Section 15 – Mandatory and Technical Proposal: Defines the required format of the technical proposal and the minimum information to be provided in the proposal.

16. Section 16 – Evaluation and Selection: Defines the evaluation criteria and explains the evaluation process.

B. Various appendices are included to support the information presented in Sections 1 through 16.

1.4 Issuing Officer and Point of Contact

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

Mr. Jon Fujii
Department of Human Services
Med-QUEST Division
1001 Kamokila Boulevard, Suite 317
Kapolei, Hawaii 96707
Email: jfujii@dhs.hawaii.gov

1.5 RFP Timeline

A. The delivery schedule set forth herein represents DHS' best estimate of the schedule that will be followed. If a component of this schedule,

such as the Proposal Due Date, is delayed, the rest of the schedule will likely be shifted by the same number of days. The proposed schedule is provided in Table 1: 1.5 below:

Table 1: 1.5. Schedule of RFP Events

Schedule of RFP Events	Date
Issue RFP	December 8, 2020
Orientation	December 21, 2020
Submission of Technical Proposal Questions	January 11, 2021
Responses to Technical Proposal Questions	January 22, 2021
Notice of Intent To Propose	January 25, 2021
Proposal Due Date	February 16, 2021
Proposal Evaluation Period	February 17, 2021 – March 12, 2021
Contract Award	March 18, 2021
Contract Execution Date	April 30, 2021 (approximate)
Date of Commencement of Services to Members	July 1, 2021

1.6 Orientation

A. An orientation for Health Plans in reference to this RFP will be held at 1:00 pm Hawaii Standard Time (HST) on the date identified in §1.5.

B. Health Plans may attend the orientation via teleconference at: Call-In Number: 1-808-829-4853, Conference ID: 379 593 472#.

C. Impromptu questions will be permitted at the orientation and spontaneous answers provided at DHS' discretion. However, answers provided at the orientations are only intended as general direction and may not represent DHS' final position, which will be detailed in a formal official response. Formal official responses will be provided in writing. To ensure a written response, any oral questions shall be submitted in writing on the date identified in §1.5 in accordance with the process identified in §1.8.

1.7 Notice of Intent to Propose

A. Health Plan shall submit a Notice of Intent to Propose to the issuing

Officer no later than the date identified in §1.5 at 2:00 p.m. HST using the format provided in Appendix B. The Notice of Intent to Propose shall be on the official business letterhead of the Health Plan and shall be signed by an individual authorized to commit the Health Plan to the work proposed. The Submission of a Notice of Intent to Propose is necessary for the Issuing Officer to provide the designated proposal electronic submission site.

B. The Notice of Intent shall include the subject line "The Notice of Intent to Propose for QI RFP" and shall be emailed to the following email address: rsouza2@dhs.hawaii.gov.

1.8 Submission of Written Questions

A. Health Plans shall submit all questions in writing with subject line "QI RFP Questions" via email to the following email address: QUEST_Integration@dhs.hawaii.gov

B. Technical proposal questions shall be submitted on the appropriate format provided in Appendix A by 12:00 p.m. HST on the applicable dates identified in §1.5.

C. DHS shall respond to the written questions no later than the dates identified in §1.5. No verbal responses shall be considered as official.

D. Health Plans that intend to submit a proposal for this RFP may send a request for the draft Heath Plan Manual to QUEST_Integration@dhs.hawaii.gov with subject line "Health Plan Manual" before the proposal due date identified in §1.5.

1.9 Use of Subcontractors

A. In the event of one proposal submitted jointly or by multiple organizations, one organization shall be designated as the prime Health Plan. The project leader shall be an employee of the prime Health Plan. 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 Health Plan shall be wholly responsible for the entire performance whether or not Subcontractors are used. The prime Health Plan shall sign the contract with DHS.

1.10 Confidentiality of Information

A. DHS shall maintain the confidentiality of proposals only to the extent allowed or required by law, including but not limited to HRS §§92F-13 and 103F-402, and HAR §§3-143-604 and 3-143-616.

B. If the Health Plan seeks to maintain the confidentiality of specific information contained in its proposal, the Health Plan is responsible for clearly identifying the confidential information and shall mark each page where the confidential information appears as "Proprietary" or "Confidential." An explanation to 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 HRS §92F-13 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.

C. 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.

1.11 Requirements to Conduct Business in the State of Hawaii

A. Health Plans are advised that if selected to be awarded a contract under this RFP, each Health Plan shall, prior to award of the contract, furnish proof of compliance with the following requirements of HRS,

required to conduct business in the State:

1. HRS Chapter 237, tax clearance
2. HRS Chapter 383, unemployment insurance
3. HRS Chapter 386, workers' compensation
4. HRS Chapter 392, temporary disability insurance
5. HRS Chapter 393, prepaid health care
6. One of the following:
    a. Be registered and incorporated or organized under the laws of the State (hereinafter referred to as a "Hawaii business"); or
    b. Be registered to do business in the State (hereinafter referred to as a "compliant non-Hawaii business").

B. Health Plans are advised that there are costs associated with compliance under this section. Any costs are the responsibility of the Health Plan.

C. Proof of compliance may be shown by providing the Certificate of Vendor Compliance issued by Hawaii Compliance Express (HCE).

1.12 Hawaii Compliance Express

A. DHS utilizes the HCE to verify compliance with the requirements to conduct business in the State, upon contract award. The HCE is an electronic system that allows vendors/contractors/service providers doing business with the State to quickly and easily demonstrate compliance with applicable laws. It is an online system that replaces the necessity of obtaining paper compliance certificates from the Department of Taxation (DOTAX) and Internal Revenue Service (IRS) tax clearance Department of Labor and Industrial Relations labor law compliance, and Department of Commerce and Consumer Affairs

(DCCA) good standing compliance. There is a nominal annual fee for the service and is the responsibility of the Health Plan. The

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

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

B. Pursuant to Office of Management and Budget, 2 CFR Part 180, no award of contract under this RFP shall be made if the Health Plan, its Subcontractors, and its principals have been suspended or debarred, disqualified or otherwise excluded from participating in this procurement.

1.13 Cost Principles

A. To promote uniform purchasing practices among State purchasing agencies procuring health and human services under HRS Chapter 103F, State purchasing agencies will utilize standard cost principles as outlined on the State Procurement Office (SPO) website. See http://spo.hawaii.gov, search Keyword "Cost Principles". Nothing in this section shall be construed to create an exemption from any cost principle arising under federal law.

1.14 Campaign Contributions by State and County Contractors

A. Pursuant to HRS §11-355, 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 website at http:ags.hawaii.gov/campaign/.

1.15 Documentation

A. The Health Plan may review information describing Hawaii's Medicaid

program by visiting the DHS MQD website: https://medquest.hawaii.gov. All possible efforts shall be made to ensure the information contained in the website is complete and current. However, DHS does not warrant that the information in the website is indeed complete or correct and reserves the right to amend, delete and modify the information at any time without notice.

1.16 Rules of Procurement

A. No Contingent Fees

1. No Health Plan shall employ any company or person, other than a bona fide employee working solely for the Health Plan 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 Health Plan or a company regularly employed by the Health Plan 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.

B. Discussions with Health Plans

1. Prior to the submittal deadline, questions shall be submitted in writing follow §1.8 and answers shall be provided in the SPO's Hawaii Awards & Notices Data System (HANDS) website.

2. After the proposal submittal deadline, discussions may be conducted with Health Plans whose proposals are determined to be reasonably susceptible of being selected for award, but proposals may be accepted without discussions, in accordance with HAR §3-143-403.

C. RFP Amendments

1. DHS reserves the right to modify, amend, change, add or delete any requirements in this RFP to serve the best interest of the State. DHS reserves the right to issue amendments to the RFP any time prior to the closing date for the submission of the proposals.

2. In addition, addenda may also be made after proposal submission, consistent with HAR §3-143-301(e).

D. Costs of Preparing Proposal

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

E. Provider Participation in Planning

1. Provider participation in DHS' efforts to plan for or to purchase health and human services prior to DHS' 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 HAR §§3-142-202 and 3-142-203, and HRS Chapter 103F

F. Disposition of Proposals

1. All proposals become the property of DHS. The successful proposal, excluding inconsistent terms, as determined by DHS, with this RFP, 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 HAR §3-143-616, pursuant to HRS Chapter 103F, after the execution of

the contract. DHS 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.

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

G. Rules for Withdrawal or Revision of Proposals

1. A proposal may be withdrawn or revised at any time in the designated DHS proposal electronic submission site prior to, but not after, the proposal due date specified in §1.5

2. After the proposal due date as defined in §1.5, all proposals timely received shall be deemed firm offers that are binding on the Health Plans for ninety (90) days. During this period, a Health Plan may neither modify nor withdraw its proposals without written authorization or invitation from DHS.

3. Notwithstanding the general rules for withdrawal or revision of proposals, DHS may request that a Health Plan submit a final revised proposal in accordance with HAR §3-143-607.

1.17 Submission of Proposals

A. Each qualified Health Plan shall submit only one (1) proposal to provide Medicaid services. In the event that more than one (1) proposal is submitted, DHS shall reject all proposals. The Proposal Application Identification Form (SPO-H-200) shall be completed and submitted with the proposal (Appendix C). The format and content of

the proposal is specified in Section 15.

B. The Heath Plan shall submit both mandatory and technical proposals in one (1) single electronic primary folder and a redacted version of the mandatory and technical proposals, removing all confidential/proprietary information, in one (1) single electronic redacted version folder to the DHS-designated proposal electronic submission site provided by the Issuing Officer. If there are discrepancies between the electronic primary folder and the electronic redacted version folder, the electronic primary folder will be the final version. The Issuing Officer shall receive both electronic primary and redacted version of the mandatory and technical proposals no later than 2:00 p.m. HST on the proposal due date specified in §1.5.

C. The one (1) single electronic primary folder shall have two (2) subfolders: Mandatory Proposal and Technical Proposal.

D. The Health Plan shall submit the mandatory and technical proposals to the designated electronic submission site as follows:

   1. All proposals shall be submitted in a fully searchable Adobe Acrobat Portable File Format (PDF).

   2. The PDF submission shall not be password-protected or encrypted.

   3. Any forms and/or documents requiring signature(s) shall be scanned into the respective PDF files.

E. The Health Plan shall place the Mandatory requirements, as described in Section 15, in the Mandatory Proposal subfolder as one (1) PDF file. The information required in Appendix I and Appendix J shall be submitted as two (2) separate files from other submissions in the Mandatory Proposal subfolder.

F. For the Technical Proposal subfolder, the Health Plan shall create one (1) PDF file for each evaluation category described in §16.5. Each file nomenclature shall be the same as the evaluation category and question (e.g., Category 1-Question 15.3.C.1.a). For each evaluation category PDF file submission, the Health Plan shall include all appendices, graphics and attachments as required in this RFP or to support the responses only for the specific evaluation category. No video shall be included.

G. The Health Plan shall solely bear the whole and exclusive responsibility for ensuring the documents are received by the Issuing Officer and for ensuring the complete, correctly formatted, legible, and timely transmission of all documents. The Health Plan shall assume all risk that the Issuing Officer receiving equipment and system may be inoperative or otherwise unavailable at the time transmission is attempted.

H. The Health Plan file submissions to the designated DHS proposal designated electronic submission site can reviewed or revised until 2:00 p.m. HST on the proposal due date specified in §1.5.

I. After the closing date and time, the DHS-designated proposal electronic submission site will be closed to prevent further proposal submissions or revisions.

1.18 Multiple or Alternate Proposals

A. Multiple or alternate proposals shall not be accepted. If the Health Plan submits multiple proposals or alternate proposals, then all such proposals shall be rejected.

1.19 Mistakes in Proposals

A. In compliance with HAR §3-143-606, after the submittal deadline, only patent errors may be corrected as provided in this section. A

patent error is an error that would be readily ascertainable by a reasonably knowledgeable person in the field of health and human services. Depending on the circumstances, patent errors may include, but are not limited to arithmetical errors, typographical errors, transposition errors, and omitted signatures.

B. To correct a patent error, the Health Plan shall identify the error in the proposal and establish the following to DHS' satisfaction:

   1. That the error identified is a patent error;

   2. That the proposed correction constitutes the information intended at the time the proposal was submitted, and not a modification of the proposal based on information received after the submittal deadline; and

   3. That the proposed correction is not contrary to the best interest of the purchasing agency or to the fair treatment of other Health Plans.

1.20 Rejection of Proposals

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

B. Any proposal offering terms and conditions contradictory to those included in this RFP may be rejected without further notice.

C. A proposal shall be rejected for any one of the following reasons:

   1. Failure to cooperate or deal in good faith (HAR §3-141-201);

   2. Inadequate accounting system (HAR §3-141-202);

   3. Late proposals (HAR §3-143-603) received after the proposal due date; or

   4. Proposal is in non-compliance with applicable laws (HAR §3-

143-610(a).

D. A proposal shall be rejected for any one of, but not limited to, the following reasons:

1. Proposal was not responsive (HAR §3-143-610[a][1]):

   a. Proof of collusion among Health Plans, in which case all bids involved in the collusive action shall be rejected and any participant to such collusion shall be barred from future bidding until reinstated as a qualified Health Plan.

2. Health Plan is not responsible (HAR §3-143-610[a][2]):

   a. A Health Plan's lack of responsibility and cooperation as shown by past work or services.

   b. A Health Plan being in arrears on existing contracts with the State or having defaulted on previous contracts.

   c. A Health Plan's lack of proper provider network and/or sufficient experience to perform the work contemplated, if required.

   d. A Health Plan's lack of a proper license to cover the type of work contemplated, if required.

   e. A Health Plan in non-compliance with applicable laws.

   f. A Health Plan'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.

   g. A Health Plan's lack of financial stability and viability.

   h. A Health Plan's consistently substandard performance related to meeting the DHS requirements from previous contracts.

1.21 Acceptance of Proposals

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

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

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

D. DHS also reserves the right to accept only those proposals that meet all terms of the RFP without changing the requirements, submitted in accordance with all technical proposal requirements set forth in this RFP and which demonstrate an understanding of the requirements. Any proposal disagreeing with terms set forth in the RFP, or offering any other set of terms and conditions contradictory to those included in this RFP maybe deemed inconsistent with the RFP and disqualified.

1.22 Opening of Proposals

A. Proposals, modifications to proposals, and withdrawals of proposals shall be date-stamped and, when possible, time stamped upon receipt by DHS. All documents so received shall be held in a secure place by DHS and not opened until the proposal due date as described in §1.5.

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

1.23 Additional Materials and Documentation

A. Upon request from DHS, each Health Plan shall submit any additional materials and documentation reasonably required by DHS in its

evaluation of the proposal.

1.24 Final Revised Proposals

A. If requested, final revised proposals shall be submitted to the DHS-designated proposal electronic submission site by the date and time specified by DHS. If a final revised proposal is not submitted, the previous submittal shall be construed as the Health Plan's best and final offer/proposal. The Health Plan shall submit only the section(s) of the proposal that are amended, along with the Proposal Application Identification Form (SPO-H-200). After final revised proposals are received, final evaluations will be conducted for an award.

1.25 Cancellation of RFP

A. 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 interest of the State. The State shall not be liable for any costs, expenses, loss of profits, or damages whatsoever, incurred by the Health Plan in the event this RFP is cancelled, or a proposal is rejected.

1.26 On-Site Visits

A. DHS reserves the right to conduct an on-site visit in addition to desk reviews to verify the appropriateness and adequacy of the Health Plan's proposal before the award of the contract.

B. After the award of the contract, prior to implementation, an on-site readiness review may be conducted by a team from DHS and will examine the prospective contractor's information system, staffing for operations, case management, provider contracts, and other areas that will be specified prior to review.

C. After implementation of the contract, DHS shall conduct unannounced on-site visits to the Health Plan and contracted

providers in addition to desk reviews to verify adequate, appropriate, and timely access to services are being provided to the Members enrolled in QUEST Integration (QI).

1.27 Award Notice

A. A notice of intended contract award, with a statement of findings and decisions, if any, shall be sent to the selected Health Plan on or about the Contract Award date identified in §1.5. The successful Health Plan receiving award shall enter into a formal written contract.

B. The contract award is subject to the available funding. The award of a contract and any allowed renewal or extension thereof, is subject to allotments made by the Director of Finance, the State of Hawaii, pursuant to HRS Chapter 37, and subject to the availability of State and/or federal funds.

C. 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.

D. DHS is not liable for any costs incurred prior to the Date of Commencement of Services to Member identified in §1.5.

1.28 Protests

A. Health Plans may file a Notice of Protest against the awarding of the contract. The Notice of Protest Form, SPO-H-801, is available from the SPO. Only the following may be protested:

1. DHS' failure to follow procedures established by HRS Chapter 103F;

2. DHS' failure to follow any rule established by HRS Chapter 103F; and

3. DHS' failure to follow any procedure, requirement, or evaluation criterion in the RFP.

B. The Notice of Protest shall be postmarked by the United States Postal Service (USPS) or hand delivered to: (1) the head of DHS conducting the protested procurement; and (2) the procurement officer who is conducting the procurement (as indicated in Table 2: 1.28. below) within five (5) business 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 DHS.

Table 2: 1.28. Notice of Protest Delivery

Procurement Officer	Head of DHS
Name: Meredith Nichols	Name: Catherine Betts
Title: Med-QUEST Division Assistant Administrator	Title: Director, Department of Human Services
Mailing Address: P.O. Box 700190 Kapolei, Hawaii 96709-0190	Mailing Address: P.O. Box 339 Honolulu, Hawaii 96809-0339
Business Address: 601 Kamokila Boulevard, Room 518 Kapolei, Hawaii 96707	Business Address: 1390 Miller Street, Room 209 Honolulu, Hawaii 96813

All protests are pursuant to HAR Title 3, Chapter 148. By submitting a proposal, the Health Plan is agreeing to the rules of HAR Title 3, Chapter 148.

1.29 Planning Activities Conducted in Preparation for this RFP

A. DHS received information on community needs, best practices, and resources. Planning activities related to this RFP included a Request for Information (RFI) which was posted on the SPO HANDS site on July 21, 2020. DHS received thirty-seven (37) responses from stakeholders and the public. All responses are available on DHS MQD website. However, the terms of this RFP are self-contained. The Health Plan shall not rely on the RFI or responses to the RFI in

forming its proposals. The Health Plan has the opportunity to ask questions about this RFP pursuant to §1.8.

SECTION 2 – Background and Scope

2.1 Scope of the RFP

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

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

2.2 Background

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

Quality care

Universal access

Efficient utilization

Stabilizing costs, and

Transforming the way healthcare is provided to QUEST Members.

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

C. The QUEST program has gone through many changes since 1994. In 2009, DHS implemented its QUEST Expanded Access (QExA)

program that allowed its aged, blind, or disabled (ABD) population to also benefit from managed care. In 2014, the QI program combined several programs into one-statewide program providing managed care services to all of Hawaii's Medicaid population.

D. In this RFP, DHS carries on the tradition of innovation by implementing the Hawaii Ohana Nui Project Expansion (HOPE) program initiative to develop and implement a roadmap to achieve this vision of healthy families and healthy communities.

E. Under the HOPE initiative, DHS' vision is that the people of Hawaii embrace health and wellness. DHS' mission is to empower Hawaii's residents to improve and sustain wellbeing by developing, promoting and administering innovative and high-quality healthcare programs with aloha.

F. The following guiding principles describe the overarching framework that has been used to develop a transformative healthcare system that focuses on healthy families and healthy communities.

    1. Assuring continued access to health insurance and healthcare;
    2. Emphasizing whole person and whole family care over an individual's life course;
    3. Addressing the social determinants of health (SDOH);
    4. Emphasizing health promotion, prevention, and primary care;
    5. Investing in system-wide changes;
    6. Leveraging and supporting community initiatives.

G. In order to accomplish the principles, HOPE activities are focused on four strategic areas:

    1. Investing in primary care, prevention, and health promotion;

2. Improving outcomes for individuals with special healthcare needs (SHCN);

3. Reforming and aligning payment to providers; and

4. Supporting community-driven initiatives to improve population health.

H. In addition, HOPE activities are supported by initiatives that enhance three foundational building blocks.

1. Health information technology (HIT) that drives transformation;

2. Increase workforce capacity and flexibility; and

3. Performance measurement and evaluation.

I. This RFP seeks to implement HOPE principles and strategic areas through the QI program. In Section 3 and Section 4, DHS details its strategy and Health Plan requirements to invest in primary care, prevention, and health promotion; develop new care management strategies for individuals with SHCN; and support community-driven initiatives.

J. In Section 5 and Section 6, DHS describes its approach to new quality improvement, measurement, and reporting strategies that support the HOPE initiative, including the development of a SDOH Transformation plan.

K. In Section 7, DHS details its efforts to reform and align payment between Health Plans and providers, including Health Plan withhold and bonus programs and a value-based payment (VBP) schedule to drive innovation and quality-based payment to providers.

2.3 Program Populations

A. QI is a mandatory managed care program that provides a package of medical, behavioral health, and LTSS benefits to individuals meeting the Medicaid financial and non-financial eligibility requirements for individuals and families. Description of the individuals eligible and benefits for QI are found in Hawaii Administrative Rules, Title 17, MQD (1700 series).

B. Medicaid Covered Populations

1. Children Group (HAR Chapter 17-1715);
2. Former Foster Care Children Group (HAR Chapter 17-1715.1);
3. Pregnant Women Group (HAR Chapter 17-1716);
4. Parent or Caretaker Relatives Group (HAR Chapter 17-1717);
5. Individuals Receiving Transition Medical Assistance (HAR Chapter 17-1717.1);
6. Adults Group (HAR Chapter 17-1718);
7. ABD Group (HAR Chapter 17-1719);
8. Non-citizens or refugees (HAR Chapter 17-1723.2); and
9. Individuals with breast and cervical cancer (HAR Chapter 17-1733.1).

C. Non-Medicaid Covered Populations

1. Individuals who are aged, blind, or disabled, ineligible for Medicaid due to citizenship status, and legally reside in Hawaii (HAR Chapter 17-1719.1); and
2. Individuals with breast and cervical cancer who are ineligible for Medicaid due to citizenship status (HAR Chapter 17-1734.1).

D. Excluded Populations

1. Individuals excluded from participation in managed care under this Contract include those who are:

   a. Repatriates (HAR Chapter 17-1723.3);

   b. Medicare Savings Program Members and Qualified Disabled Working Individuals not eligible for full Medicaid benefits (HAR §17-1700.1-2);

   c. Enrolled in the State of Hawaii Organ and Tissue Transplant Program (SHOTT) (HAR Chapter 17-1737);

   d. Retroactively eligible only (HAR Chapter 17-1735.1); and

   e. Eligible under non-ABD medically needy spenddown (HAR §17-1730.1-11[1]).

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

2.4 Overview of DHS Responsibilities

A. DHS shall administer this Contract and monitor the Health Plan's performance in all aspects of the Health Plan's operations. Specifically, DHS shall:

1. Establish and define the medical, behavioral health, community integration, and LTSS benefits to be provided by the Health Plan;

2. Develop the rules, policies, regulations and procedures governing the programs;

3. Establish the Health Plan capitation rates;

4. Negotiate and contract with the Health Plans;
5. Determine initial and continued eligibility of Members;
6. Enroll and dis-enroll beneficiaries;
7. Provide benefits and services as described in Section 4;
8. Conduct the readiness review as described in Section 13 and determine if the Health Plan is ready to commence services on the date described in §1.5;
9. Review and monitor the adequacy of the Health Plan's provider networks;
10. Provide routine and responsive feedback to improve data quality;
11. Oversee the development of DHS Quality Strategy;
12. Monitor the quality assessment and performance improvement (QAPI) programs of, and quality of data and reports submitted by, the Health Plan and providers, and provide routine and responsive feedback as needed;
13. Review and analyze utilization of services and reports provided by the Health Plan;
14. Participate in the State administrative hearing processes;
15. Monitor the Health Plan's grievance processes;
16. Monitor the financial status of the programs;
17. Analyze the programs to ensure they are meeting the stated objectives;
18. Manage the Hawaii Prepaid Medicaid Management Information System (HPMMIS);

19. Provide Member information to the Health Plan;

20. Review and approve the Health Plan's marketing materials;

21. Review and approve all Health Plan materials that are distributed to their Members;

22. Establish Health Plan incentives when deemed appropriate;

23. Oversee the activities of other DHS contracts, including but not limited to the SHOTT program contractor;

24. Oversee the activities of the Ombudsman Program which will be available to all Medicaid providers and Medicaid Members to ensure access to care, to promote quality of care, and to strive to achieve provider and Member satisfaction with QI;

25. Impose civil or administrative monetary penalties and/or financial sanctions for violations or Health Plan non-compliance with contract provisions;

26. Report criminal conviction information disclosed by providers and report provider application denials pursuant to 42 CFR §455.106(b);

27. Verify out-of-state provider licenses during provider enrollment and review and monitor provider licenses on an ongoing basis;

28. Ensure the Health Plan is not located outside of the United States;

29. Refer Member and provider fraud cases to appropriate law enforcement agencies; and

30. Coordinate with and monitor fraud and abuse activities of the Health Plan.

B. DHS shall comply with, and monitor the Health Plan's compliance with, all applicable State and federal laws and regulations.

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

D. DHS shall issue a Health Plan Manual, which includes HPMMIS Technical Guides, and policy memorandums to offer clarity on policy or operational issues or legal changes impacting the Health Plan.

2.5 The Health Plan's Role in Managed Care and Qualified Health Plans

A. The Health Plan shall provide for the direction, coordination, monitoring, and tracking of the medical, behavioral health, and LTSS services needed by the Members under the QI program.

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

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

D. The Health Plan shall participate in DHS efforts to promote the delivery of services in a culturally competent manner to all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.

E. The Health Plan shall comply with the requirements of the Contract and execute all QI policy memoranda during the course of the Contract when distributed by DHS. The Health Plan shall acknowledge receipt of the memoranda through electronic mail.

F. The Health Plan shall comply with requirements included in the Health Plan Manual, which includes the HPMMIS Technical Guide, and policy memorandums issued by DHS.

2.6 Definitions/Acronyms

A. The definitions that follow are used in this Contract.

1. **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 healthcare in the managed care setting, including incidents or practices of providers that are inconsistent with accepted sound medical practices. It also includes Member practices that result in unnecessary cost to the Medicaid program.

2. **Accountable Care Organization (ACO)** – An entity comprised of healthcare providers responsible for coordinating patient care for a defined population with alignment of provider and payer incentives. An ACO model emphasizes value over volume of healthcare through value-based payments, quality improvement measures, and healthcare data analysis.

3. **Activities of Daily Living (ADLs)** – Basic personal everyday activities including, but not limited to, tasks such as eating,

toileting, grooming, dressing, bathing, and transferring.

4. **Acute Care** – Short-term medical treatment, usually in an acute care hospital, for individuals having an acute illness or injury.

5. **Adult Group** – Individuals who obtain Medicaid eligibility in accordance with Hawaii Administrative Rules Chapter 17-1718.

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

7. **Adult Day Health Center** – A licensed facility that provides organized day programs of therapeutic, social, and health services provided to adults with physical or mental impairments, or both, which require nursing oversight or care, for the purpose of restoring or maintaining, to the fullest extent possible, their capacity for remaining in the community.

8. **Advance Directive** – A written instruction, such as a living will or durable power of attorney for healthcare, recognized under state law relating to provision of healthcare when the individual is incapacitated.

9. **Advanced Practice Registered Nurse with Prescriptive Authority (APRN-Rx)** – A registered nurse (RN) 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 healthcare services, prescribe medication, and diagnose and treat common minor illnesses and injuries consistent with HAR Title 16, Chapter 89, Subchapter 16.

10. **Adverse Benefit Determination** – Any one of the following:

a. The denial or restriction of a requested service, including the type or level or service, based on requirements for Medical Necessity, appropriateness, setting, or effectiveness of a covered benefit;

b. The reduction, suspension, or termination of a previously authorized service;

c. The denial, in whole or part, of payment for a service;

d. The failure to provide services in a timely manner, as defined in §8.1.C;

e. The failure of the Health Plan to act within prescribed timeframes regarding the standard resolution of grievances and appeals;

f. 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:

1) From any other provider (in terms of training, experience, and specialization) not available within the network;

2) 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;

3) If the provider does not choose to join the network or does not meet the qualifications, the Member is given a choice of participating providers and is transitioned to a participating provider within sixty (60) days;

4) Because the only Health Plan or provider does not

provide the service because of moral or religious objections;

5) 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

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

g. The denial of a Member's request to dispute a financial liability, including cost sharing, co-payments, premiums, deductibles, coinsurance, and other Member financial liabilities.

11. **Aged, Blind, or Disabled (ABD)** – A category of eligibility under the State Plan for persons who are aged (sixty-five [65] years of age or older), legally blind, and/or disabled.

12. **Alternative Payment Model (APM)** – Payment models that deviate from traditional fee-for-service (FFS) payment, adjusting FFS payments to account for performance on cost and quality metrics, or when using population-based payments that are linked to quality performance.

13. **Ambulatory Care** – Preventive, diagnostic, and treatment services provided on an outpatient basis by physicians, nurse practitioners, physician assistants (PAs), and other providers.

14. **Annual Plan Change Period** – A period when an eligible individual is allowed to change from one participating health plan to another participating health plan.

15. **Appeal** – A review by the Health Plan and State Administrative

Appeal of an adverse benefit determination.

16. **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 email interaction.

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

18. **Attending Physician** – A medical doctor (MD) or a doctor of osteopathy (DO), authorized to practice medicine and surgery by the State, who orders and directs the services required to meet the care needs of a Medicaid Member. The attending physician may be a physician from a group practice who is designated as the primary physician or an alternate physician that has been delegated the role of the attending physician by the Member's initial attending physician during the physician's absence. At the time he or she elects to receive hospice care, the attending physician has the most significant role in the determination and delivery of the individual's medical care.

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

through the same modalities as applications for medical assistance.

20. **Auto-Assignment** – The process utilized by DHS to enroll Members into a Health Plan, using predetermined algorithms, who (1) are not excluded from Health Plan participation and (2) do not proactively select a Health Plan within the DHS-specified timeframe. Also, the process of assigning a new Member to a primary care physician chosen by the Health Plan, pursuant to the provisions of this Contract.

21. **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 (MCOs) and organizations receiving capitation payments.

22. **Behavioral Health Services** – The full continuum of services from screening to specialty treatment services to support individuals who have mental health and substance use needs, including those with mild to moderate conditions, emotional disturbance, mental illness, or substance use conditions.

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

24. **Beneficiary** – An individual who has been determined eligible and is currently receiving Medicaid.

25. **Benefit Year** – A continuous twelve (12)-month period generally following an open enrollment period. In the event the contract is not in effect for the full benefit year, any benefit limits shall be pro-rated.

26. **Benefits** – Those health services that the Member is entitled to

under the QI program and that the Health Plan arranges to provide to its Members.

27. **Breast and Cervical Cancer Program** – A program implemented by the State of Hawaii, Department of Health (DOH) to detect breast and cervical cancer or pre-cancerous conditions of the breast or cervix. Enrolled individuals receive treatment in the QI program when referred by DOH.

28. **Capitated Payment** – A fixed monthly payment paid per Member by DHS to the Health Plan for which the Health Plan provides the defined set of benefits and the payment may be prorated for the portion of the month for which the Member was enrolled with the Health Plan.

29. **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.

30. **Care Team** – A team of healthcare professionals from different professional disciplines who work together to manage the physical, behavioral health, and social needs of the Member.

31. **Centers for Medicare & Medicaid Services (CMS)** – The United States federal agency which administers the Medicare program and, working jointly with state governments, the Medicaid program, and the SCHIP.

32. **Child and Adolescent Mental Health Division (CAMHD)** – A division of the DOH that provides behavioral health services to children ages three (3) years through twenty (20) years who require support for emotional or behavioral development.

33. **Children's Health Insurance Program (CHIP) or State Children's Health Insurance Program (SCHIP)** – A joint

federal-state healthcare program for uninsured, targeted, low-income children, established pursuant to Title XXI of the Social Security Act that is implemented as a Medicaid expansion program in Hawaii.

34. **Chronic Condition** – Any ongoing 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.

35. **Claim** – A document which is submitted by the provider for payment of health-related services rendered to a Member.

36. **Clean Claim** – A claim that can be processed without obtaining additional information from the Health Plan of the service from a third party. It includes a claim with errors originating in a State's claims system. It does not include a claim from a provider who is under investigation for fraud, abuse, or a claim under review for Medical Necessity.

37. **Claim Reference Number (CRN)** – A unique 15-digit number assigned to each claim or encounter received by the Hawaii Prepaid Medical Management Information System.

38. **Code of Federal Regulations (CFR)** – The codification of the general and permanent rules and regulations published in the Federal Register by the executive departments and agencies of the federal government of the United States.

39. **Cold-Call Marketing** – Any unsolicited personal contact, whether by phone, mail, or any other method, by the Health Plan with a potential Member, Member, or any other individual

for marketing.

40. **Community Care Foster Family Home (CCFFH)** – A home that is certified by the State DOH to provide an individual with twenty-four (24) hour a day living accommodations and home and community-based services (HCBS).

41. **Community Care Management Agency (CCMA)** – An agency that engages in locating, coordinating, and monitoring comprehensive services to residents in community care foster family homes or Members in Expanded Adult Residential Care Homes and assisted living facilities. A Health Plan may be the owner of a CCMA.

42. **Community Care Services (CCS)** – A behavioral health program administered by DHS. CCS provides eligible adult Members specialized behavioral health services to severe mental illness (SMI) and severe and persistent mental illness (SPMI).

43. **Community Health Worker (CHW)** – A frontline public health worker who is a trusted Member of and/or has a close understanding of the community served to facilitate access to services and improve the quality and cultural competence of service delivery. A CHW serves as an integral Member of the care team, providing in-home visits, accompanying Members to provider visits as needed, and assisting Members with healthcare needs.

44. **Community Integration Services Plus (CIS+)** – A program to address a Member's housing-related needs that includes housing navigation supports and medical respite services which are also known as episodic interventions.

45. **Community Paramedic (CP)** – An advanced paramedic that

works to increase access to primary and preventive care and decrease use of emergency departments, which in turn decreases healthcare costs. Among other things, CPs may play a key role in providing follow–up services after a hospital discharge to prevent hospital readmission. CPs can provide health assessments, chronic disease monitoring and education, medication management, immunizations and vaccinations, laboratory specimen collection, hospital discharge follow–up care, and minor medical procedures. CPs work under the direction of an Ambulance Medical Director.

46. **Intentionally Left Blank**

47. **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 (EPSDT) services, LTSS, and family planning services.

48. **Conspicuously Visible** – Individuals seeking services from, or participating in, the health program or activity could reasonably be expected to see and be able to read the information that is sufficiently conspicuous and visible as defined by HHS Office of Civil Rights at 45 CFR §92.8(f)(1).

49. **Consumer Assessment of Healthcare Providers and Systems (CAHPS®)** – A comprehensive set of surveys that ask consumers and patients to report on and evaluate various aspects of quality of their healthcare. The acronym CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

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

51. **Contract Services** – The services to be delivered by the contractor that are designated by DHS.

52. **Contractor** – Successful applicant that has executed a contract with DHS.

53. **Co-Payment** – The amount that a Member shall pay, usually a fixed amount of the cost of a service.

54. **Corrective Action** – An action required by DHS to correct or resolve a deficiency in the Health Plan's business processes or actions. Documentation for a Corrective Action shall include an action plan to correct the deficiency and implementation of internal controls to prevent a reoccurrence.

55. **Corrective Action Plan** – The detailed corrective action plan, written by the Health Plan, required by DHS to correct or resolve a deficiency, violation, non-performance, event, or breach causing the assessment of a liquidated damage, sanction, or other remedy against the Health Plan.

56. **Cost-Neutral** – When the aggregate cost of serving people in the community is not more than the aggregate cost of serving the same (or comparable) population in an institutional setting.

57. **Covered Services** – Those services and benefits to which the Member is entitled under Hawaii's Medicaid programs.

58. **Critical Access Hospital (CAH)** – A hospital designated and certified as a CAH under the Medicare Rural Hospital Flexibility Program.

59. **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.

60. **Current Period Floor Rate** – The minimum expected target on a specific performance measure for the current reporting period.

61. **Current Period Rate Gap** – The difference between the current reporting period's floor rate and the current period's performance rate on a specific performance measure.

62. **Current Period Growth Rate** – The extent to which the current period performance rate exceeds the current period floor rate towards approaching, meeting, or exceeding the current period target rate.

63. **Days** – Unless otherwise specified, the term "days" refers to calendar days.

64. **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, and treat acute injuries to teeth or supportive structures of the oral-facial complex.

65. **Department of Health, Developmental Disabilities Division (DOH-DDD)** – The DOH-DDD provides services for persons with intellectual and/or developmental disabilities (I/DD). Most services provided are through the Medicaid

    1915(c) HCBS Waiver for individuals with I/DD to support these participants to live in their homes and communities through services that promote each person's self-determination, health, community integration, and safety (Section 1915(c) of the Social Security Act).

66. **Department of Human Services (DHS)** – The Department of Human Services of the State of Hawaii, which also serves as the single State agency responsible for administering the medical assistance program.

67. **Department of Health and Human Services (DHHS)** – United States Department of Health and Human Services.

68. **Director** – The administrative head of the department of human services unless otherwise specifically noted.

69. **Dual Eligible** – Member eligible for both Medicare and Medicaid.

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

71. **Durable Medical Equipment (DME)** – Medical equipment that is ordered by a doctor for use in the home. These items shall be reusable, such as walkers, wheelchairs, or hospital beds. DME is paid for under both Medicare Part B and Part A for home health services.

72. **Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services** – EPSDT services aim to identify physical or mental defects in individuals and provide healthcare, treatment, and other measures to correct or ameliorate any defects and chronic condition discovered in accordance with Section 1905r of the Social Security Act. EPSDT includes services to:

    a. Seek out individuals and their families and inform them of the benefits of prevention and the health services available;

    b. Help the individual or family use health resources, including their own talents, effectively, and efficiently; and

    c. Ensure the problems identified are diagnosed and treated early, before they become more complex and their treatment more costly.

73. **Effective Date Of Enrollment** – The date as of which a participating health plan is required to provide benefits to an Member.

74. **Eligibility Determination** – An approval or denial of eligibility for medical assistance, as well as a redetermination or termination of eligibility for medical assistance.

75. **Emergency Medical Condition** – The sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms, substance abuse) such that a

prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of emergency services or immediate medical attention to result in:

a. 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;

b. Serious impairment to body functions;

c. Serious dysfunction of any bodily functions;

d. Serious harm to self or others due to an alcohol or drug abuse emergency;

e. Injury to self or bodily harm to others; or

f. With respect to a pregnant woman who is having contractions:

    1) That there is inadequate time to affect 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.

76. **Emergency Medical Transportation** – Ambulance services for an emergency medical condition.

77. **Emergency Room Services** – Emergency services provided in an emergency room.

78. **Emergency Services** – Covered inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition that is found to exist using a prudent layperson standard.

79. **Encounter** – A record of medical services rendered by a provider to a Member enrolled in the Health Plan on the date of

service.

80. **Encounter Data** – A compilation of encounters.

81. **Enrollment** – The process by which an individual, who has been determined eligible, becomes a Member in a Health Plan, subject to the limitations specified in DHS rules.

82. **Enrollment Fee** – The amount a Member is responsible to pay that is equal to the spenddown amount for a medically needy individual or cost share amount for an individual receiving long-term care services. A resident of an intermediate care facility for I/DD or a participant in the Medicaid waiver program for individuals with developmental disabilities or intellectual disabilities are exempt from the enrollment fee.

83. **Excluded Services** – Healthcare services that health plan does not pay for or cover.

84. **Expanded Adult Residential Care Home (E-ARCH)** – A facility, as defined in Section 11-100.1.2, HAR, and licensed by the department of health, that provides twenty-four (24)-hour living accommodations, for a fee, to adults unrelated to the family, who require at least minimal assistance in the ADL, personal care services (PCS), protection, and healthcare services, and who may need the professional health services provided in a nursing facility.

    a. There are two types of expanded care ARCHs in accordance with HRS §321-15.62:

        1) Type I – home allowing five (5) or fewer residents provided that up to six (6) residents may be allowed at the discretion of DOH to live in a type I home, with no more than three (3) nursing facility-level

residents; and

2) Type II – home allowing six (6) or more residents with no more than twenty percent (20 percent) of the home's licensed capacity as nursing facility-level residents.

85. **Expanded Health Care Needs (EHCN)** – A Member that has complex, costly health care needs and conditions, or who is at risk of developing these conditions is imminent. The Members that meet EHCN criteria are considered to be highly impactable and likely to benefit from health coordination services (HCS).

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

87. **Fast Healthcare Interoperability Resources (FHIR)** - A Health Level Seven International (HL7) standard for exchanging healthcare information electronically. It is the next generation exchange framework being adopted by the healthcare community to advance interoperability.

88. **Federal Financial Participation (FFP)** – The contribution that the federal government makes to State Medicaid programs.

89. **Federal Poverty Level (FPL)** – The federal poverty level (FPL) updated periodically in the Federal Register by the Secretary of Health and Human Services under the authority of 42 USC §9902(2), as in effect for the applicable budget period used to determine an individual's eligibility in the medical assistance programs.

90. **Federally Qualified Health Center (FQHC)** – An entity that has been determined by the Secretary of the DHHS to meet the

qualifications for an FQHC, as defined in Section 1861(aa)(4) of the Social Security Act.

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

92. **Fee-for-Service (FFS)** – A method of reimbursement based on payment for specific services rendered to an individual eligible for coverage under Med-QUEST.

93. **Financial Relationship** – A direct or indirect ownership or investment interest (including an option or non-vested 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.

94. **Fraud** – An intentional deception or misrepresentation made by an individual with the knowledge that the deception could result in some unauthorized benefit to that individual or some other individual. It includes any act that constitutes fraud under applicable federal or state law.

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

96. **Grievance Review** – A State process for the review of a denied or unresolved grievance by a Health Plan, including instances where the aggrieved party is dissatisfied by the proposed resolution.

97. **Grievance and Appeal 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.

98. **Habilitation Devices** – Devices that support the provision of Habilitation Services in inpatient and/or outpatient settings. Habilitation devices include but are not limited to:

    a. Mobility devices, such as wheelchairs, motorized scooters, walkers, crutches, canes, prosthetic devices, orthotic braces, and other orthotic devices.

    b. Devices that aid hearing loss, including hearing aids, cochlear implants (pediatric and adult), and hearing assistive technology.

    c. Devices that aid speech include DME, and augmentative and alternative communication devices, such as voice amplification systems.

    d. Prosthetic eyeglasses and prosthetic contact lenses for the management of a congenital anomaly of the eye.

    e. Dental devices (not for cosmetic purposes).

99. **Habilitative/Habilitation Services** – Healthcare services that help to keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may

    include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

100. **Hawaii Prepaid Medicaid Management Information System (HPMMIS)** – Federally-certified Medicaid Management Information System (MMIS) used for the processing, collecting,

analysis, and reporting of information needed to support Medicaid and CHIP functions.

101. **Health Action Plan (HAP)** – A person-centered individualized plan that is developed with the Member and/or authorized representative based on the SHCN, expanded health care needs (EHCN), or LTSS assessment conducted by the Health Coordinator. A HAP includes, but is not limited to, the following: LTSS assessment conducted by the Health Coordinator. A HAP includes, but is not limited to, the following:

    a. Person-centered goals, objectives, or desired outcomes;

    b. A list of all services and interventions required (Medicaid and non-Medicaid), the amount, the frequency and duration of each service, and the type of provider to furnish each service.

    c. A description how all clinical and non-clinical healthcare-related needs and services will be coordinated, including coordination with outside entities providing supports for the Member.

    d. For Members receiving HCBS, the HAP shall be developed consistent with 42 CFR §441.301(c).

    e. The HAP is regularly reviewed, updated, and agreed upon by the Member or authorized representative with the entity providing health coordination.

102. **Healthcare Professional** – A physician, podiatrist, optometrist, psychologist, dentist, PA, physical or occupational therapist, speech-language pathologist, audiologist, registered or practical nurse, licensed clinical social worker, nurse practitioner, or any other licensed or certified professional who

meets the State requirements of a healthcare professional.

103. **Healthcare Provider** – Any individual or entity that is engaged in the delivery of healthcare services and is legally authorized to do so by the State.

104. **Health Information Exchange (HIE)** – HIE allows doctors, nurses, pharmacists, other Healthcare Providers and patients to appropriately access and securely share a patient's vital medical information electronically—improving the speed, quality, safety and cost of patient care.

105. **Health Information Technology (HIT)** – Hardware, software, integrated technologies or related licenses, intellectual property, upgrades, or packaged solutions sold as services that are designed for or support the use by providers, healthcare entities, or patients for the electronic creation, maintenance, access, or exchange of health information. Source is ARRA - H.R.1-115 Sec. 3000 (5).

106. **Health Insurance** – A contract that requires the health insurer to pay some or all of healthcare costs in exchange for a premium.

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

108. **Health Plan** – Any healthcare organization, insurance company, ACO, HMO, or MCO that provides Covered Services on a risk basis to Members in exchange for capitated payments. A Health Plan shall meet the definition of an MCO under this section.

109. **Health Plan Manual** – DHS manual contains operational guidance, policies, and procedures required of the Health Plan

participating in QI. It will clarify reporting requirements and metrics used by DHS to oversee and monitor the Health Plan's performance. The Health Plan Manual, as amended or modified, is incorporated by reference into the Contract.

110. **Health Professional Shortage Area (HPSA)** – An area designated by the United States DHHS' Health Resources and Services Administration (HRSA) as being underserved in primary medical care, dental, or mental health providers. These areas can be geographic, demographic, or institutional in nature.

111. **Healthcare Effectiveness Data and Information Set (HEDIS)** – A standardized reporting system for Health Plans to report on specified performance measures that are developed by the National Committee for Quality Assurance (NCQA).

112. **Healthcare Payment Learning and Action Network (HCP LAN or LAN)** – A national collaboration between private, public, and non-profit healthcare stakeholders convened by HHS to provide clinical and policy leadership with the goal of transforming "the nation's health system to emphasize value over volume." HHS launched the LAN to advance the adoption of VBP and APMs across healthcare sectors. More information may be found at https://hcp-lan.org/.

113. **Healthcare Payment Learning and Action Network APM Framework** – A four category APM classification system designed to establish a common nomenclature for discussing and measuring progress in VBP.

114. **Health Insurance Portability and Accountability Act (HIPAA)** – The Health Insurance Portability and Accountability Act that was enacted in 1996.

114.1 **Health Related Social Needs (HRSN)** - Individual-level adverse social conditions that can negatively impact a person's health or health care, such as financial instability, lack of access to healthy food, lack of access to affordable and stable housing and utilities, lack of access to health care, and lack of access to transportation.

115. **Home and Community Based Services (HCBS)** – Long-term care services provided to an individual residing in a community setting who is certified by DHS to be at the nursing facility level of care (LOC) and would be eligible for care provided to an individual in a nursing facility or a medical facility receiving nursing facility LOC.

116. **Home Healthcare** – Limited part-time or intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, speech-language therapy, medical social services, DME (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services.

117. **Hospice Services** – Services to provide comfort and support for Members in the last stages of a terminal illness and their families.

118. **Hospital** – Any licensed acute care facility in the service area to which a Member is admitted to receive inpatient services pursuant to arrangements made by a physician. Acute care hospitals may additionally be designated as CAHs, as defined by the Medicare Rural Hospital Flexibility Program.

119. **Hospital Outpatient Care** – Care in a hospital that usually does not require an overnight stay.

120. **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.

121. **Hospitalization** – Care in a hospital that requires admission as an inpatient for an overnight stay. An overnight stay for observation could be outpatient care.

121.1 **Housing Navigation Supports** – Housing navigation supports include two services:

a. Pre-tenancy supports, which support Members in identifying and securing housing and preparing to become successful tenants. Supports may include:

1) Assessing housing needs and preferences;

2) Assisting with documentation and benefits;

3) Linking the Member to immediate basic needs and supportive services;

4) Coordinating the housing search and move-in process to promote stable community living; and

5) Other similar services.

b. Tenancy sustaining services, which support Members in maintaining stable housing and independent living sustainability. Supports may include:

1) Tenant and landlord education;

2) Tenant coaching on independent living, financial management, and other household skills;

3) Tenant assistance with community integration and inclusion to help develop natural support networks;

4) Connecting the Members to community resources and benefits; and

5) Providing referrals to address housing-related legal or tenancy issues, as needed.

122. **In Lieu of Service (ILS)** – Under the federal Medicaid managed care rules (42 CFR 438.3[e][2]), ILS substitute for services or settings covered in a state plan because they are a cost-effective alternative. The actual costs of providing the ILS are included when setting capitation rates, and they also count in the numerator of the medical loss ratio. ILS, however, can only be covered if the State determines the service or alternative setting is a medically appropriate and cost-effective substitute or setting for the State Plan service; if beneficiaries are not required to use the ILS; and if the ILS is authorized and identified in the contract with Medicaid managed care plans.

123. **Incentive Arrangement** – Any payment mechanism under which a Health Plan may receive funds for meeting targets specified in the contract; or any payment mechanism under which a provider may receive additional funds from the Health Plan for meeting targets specified in the contract.

124. **Incurred But Not Reported (IBNR)** – Liability for services rendered for which claims have not been received. Includes reported but unpaid claims.

125. **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 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 Member admitted on December 22, 2014 and discharged on January 5, 2015 would be associated with the 2014 benefit year because the admission date occurred during that benefit year. All other costs apply to the benefit year in which the service was rendered.

126. **Indian** – The term ''Indians'' or ''Indian'', unless otherwise designated, means any person who is a Member of an Indian tribe, as defined in this §2.6, except that, for the purpose of 25 USC §§1612 and 1613, such terms shall mean any individual who:

    a. irrespective of whether he or she lives on or near a reservation, is a Member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such Member; or

    b. is an Eskimo or Aleut or other Alaska Native; or

    c. is considered by the Secretary of the Interior to be an Indian for any purpose; or

    d. is determined to be an Indian under regulations promulgated by the Secretary of Health and Human Services.

127. **Indian Health Care Provider (IHCP)** means a health care program operated by the Indian Health Service (IHS) or by an Indian tribe, tribal organization, or urban Indian organization (otherwise known as an I/T/U) as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 USC §1603).

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

129. **Inquiry** – A contact from a Member that questions any aspect of a Health Plan, subcontractor, or provider's operations, activities, or behavior, or requests disenrollment, but does not express dissatisfaction.

130. **Institutional or Nursing Facility Level of Care (NF LOC)** – The determination that a Member requires the services of licensed nurses in an institutional setting to carry out the physician's planned regimen for total care. These services may also be provided in the home or in community-based programs as a cost-neutral, less restrictive alternative to institutional care in a hospital or nursing home.

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

housework.

132. **Kauhale Online Eligibility Assistance (KOLEA) System** – The State of Hawaii certified system that maintains eligibility information for Medicaid and other medical assistance beneficiaries. Kauhale means community in Hawaiian.

132.1 **Legally Responsible Individuals (LRI)** – Persons who have a duty under State law to care for another person. This category typically includes: the biological or adoptive parent of a minor child; the guardian of a minor child who must provide care to the child; or the spouse of a Member. An LRI authorized as a paid provider under the self-direction option must meet Hawaii's employment qualifications and training standards.

133. **Long-Term Services and Supports (LTSS)** – Services provided to a Member in an inpatient medical facility receiving NF LOC or to a resident of a NF LOC. These facilities include assisted living facilities, expanded adult care homes, community care foster family homes, nursing facilities, and sub-acute units.

134. **Managed Care** – A comprehensive approach to the provision of healthcare 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.

135. **Managed Care Organization (MCO)** – An entity that has, or is seeking to qualify for, a comprehensive risk contract under 42 CFR Subpart A that is: (1) a federally qualified HMO that meets the advance directives requirements under 42 CFR Subpart I; or (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 to other Medicaid Members within the area served by the entity; and

b. meets the solvency standards of 42 CFR §438.116.

136. **Marketing** – Any communication from a Health Plan to a Member or any other individual that can reasonably be interpreted as intending to influence the individual to enroll in the particular Health Plan, or dissuade them from enrolling into, or dis-enrolling from, another Health Plan.

137. **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 Members.

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

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

b. The SCHIP under Title XXI of the Social Security Act; and

c. The Section 1115 demonstration project under Title XI of the Social Security Act (42 USC subchapters XIX, XXI, and XI).

139. **Medical Expenses** – The costs, excluding administrative costs, associated with the provision of covered medical services under a Health Plan.

140. **Medical Facility** – A means a facility which:

a. Is organized to provide medical care, including nursing and

convalescent care;

b. Has the necessary professional personnel, equipment, and facilities to manage the medical, nursing, and other health needs of the individuals on a continuing basis in accordance with accepted standards;

c. Is authorized under state law to provide medical care; and

d. Is staffed by professional personnel who have clear and definite responsibility to the institution in the provision of professional medical and nursing services including adequate and continual medical care and supervision by a physician, sufficient RN, or licensed practical nurse (LPN) supervision and services and nurse aid services to meet nursing care needs, and appropriate guidance by a physician on the professional aspects of operating the facility.

141. **Medical Loss Ratio (MLR)** – The ratio of the numerator, as defined in accordance with 42 CFR §438.8(e) to the denominator and as defined in accordance with 42 CFR §438.8(f). For the purposes of this Contract, MLR requirements apply to the Health Plan and to its subcontractors that meet DHS' definition of applicable risk-bearing subcontractors, as specified by DHS.

142. **Medical Necessity** – Procedures and services, as determined by DHS, which are considered to be necessary and for which payment will be made. Medically-necessary health interventions (services, procedures, drugs, supplies, and equipment) shall be used for a medical condition. There shall be sufficient evidence to draw conclusions about the intervention's effects on health outcomes. The evidence shall demonstrate that the intervention can be expected to produce its intended effects on health

outcomes. The intervention's beneficial effects on health outcomes shall outweigh its expected harmful effects. The intervention shall be the most cost-effective method available to address the medical condition. Sufficient evidence is provided when evidence is sufficient to draw conclusions, if it is peer-reviewed, is well- controlled, directly or indirectly relates the intervention to health outcomes, and is reproducible both within and outside of research settings.

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

143.1 **Medical Respite Services** – Medical respite services, also known as episodic interventions, provide short-term room and board with clinical services and other supports. Medical respite services are time-limited based on clinical need, not to exceed six (6) months within a rolling twelve (12) month period. There are three (3) distinct medical respite services:

a. Short-term pre-procedure housing services are intended for eligible Members who have a planned medical procedure or treatment that requires care prior to or following the procedure or treatment. This service provides:

    1) Housing; and

    2) Clinically-oriented recuperative or rehabilitative services and supports.

b. Short-term recuperative care services are intended for eligible Members who have ongoing medical or psychiatric needs. This service provides:

1) Housing;

2) Clinically-oriented recuperative or rehabilitative services and supports;

3) On-going patient monitoring; and

4) Continuous access to medical care.

c. Short-term post-hospitalization housing services are intended for eligible Members who are recovering from a physical, psychiatric, or substance use condition following discharge or that exists from an institutional setting. This service provides:

1) Housing; and

2) Clinically-oriented recuperative or rehabilitative supports and services.

144. **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.

145. **Medical Specialist** – A physician, surgeon, or osteopath who is board certified or board eligible in a specialty listed by the American Medical Association, or who is recognized as a specialist by the participating healthcare plan or managed care health system.

146. **Medicare** – Means the healthcare insurance program for the aged and disabled administered by the Social Security Administration under title XVIII of the Social Security Act.

147. **Medicare Special Savings Program Members** – Qualified severely impaired individuals, medical payments to pensioners, qualified Medicare beneficiaries, specified low-income Medicare beneficiaries, qualifying individuals and QDWIs who may be eligible to receive assistance with some Medicare cost sharing.

148. **Med-QUEST Division (MQD)** – The offices of the State of Hawaii, DHS, which oversees, administers, determines eligibility, and provides medical assistance and services for state residents.

149. **Member** – An individual who has been designated by DHS to receive medical services through the QI program and is currently enrolled in a QI Health Plan.

150. **Model of Care (MOC)** – A quality improvement tool used to ensure the unique needs of each Member enrolled in a special needs plan (SNP) are identified and addressed. In 2010, the ACA designated the NCQA to execute the review and approval of SNPs' MOC based on standards and scoring criteria established by CMS. NCQA assess MOC from SNPs according to detailed CMS scoring guidelines.

151. **National Committee for Quality Assurance (NCQA)** – An organization that sets standards, develops HEDIS measures, and evaluates and accredits Health Plans and other MCOs.

152. **Native Hawaiian** – Refers specifically to people of native Hawaiian descent.

153. **Neighbor Islands (neighbor islands)** – Islands in the State of Hawaii other than Oahu – Hawaii Island, Maui, Lanai, Molokai, Kauai, and Niihau.

154. **Network** – A group of doctors, hospitals, pharmacies, and

other healthcare experts hired by a health plan to take care of its Members.

155. **New Member –** A Member who has not been enrolled in a Health Plan during the prior six (6) month period.

155.1 **Non-Emergency Medical Transportation (NEMT)** – Transportation to and from Medicaid covered medical appointments when Medical Necessity is established for the Members who have no means of transportation and who reside in areas not served by public transportation or cannot access public transportation. Non-emergency medical transportation services include both ground and air services.

155.2 **Non-Medical Transportation (NMT)** – Transportation services provided to and from CIS+ or HCBS for Members receiving such services, as authorized in the Member's care plan. NMT must be provided in alignment with applicable technical specifications and safeguards required under 1915(c) waiver or 1915(i) state plan authorities.

156. **Non-Participating Provider** – A provider who does not have a contract with any health insurers or plans to provide services to Members.

157. **Nurse Delegation** – In accordance with the current HAR §16-89-100, the ability of a RN to delegate the special task for nursing care to an unlicensed assistive person.

158. **Nursing Facility (NF)** – A freestanding or a distinct part of a facility that is licensed and certified to provide appropriate care to individuals referred by a physician. Such individuals are those who need twenty-four hour a day assistance with the normal ADL, need care provided by licensed nursing personnel and paramedical personnel on a regular, long-term basis, and may

have a primary need for twenty-four hours per day of skilled nursing care on an extended basis and regular rehabilitation services.

159. **Operational Effectiveness Program** - A quality assurance program for Health Plan operations.

160. **Paraprofessional** – An unlicensed, licensed, or certified healthcare team Member that provides person centered care, patient engagement, community resources, and culturally-competent care. A paraprofessional may include a medical assistant, community health worker, a peer support specialist or other specific titles, and provides basic healthcare services in settings such as hospitals, health clinics, physical offices, nursing care facilities and patient homes.

161. **Parent Company** – A company which owns and controls other companies.

162. **Participating** – When referring to a Health Plan it means a Health Plan that has entered into a contract with DHS to provide Covered Services to Members. When referring to a Healthcare 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 Members. When referring to a facility it means a facility that has entered into a contract with a Health Plan for the provision of Covered Services to Members.

163. **Participating Provider** – A provider who has a contract with health plans to provide services.

164. **Patient-Centered Medical Home (PCMH)** – A system of care designed to meet the needs of the whole patient. The model utilizes a team-based approach, but the PCP is responsible for

the continuity and coordination of a patient's care.

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

166. **Pay-for-Infrastructure (P4I)** – Refers to LAN Category 2A payments: Reimbursement for foundational payments for infrastructure and operations (e.g., care coordination fees and payments for HIT investments). See §7.2.D for information about LAN Category 2A.

167. **Pay-for-Performance (P4P)** – Refers to (1) LAN Category 2C incentives or bonuses for quality performance in care delivery; and (2) DHS incentive program comprised of multiple performance measures aligned with the Quality Strategy. See §7.2.D for information about LAN Category 2C.

168. **Peer Support Services** – Peer support services are provided by a Peer Support Specialist certified by Adult Mental Health Division of the DOH. Peer support services are coordinated within the needs and preferences of the Member in achieving the specific, individualized goals that have measurable results and are specified in the care, service, or treatment plan.

169. **Peer Support Specialist** – An individual who uses their lived experience of recovery from mental illness, addiction, and/or chronic disease management, plus skills learned in formal training, to deliver services that promote recovery, health, and resiliency. Peer support specialists are certified by Adult Mental Health Division (AMHD) as a part of the Hawaii certified peer specialist program or a program that meets the criteria established by AMHD, and shall complete ongoing continuing education requirements. Additionally, they shall be supervised

by a mental health professional, as defined by the State.

170. **Per Member Per Month (PMPM)** – Unit used to calculate capitation payments made to contracted Health Plan.

171. **Performance Improvement Project (PIP)** – Quality improvement initiatives undertaken by Health Plans in accordance with 42 CFR §438.240(d) that are designed to achieve, through ongoing measurements and interventions, significant improvement, sustained over time, in clinical and non-clinical care areas that are expected to have a favorable effect on health outcomes and Member satisfaction.

172. **Person-Centered Planning** – As defined in 42 CFR §441.301(c)(1)-(3).

173. **Personal Assistance** – Care provided when a Member, Member's parent, guardian, or legal representative employs and supervises a personal assistant. The personal assistant is certified by the Health Plan as able to provide assistance with ADL and/or IADL provided as an alternative to nursing facility placement to persons with a physical disability. Documentation of this certification will be maintained in the Member's individual plan of care.

174. **Physician** – A licensed MD or DO.

175. **Physician Services** – Services provided by an individual licensed under state law to practice medicine.

176. **Plan** – A benefit provided by employers, unions, or other group sponsors to pay for healthcare services.

177. **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.

178. **Preauthorization** – A decision by a Health Plan that a healthcare service, treatment plan, prescription drug, or DME is medically necessary. Sometimes called prior authorization, prior approval or precertification. A Health Plan may require preauthorization for certain services prior to Members receiving them, except in an emergency. Preauthorization does not guarantee the Health Plan will cover the cost.

179. **Prepaid Plan** – A Health Plan for which premiums are paid on a prospective basis, irrespective of the use of services.

180. **Prescription Drug** – Drugs and medications that, by law, require a prescription.

181. **Prescription Drug Coverage** – Health plan that helps pay for prescription drugs and medications.

182. **Prescription Monitoring Program (PMP)** – The purpose of the program is to improve patient care and stop controlled substance misuse. PMPs use formulary controls, provider-directed interventions such as education, screening, and intervention programs to decrease inappropriate utilization. Additionally, PMPs include a patient review and restriction program that can limit use by Members who are seeking multiple controlled substance prescriptions from different providers, often from multiple pharmacies, within a short period of time.

183. **Presumptive Eligibility** – Initial Medicaid eligibility given to a potential Member for a specified period of time prior to the final determination of their eligibility.

184. **Preventive Services (Adult Health)** – Services that can

prevent or detect illnesses and disease in earlier, more treatable stages, thereby significantly reducing the risk of illness, disability, early death, and medical costs. Examples include screening and preventive services identified in recognized clinical practice guidelines such as those published by the United States Preventive Services Task Force, the Centers for Disease Control and Prevention (CDC), HRSA's women's preventive services guidelines, and DOH's guidelines on screening for tuberculosis. Additional examples of adult preventive services include:

a. Immunizations;

b. Screening for common chronic and infectious diseases and cancers;

c. Clinical, non-clinical, and behavioral interventions to manage chronic disease and reduce associated risks and complications;

d. Support for self-management of chronic disease;

e. Support for self-management for individuals at risk of developing a chronic disease;

f. Screening for pregnancy intention as appropriate;

g. Counseling to support healthy living;

h. Support for lifestyle change when needed; and

i. Screening for behavioral health conditions.

185. **Preventive Services (Pediatrics and Adolescent Health)** – Services that can prevent or detect illnesses and disease in earlier, more treatable stages, thereby significantly reducing the risk of illness, disability, early death, and medical costs. This includes evidence-based screening and preventive interventions

such as those recognized in Bright Futures guidelines issued by HRSA and the CDC, all screening, assessment, and preventive services covered by EPSDT, and DOH screening guidelines for tuberculosis. Additional examples of preventive services include:

a. Immunizations;

b. Screening for common chronic and infectious diseases and cancers;

c. Clinical, non-clinical, and behavioral interventions to manage chronic disease and reduce associated risks and complications;

d. Support for self-management of chronic disease;

e. Support for self-management for individuals at risk of developing a chronic disease;

f. Screening for pregnancy intention as appropriate;

g. Counseling to support healthy living;

h. Support for lifestyle change when needed; and

i. Screening for behavioral health and developmental conditions.

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

187. **Primary Care Provider (PCP)** – A practitioner selected by the

Member to manage the Member's utilization of health care services who is licensed in Hawaii and is:

a. A physician, either an MD or a DO, and shall generally be a family practitioner, general practitioner, general internist, pediatrician or obstetrician-gynecologist (for women, especially pregnant women) or geriatrician;

b. An APRN-Rx. PCPs have the responsibility for supervising, coordinating, and providing initial and primary care to enrolled individuals and for initiating referrals and maintaining the continuity of their care; or

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

188. **Prior Period Coverage** – The period from the eligibility effective date as determined by DHS up to the date of enrollment in a Health Plan.

189. **Prior Period Performance Rate** – The actual score on a specific performance measure for the prior reporting period.

190. **Private Duty Nursing (PDN)** – PDN is a service provided to individuals requiring ongoing, long-term maintenance nursing care at home or in the community (in contrast to home health or part time, intermittent skilled nursing services under the Medicaid State Plan [MSP]). The service is provided by licensed nurses (as defined in HRS, Chapter 457) within the scope of state law, consistent with physician's orders, and in accordance with the Member's HAP. PDN services may be self-directed under personal assistance level II/delegated using nurse delegation procedures as outlined in HRS §457-7.5.

191. **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.

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

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

194. **Provider** – Any licensed or certified person or public or private institution, agency, or business concern authorized by DHS to provide healthcare, services, or supplies to individuals receiving medical assistance.

195. **Provider Grievance** – An expression of dissatisfaction made by a provider as described in §8.4.B.

196. **Provider Preventable Conditions (PPC)** – Provider-preventable conditions are conditions that meet the definition of a healthcare-acquired condition or other provider-preventable conditions. A healthcare-acquired condition (HAC) means a condition occurring in any inpatient hospital setting, identified as a HAC by the Secretary under Section 1886(d)(4)(D)(iv) of the Act; other provider-preventable condition may include conditions that have been found based upon a review of medical literature by qualified professionals to be reasonably preventable through the application of procedures supported by evidence-based guidelines, and have a negative consequence for the Member. At a minimum, other provider-preventable conditions include wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; or

surgical or other invasive procedure performed on the wrong patient.

197. **Quality Assurance and Performance Improvement (QAPI)** – Consistent with 42 CFR §438.240, QAPI is the simultaneous application of quality assurance (i.e., assurance that minimum specified standards for care are met) and performance improvement (i.e., implementing new processes to improve services by resolving persistent and/or underlying barriers) to conduct comprehensive quality management that strives to improve safety and quality in a given setting.

198. **Quality Strategy** – A comprehensive plan to systematically and iteratively assess the quality of care provided to beneficiaries, use data gathered to identify gaps and opportunities for improvement, set measurable goals and targets, identify evidence-based interventions to conduct targeted quality improvement, implement interventions, track implementation progress and effectiveness, and evaluate improvements in outcomes.

199. **QUEST Integration (QI)** – QI is the managed care program that provides healthcare benefits, including LTSS, to individuals, families, and children; the program serves both non-ABD individuals and ABD individuals, with household income up to a specified FPL. This is the demonstration project developed by DHS.

199.1 Reentry Services - Provision of limited pre-release services to eligible incarcerated individuals for up to ninety (90) days immediately prior to the individual's expected release date from incarceration, or provision of such services in the period immediately following release if not practicable to provide such services in the ninety (90) days immediately prior to the

individual's expected release date from incarceration. Reentry Services also include limited additional services for eligible juveniles covered under Section 5121 of the Consolidated Appropriations Act, 2023 (P.L. 117-328) in the thirty (30) days prior to release and for at least thirty (30) days following release.

200. **Recovery Audit Contractor (RAC)** – The State's selected contractor with whom the State is contracted to carry out activities described in 42 CFR §455.506 intended to promote the integrity of the Medicaid program.

201. **Rehabilitative/Rehabilitation Services** – Healthcare services that help you keep, get back, or improve skills and functioning for daily living that have been lost or impaired because you were sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

202. **Rehabilitation Devices** – Devices that support the provision of rehabilitation services in inpatient and/or outpatient settings. Rehabilitation devices include but are not limited to:

    a. Mobility devices, such as wheelchairs, motorized scooters, walkers, crutches, canes, prosthetic devices, orthotic braces, and other orthotic devices.

    b. Devices that aid hearing loss, balance or tinnitus disorders, including hearing aids, aural rehabilitation with cochlear implants for both pediatric and adult, and hearing assistive technology.

    c. Devices that aid speech include DME, speech-generating equipment, and augmentative and alternative

communication devices, such as voice amplification systems.

d. Cognitive aids to assist with memory, attention, and other challenges with cognition.

e. Prosthetic eyeglasses and prosthetic contact lenses for the management of trauma to the eye or ophthalmologic disease.

f. Dental devices, excluding devices for cosmetic purposes).

203. **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.

204. **Request for Proposal (RFP)** – This RFP.

205. **Risk Share** – The losses or gains associated with Health Plan costs or savings related to expected healthcare expenditures that are shared between the Health Plan and DHS. A Health Plan may separately enter into risk share arrangements with providers.

206. **Rural Health Center (RHC)** – An entity that meets the qualifications for an RHC, as defined in Section 1861(aa)(2) of the Social Security Act.

207. **Rural Providers** – Primary medical care, dental, or mental health Providers who serve in a HRSA-designated HPSA. HRSA-designated HPSA can be found using the following website: http://hpsafind.hrsa.gov/.

208. **Self-Direction** – A service delivery option under LTSS HCBS. Personal assistance services provided for an LTSS Member when the Member, Member's parent, guardian, or legal representative employs and supervises a personal assistant.

The personal assistant is certified by the Health Plan as able to provide assistance with ADL and/or IADL provided as an alternative to nursing facility placement to persons with a physical disability. Documentation of this certification will be maintained in the Member's individual plan of care.

209. **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 DHS.

210. **Severe Mental Illness (SMI)** – A mental disorder which exhibits emotional or behavioral functioning that is so impaired as to interfere substantially with a person's capacity to remain in the community without treatment or services of a long-term or indefinite duration. This mental disability is severe and persistent, encompassing individuals with SMI, SPMI, or requiring support for emotional and behavioral development (SEBD), resulting in a long-term limitation of a person's functional capacities for primary ADL such as interpersonal relationships, homemaking, self-care, employment, and recreation.

211. **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.

212. **Skilled Nursing (SN)** – Skilled nursing is a service provided to individuals requiring home health or part time, intermittent skilled nursing services under the MSP (in contrast to ongoing, long-term nursing care) at home or in the community. The

service is provided by licensed nurses (as defined in HRS Chapter 457) within the scope of state law, consistent with physician's orders and in accordance with the Member's HAP.

213. **Skilled Nursing Care** – A LOC that includes services that can only be performed safely and correctly by a licensed nurse (either a RN, a LPN, or APRN).

214. **Social Determinants of Health (SDOH)** – Conditions in which people are born, grow, live, work, and age that shape health. Socio-economic status, discrimination, education, neighborhood and physical environment, employment, housing, food security and access to healthy food choices, access to transportation, social support networks and connection to culture, as well as access to healthcare are all determinants of health. Hawaii state law recognizes that all state agency planning should prioritize addressing these determinants to improve health and wellbeing for all, including Native Hawaiians.

215. **Special Health Care Needs (SHCN)** – A Member that has chronic physical, behavioral, developmental, or emotional conditions that require health-related services of a type or amount that is beyond what is required of someone of their general age.

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

217. **Specialist** – A physician specialist focuses on a specific area of

medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of healthcare.

218. **State** – The State of Hawaii.

219. **State Fiscal Year (SFY)** – The period July 1 through the following June 30 of consecutive calendar years.

219.1 **State Medicaid Agency Contract (SMAC)**– Pursuant to the Medicare Improvements for Patients and Providers Act of 2008, the State Medicaid Agency Contract is a federally required contract between Health Plans offering D-SNPs and the Hawaii Department of Human Services, Med-QUEST Division. The SMAC includes federally required elements, as well as additional provisions required by DHS to advance its Medicare-Medicaid integration goals.

220. **State Plan** – The document approved by DHHS that defines how Hawaii operates its Medicaid program. The State Plan addresses areas of state program administration, Medicaid eligibility criteria, service coverage, and provider reimbursement.

221. **Stepped Care** – The concept of Stepped Care is that individuals can move up or down a continuum of services as needed and that treatment level and intervention will be paired with the individual's level of acuity to provide effective care without overutilization of resources. The goal is to meet individual need at the lowest level possible while ensuring high-quality results which allows the system to use limited resources to their greatest effect on a population basis.

222. **Sub-Acute Care** – A LOC that is needed by an individual not

requiring acute care, but who needs more intensive skilled nursing care than is provided to the majority of patients in a SNF.

223. **Subcontract** – Any written agreement between the Health Plan and anther party to fulfill the requirements of this Contract.

224. **Subcontractor** – A party with whom the Health Plan contracts to provide services and/or conduct activities related to fulfilling the requirements of this RFP and Contract.

225. **Subsidiary** – A majority owned or wholly owned entity of the Parent Company.

226. **Substance Abuse and Mental Health Services Administration (SAMHSA)** – The agency within DHHS that leads public heath efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

227. **Substance Use Disorder (SUD)** – SUDs occur when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.

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

229. **Telehealth** – As defined by HRS §346-59.1, the use of telecommunications services to encompass four modalities: store and forward technologies, remote monitoring, live consultation, and mobile health; and which shall include but not be limited to real-time video conferencing-based

communication, secure interactive and non-interactive web-based communication, and secure asynchronous information exchange, to transmit patient medical information, including diagnostic-quality digital images and laboratory results for medical interpretation and diagnosis, for the purpose of delivering enhanced healthcare services and information while a patient is at an originating site and the Healthcare Provider is at a distant site. Standard telephone contacts, facsimile transmissions, or email text, in combination or by itself, does not constitute a telehealth service for the purposes of this definition.

230. **Temporary Assistance to Needy Families** – Time-limited public financial assistance program that replaced Aid to Families with Dependent Children that provides a cash grant to qualified adults and children.

231. **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.

232. **Transitions of Care** – The movement of Members between healthcare practitioners, settings, and home as their conditions and care needs change. For example, a Member might receive care from a PCP or specialist in an outpatient setting, then transition to a hospital physician and nursing team during an inpatient admission before moving to another care team at a SNF.

233. **United States of America** – means the several States, the District of Columbia, the Commonwealth of Puerto Rico, the

Virgin Islands, Guam, America Samoa and the Northern Mariana Islands.

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

235. **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.

236. **Value-Added Services** – Under the federal Medicaid managed care rules (42 CFR §438.3[e][1][i]), services that are not covered under the State Plan, but that a Health Plan chooses to spend capitation dollars on to improve quality of care and/or reduce costs. Value-added services seek to improve quality and health outcomes, and/or reduce costs by reducing the need for more expensive care. The cost of value-added services cannot be included in the capitation rates; it can, however, be included in the numerator of the MLR if it is part of a quality initiative.

237. **Value-Based Payment (VBP)** – An approach to payment reform that links provider reimbursement to improved performance or that aligns payment with quality and efficiency. This form of payment holds Healthcare Providers accountable for both the cost and quality of care they provide. VBP strives to reduce inappropriate care and to identify and reward the highest performing providers. VBP may include but not be limited to different reimbursement strategies such as FFS with incentives for performance, capitation payment to providers

with assigned responsibility for Member care, or a hybrid model.

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

239. **Whole-Person Care** – Whole-person care addresses the health, behavioral health, psycho-social, and social services needs of a Member in a person-centered manner with the goals of improved health outcomes and more efficient and effective use of resources.

240. **Z Codes** – A category of International Classification of Diseases (ICD)-10 codes (Z00-Z99) used to identify persons with potential health risks related to socioeconomic and psychosocial circumstances. Z codes are not procedure codes and may be used in any healthcare setting.

SECTION 3 – Care Delivery and Health Coordination

3.1 Care Delivery and Health Coordination Policies and Procedures

A. The Health Plan shall develop and maintain policies and procedures that comply with all requirements in Section 3, Section 11, 42 CFR §438.208, and the Health Plan Manual. The policies and procedures are due upon request. The Health Plan shall develop policies and procedures on the following topics:

1. Advancing primary care;
2. Prevention, health promotion, and disease management;
3. Stepped approach to behavioral health; and
4. Health coordination program.

B. Any changes to the policy and procedure shall be submitted to DHS thirty (30) days prior to implementation of proposed change(s). Changes shall be approved by DHS prior to implementation.

3.2 Advancing Primary Care

A. The Health Plan shall support practices that are interested in:

1. Implementing advance primary care models;
2. Integrating primary care and behavioral health services;
3. Increasing capacity to provide care coordination services;
4. Enhancing primary care health homes, and the delivery of team-based care by leveraging all staff by incorporating community health workers, peer supports, and other lay health workers into the practice; and
5. Building infrastructure to improve access or for delivery system reform.

B. The support may include, but is not limited to, general information and administrative support, training, data systems and technology support, practice transformation technical assistance, and other support. In an effort to decrease costs and increase standardization, DHS may require Health Plans to collaborate to provide these services in a standardized and centralized manner.

C. See also §§7.2.D and 7.2.E., and the Health Plan Manual.

3.3 Health Plan Requirements for Prevention, Health Promotion, and Disease Management (PHPDM)

A. In addition to disease management and preventive services that the Health Plan is required to provide to adults and children (§4.2), the Health Plan is required to have a PHPDM program.

B. The purpose of the program is to:

1. Prevent or delay the onset of chronic diseases for the Members who are at risk of developing chronic diseases and would benefit from lifestyle change interventions; and

2. Improve self-management of chronic or medical conditions for the Members who have chronic condition(s) and would benefit from enhanced self-management strategies including plans and education.

C. The Health Plan shall have a minimum of five (5) PHPDM programs. The Health Plan shall have at least two (2) PHPDM programs at the start of the Contract. The Health Plan shall add at least one (1) additional PHPDM program each year until the Health Plan has at least five (5) PHPDM programs. The programs shall address the following conditions: pre-diabetes, diabetes, asthma, heart disease, hypertension, high-risk pregnancy, or obesity. The Health Plan may request approval from DHS to change one (1) program to address a

different health condition based upon the Member needs.

D. The Health Plan shall annually review the PHPDM and revise as necessary based upon new treatments and innovations in the standard of care.

E. The Health Plan shall provide reports on PHPDM to DHS.

3.4 Project ECHO™

The Health Plans shall support Project ECHO™, in accordance with the Health Plan Manual, including but not limited to, paying its fair share of administrative costs to Project ECHO™ programs serving Hawaii providers, as approved by DHS. In addition, the Health Plans shall:

A. Work collaboratively with Project ECHO™ programs;

B. Promote Project ECHO™ to providers; and

C. Support the evaluation of Project ECHO™ programs.

3.5 Implementing the Stepped Approach to Behavioral Health

A. DHS is adopting the framework of a stepped approach to behavioral health (Von Korff and Tiemens, 2000) in order to achieve the goals. A stepped approach allows the Members to fluidly move up and down a continuum of care, and that treatment levels and interventions will be paired with the Members' level of acuity to provide effective care without overutilization of resources.

B. The Health Plan shall collaborate with DHS and the other Health Plans to develop standardized protocols that include criteria describing how the Members should move up and down the continuum of care. The Health Plan shall implement DHS-approved protocols.

C. In an effort to expand the capacity for services or "steps" across the continuum of care, the Health Plan shall support effective integrated care models at the point of care including motivational interviewing,

which is a person-centered, directive method of communication for enhancing intrinsic motivation to change by exploring and resolving ambivalence. The Health Plan shall also support other effective integrated care models at the point of care, including but not limited to, the Collaborative Care Model, medication-assisted treatment, and screening, brief intervention, and referral to treatment (SBIRT) (§4.4.A.1).

1. The support may include, but is not limited to, general information and administrative support, training, data systems and technology support, practice transformation technical assistance, and other support. In an effort to decrease costs and increase standardization, DHS may require Health Plans to collaborate to provide these services in a standardized and centralized manner.

2. Utilize, support, and collaborate with Hawaii Coordinated Addiction Resource Entry System (CARES).

3. Hawaii CARES is a comprehensive and responsible system of care that aims to provide a continuum of care to deliver and reduce all barriers to SUD, mental health, and co-occurring treatment and recovery support services, as well as crisis intervention and support services. Hawaii CARES includes a hub of providers that complete universal intakes and screening of the Members and provide other services that support improving access to whole person care. Hawaii CARES is administered by DOH Alcohol and Drug Abuse Division (ADAD).

    a. The Health Plan and/or providers accessing mental health, substance use, and crisis intervention services on behalf of the Member shall utilize this multiple entry-point and coordinating center to access care.

4. The Health Plan shall:

   a. Work with Hawaii CARES to ensure the Members receive timely access to needed quality care;

   b. Maintain a robust provider network of behavioral health providers that is closely aligned with the Hawaii CARES and ADAD provider networks to the extent possible;

   c. Work with Hawaii CARES to ensure authorization of needed services are provided in a timely manner;

   d. Participate in training, data collection, and evaluation when feasible to ensure that services are utilized in the most effective and efficient manner possible; and

   e. Other services or supports.

3.6 Specialized Health Home

A. Hale Ola General Description

1. DHS intends to establish a specialized health pilot concept called the Hale Ola no later than the end of the fifth (5th)Contract year. The Hale Ola is a type of advanced health home for the EHCN Members. The Hale Ola will provide comprehensive care coordination services with a multi-disciplinary team. The Hale Ola will have a strong focus on behavioral health, prevention, health promotion, disease management, medication management, and other services. Pilots will be established in at least three (3) regions.

B. DHS shall:

1. Develop the Hale Ola program structure, including milestones, payment distribution methodology, and reporting requirements;

2. Pursue a Section 2703 Health Home State Plan Amendment to provide funding for the Hale Ola; and

3. Provide additional guidance on the Hale Ola during the Contract period.

C. The Health Plan shall:

1. Be accountable for ensuring quality care is provided through the Hale Ola;

2. Provide monitoring and oversight for the Hale Ola;

3. Create a process for EHCN population to be assigned to the Hale Ola, and a process to manage and monitor the services provided;

4. Support and engage strategies to facilitate partnerships between the Hale Ola and community-based providers, organizations, and programs;

5. Develop a system for sharing information with the Hale Ola including reports to the Hale Ola about the Hale Ola-enrolled population, both at the population-level and patient-level;

6. Collaborate with other Health Plans and DHS to align and develop information sharing and reporting standards;

7. Report on process and performance metrics on Hale Ola providers and the Members; and

8. Pay the Hale Ola based on common payment methodology to be developed by DHS.

3.7 Health Coordination Services (HCS)

A. Description of HCS

1. The Health Plan shall coordinate care for its Members and

provide for seamless and continuous coordination of care across a continuum of care for the Member with a focus on improving healthcare outcomes.

2. The Health Plan shall have an HCS program that complies with the requirements in 42 CFR §438.208, Section 3 and the Health Plan Manual. The Health Plan shall also comply with staffing requirements in Section 11.

3. The Health Plan shall provide HCS services to the Members that meet the criteria for:

   a. Special Health Care Needs (SHCN) as defined in §2.6;

   b. Expanded Health Care Needs (EHCN) as defined in §2.6;

   c. Long-Term Services and Supports (LTSS) as defined in §2.6;

   d. Community Integration Services Plus (CIS+) as defined in §2.6;

   e. Going Home Plus (GHP) and Institutional Relocation Services (§3.7.D.11); and

   f. Reentry Service

B. Member Outreach and Engagement

1. As part of the HCS program, the Health Plan shall develop a Member outreach and engagement plan for all programs and populations included in §3.7 as a part of the health coordination policy and procedure. The plan shall:

   a. Describe the process for contacting the Members including

harder-to-reach Members that typically do not respond to standard outreach strategies. The outreach activities may include sending Health Plan staff into the community, subcontracting or delegating outreach activities to providers, hospitals, or community organizations, or other innovative activities or best practices.

b. Describe the plan to engage Members into HCS once contact has been established including harder-to-reach Members that typically do not respond to standard engagement strategies.

C. HSC Staffing

1. The Health Plan shall maintain sufficient staff to meet the requirements in Section 3 and Section 11. The Health Plan shall utilize a multi-disciplinary team approach to provide HCS.

D. Health Plan Responsibilities for SHCN, EHCN, LTSS, CIS+, and Reentry

1. The core health coordination functions for the SHCN, EHCN, and LTSS Members include, at a minimum, identifying the population, conducting screenings and assessments, developing HAPs, implementing HAPs, and reassessing the Members' needs.

2. Identification of Population - The Health Plan shall have multiple methods to identify targeted populations that would benefit from HCS. The Health Plan shall have:

a. Advanced data analytic capabilities to identify the Members that meet HSC criteria. The Health Plan may use risk scoring methodologies and stratification to identify the populations.

b. New Member welcome call or new Member survey process

to screen and identify the Members (§9.2.B).

c. A process to accept referrals from external entities. The Health Plan does not have to approve the referral if the Member does not meet the HCS criteria.

d. A mechanism to identify Members through quality improvement activities, utilization review processes, and other Health Plan processes.

1) DHS will also use data analytics and other methods to identify the Members. DHS may require the Health Plan to provide or terminate HCS to Members based on DHS' analysis.

2) A bi-directional mechanism may be established to enable the Health Plan to notify DHS, and vice versa, about beneficiaries identified for receiving various types of HCS. The Health Plan shall utilize these mechanisms if developed.

3. Screening and Assessments

a. Screening for Social Risk Factors (SRF)

SRFs refer to an individual's social and economic barriers to health, such as housing instability or food insecurity. The Health Plan shall screen and provide interventions for certain SRF. The Health Plan shall, at a minimum:

1) Use state-approved SRF screening questions within the first year of the contract;

2) Share SRF screening data with the care team (§2.6);

3) Require that the Health Coordination Team and care

team incorporates information on the results of positive screens into clinical decision making;

4) Offer screened Members interventions to mitigate the impact of SRFs, including timely referrals with positive screens;

5) Share screening data with DHS to assist DHS in assessing the prevalence of SRFs and prioritize efforts to mitigate SRFs; and

6) Request DHS' permission to utilize additional SRF screening questions.

7) DHS will issue an implementation timeline for the Health Plan requirements as described in §3.7.D.3.a.2-6 as needed.

b. Assessments

1) The Health Plan shall conduct an assessment for all SHCN, EHCN, and LTSS Members. The assessment shall be used to collect health status, health conditions, social risk factors, and other information.

2) The Health Plan shall collaborate with DHS and the other Health Plans to develop a standardized assessment. The Health Plan shall implement the DHS-approved assessment. The Health Plan may request for approval to provide a more comprehensive assessment instrument.

3) The Health Plan shall conduct the assessment at a time and location that meets the Member's needs.

4) The Health Plan shall share the assessment with the Member's care team, as needed, to enhance communication and collaboration to serve the needs of the Member with the Member consent.

5) Frequency and Timing of Assessments – The Health Plan shall conduct a face-to-face assessment within fifteen (15) days of identification. The face-to-face assessment may take place in person or virtually.

4. Development of the Health Action Plan (HAP)

a. A HAP is a person-centered individualized plan that is developed with the Member and/or authorized representative, is based on an assessment. The HAP shall describe the medical, behavioral, and social needs of the Members, and identify all services to be utilized to include but not limited to the frequency, quantity, and provider furnishing the services.

b. A HAP shall be developed for each Member receiving SHCN, EHCN and LTSS within no more than thirty (30) calendar days of completion of the assessment.

c. The person-centered HAP must be developed using a person-centered service planning in accordance with 42 CFR §441.301(c)(1) (1915[c]) or 42 CFR §441.725(c) (1915[i]), and the written person-centered HAP must meet federal requirements at 42 CFR §441.301(c)(2) (1915[c]) or 42 CFR §441.725(b) (1915[i]).

d. The Health Plan shall collaborate with DHS and the other Health Plans to develop a state-approved HAP template. The

Health Plan shall implement the state-approved template.

e. The HAP shall be signed and dated by Health Plan and the Member. The Member's authorized representative or surrogate may sign for the Member. The signature may be an electronic signature. A copy of the HAP shall be provided to the care team.

f. Frequency of the comprehensive update to the HAP

1) At a minimum, every twelve (12) months;

2) When a Member's circumstances or needs change significantly;

3) At the Member's request; or

4) When a reassessment occurs.

5. Implementation of the HAP

a. The Health Plan shall implement the HAP as written in collaboration with the Member, Member's family if appropriate, and the care team.

b. Frequency of visits with the Member for the implementation of the HAP:

1) The Health Plan shall have at least one face-to-face visit with the Member to review and update their HAP every ninety (90) days for SCHN, EHCN, or HCBS and every six (6) months for Members living in an alternative residential setting such as CCFFH, E-ARCH, ALF, or NF. The face-to-face visit shall be done in person or through alternative communication

methods based on member's preference (e.g., telephone, text, email, video chat, etc.).

2) In addition, the Health Plan shall meet with the Member to review and update the plan at a frequency that is mutually agreed upon with the Member. These interactions shall be done face-to-face, in person, virtually, or through alternative communication methods (e.g., telephone, text, email, etc.).

3) The Health Plan shall implement the HAP; the required activities for implementing the HAP include, but are not limited to:

a) Review HAP goals, objectives, and actions with the Member and track progress;
b) Coordinate, facilitate, and arrange access to services;
c) Manage transitions of care;
d) Provide continuity of care when the Members are discharged from a facility (e.g., resolving instances like the prescribed medication is not on the Health Plan's formulary);
e) Identify if significant changes have occurred; if they have, the Health Plan shall complete a reassessment;
f) Verify receipt of services;
g) Verify satisfaction with providers and services;
h) Identify gaps in care and develop mitigation strategy to address the gaps;
i) Review if utilization patterns are appropriate and

develop mitigation strategy if the patterns are not appropriate;

j) Coordinate a team of decision makers to review the case including the PCP, other providers as appropriate, the Member, and others;

k) Facilitate timely communication across the care team to avoid duplication of services and medication error, including but not limited to discharge instructions and discharge summaries from facilities;

l) Coordinate services with Medicare FFS and/or Medicare Advantage (MA) Plans if applicable;

m) Medication management, including regular medication reconciliation and support of medication adherence;

n) Monitor progress with EPSDT requirements;

o) Train the Member on self-management strategies, as relevant;

p) Screen for social risk factors and develop mitigation strategy to address needs;

q) Provide assistance in resolving any concerns about service delivery and providers; and

r) Assist the Member with maintaining continuous Medicaid benefits.

6. Reassessment

a. The Health Plan shall complete a re-assessment and update the HAP based on the re-assessment:

1) At least every twelve (12) months;

2) Within ten (10) days of when the Member's circumstances or needs have changed significantly; or

3) Within ten (10) days of when the reassessment or new HAP is requested by the Member.

b. The Health Plan may stop providing HCS described in §3.7 if it is determined that the Member does not need services or no longer meets the criteria. The Health Plan shall document that determination. The Members shall be re-evaluated if they are re-identified to be potentially eligible for health coordination.

c. The person-centered HAP is reviewed and revised upon reassessment of functional need, as required by 42 CFR §441.365(e), at least every twelve (12) months, when the individual's circumstances or needs change significantly, or at the request of the individual.

7. Services Provided at the Site of Care for SHCN, EHCN, and CIS+ Populations

a. The Health Plan shall have the ability to provide a robust system of local services that is performed at the site of care, in the home or in the community where face-to-face interaction is possible for the Members receiving SHCN, EHCN, and CIS+. Services should be led by providers and located where the Members and providers are located.

b. The Health Plan shall subcontract or delegate services to providers, including but not limited to, PCPs and advanced

primary care providers to the greatest extent possible.

c. The Health Plan shall collaborate with DHS and the other Health Plans to develop a plan to migrate functions closer to the provider level. The Health Plan shall implement the plan that is approved by DHS by the end of year one (1) of the contract. The Health Plan shall collaborate with DHS and the other Health Plans to provide training and other support services for providers.

d. The Health Plan is accountable for the HCS program and responsible for oversight and monitoring of all functions.

8. Additional Requirements for LTSS Including HCBS

a. General Description of Services – See §4.8.

b. The Health Plan shall:

1) Assess a Member's eligibility for LTSS and HCBS in accordance with the requirements in Section 3 and the Health Plan Manual.

2) Provide options counseling regarding institutional placement and HCBS alternatives if applicable.

3) Comply with conflict free case management and other HCBS setting rules. Consistent with Medicaid HCBS requirements at 42 CFR §441.301(c)(1)(vi), providers of HCBS for a Member, or those who have an interest in or are employed by a provider of HCBS for the Member, shall not provide case management or services for that Member, nor should such a provider develop the person-centered plan. The

Health Plan shall also comply with all HCBS rules related to the Open Vendor Model.

4) Assess caregivers for potential burnout for the Members living at home receiving HCBS.

5) The Health Plan shall complete the assessment prior to the date of discharge for institutionalized Members that are preparing for discharge to the community.

6) The Health Plan shall adhere to HCBS waiver assurances set forth in 42 CFR §§441.301 and 441.302.

7) The Health Plan shall ensure the settings meet the HCBS setting requirements as specified in the benefit and in accordance with 42 CFR §§441.710(a)(1) and (2).

8) The Health Plan is not required to provide HCBS if as described in HAR §17-1720-18:

a) The Member chooses institutional services;
b) The Member cannot be served safely in the community; or
c) There are not adequate or appropriate providers for needed services.

9. Special Coordination Provisions for Self-Direction of LTSS

a. Description of Self-Direction

1) Members assessed to need personal assistance services (as defined in §2.6) and respite services (as defined in §2.6) may elect to have choice and control

over their providers (referred to as self-direction).

b. The Health Plan shall:

1) Establish and maintain self-direction policies and procedures;

2) Ensure Members that receive nurse delegable personal assistance services meet requirements in accordance with HAR §16-89-100;

3) Assist the Member in facilitating self-direction and accessing available resources and supports, including obtaining a Hawaii tax identification (ID) for member or guardian, setting up a new self-directed employee, paying required taxes, completing payroll and all legal components and documents as needed;

4) Inform the Members that are assessed to need personal assistance services or respite services of the self-direction option;

5) Develop and monitor a budget for each Member electing self-direction;

6) Have the ability to terminate provision of self-direction services on behalf of a Member for health and welfare issues. Health Plans do not have the authority to terminate self-directed providers;

7) Perform the administrative functions associated with employing self-direction providers for the Member, including ensuring that the self-directed employee is

paid on a timely basis by contracting with a payroll vender as needed;

8) Require that all Members, authorized representatives, and/or surrogates participate in a training program prior to assuming self-direction;

9) Ensure the Hawaii DHS state tax ID is no longer used for payroll purposes in the self-direction program;

10) Safeguard the self-directed employer, QI member, to ensure the member is held harmless if any entity fails in the payroll process to file any State or Federal taxes or other required documents; and

11) Confirm the self-directed payroll process moving forward complies with all existing state labor laws contained in HRS Chapter 388, such as issuing paychecks at least two (2) times per month, paying overtime rates after an employee works a prescribed number of hours, and issuing a paycheck no later than seven (7) days after the employee's timesheet is submitted.

10. CIS+

a. The Health Plan shall provide CIS+ services to eligible Members.

b. The Health Plan shall have a process in place to accept CIS+ referrals, proactively identify the Members eligible for CIS+ and administer CIS+ services. The Health Plan shall:

1) Use a DHS standardized housing assessment tool and housing support plan to coordinate housing services;

2) Use bi-directional reporting of the CIS+ Status code daily file upload to notify DHS and receive notification about beneficiaries identified for and receiving various types of CIS+ services;

3) Have policies and procedures to promote coordinated CIS+ services that vary in scope and frequency based on the Member's intensity of need;

4) Assist the Member with connecting to social services to help find and apply for housing necessary to support the individual in meeting their medical care needs;

5) Participate in person-centered plan meetings at redetermination and/or conducting revision plan meetings, as needed;

6) Provide supports and interventions per the person-centered plan; and

7) See also §5.1.A.4 and the Health Plan Manual.

c. CIS+ Member Rights

1) CIS+ services must not be used to reduce, discourage, or jeopardize Members' access to covered services;

2) Members always retain their right to receive covered services on the same terms as would apply if CIS+ services were not an option;

3) Beneficiaries who are offered or who utilize a CIS+ service retain all rights and protections afforded under 42 CFR Part 438;
4) Members cannot be denied a covered service on the basis that the beneficiary is currently receiving CIS+ services, has requested those services, has previously qualified for or received those services, or currently qualifies or may qualify in the future for those services; and
5) Members cannot be required to receive CIS+ services.

11. Going Home Plus and Institutional Relocation Service

a. The Health Plan shall provide person-centered relocation services to help the Members in institutions (i.e., hospitals, psychiatric residential treatment facilities, prisons, nursing homes, or other long-term care facilities) relocate the Member to their own homes and communities. Eligible Members may include youth with mental illnesses, the elderly, or individuals that have physical, intellectual, and developmental disabilities.

b. The Health Plan shall ensure that relocation activities include all transitions from institutions to communities, including:

1) Going Home Plus eligible Members institutionalized for at least sixty (60) days for which an enhanced federal medical assistance percentage is received; and
2) CIS+ eligible Members institutionalized for at least

sixty (60) days.

c. The Health Plan shall ensure relocation activities, including all transitions from institutions to communities, are completed.

d. The Health Plan shall have a process to designate a point of contact to receive referrals for institutionalized Members.

e. The Health Plan shall have processes in place that detail how they will:

1) Ensure all required assessments are completed prior to discharge;

2) All necessary equipment, services, including transition assistance services items, are in place on the day of discharge;

3) Identify and prepare institutionalized Members for successful community transition including transitions to independent living;

4) Track and report efforts to rebalance its LTSS system by increasing the use of community-based services rather than institutional services;

5) Conduct assessments, transitions, and implement HAPs including monitoring post institutional relocation; and

6) Provide DHS with completed assessments and HAPs upon request.

12. Reentry Services

a. DHS intends to implement Reentry Services using a phased rollout, beginning no earlier than January 1, 2026. DHS will provide additional guidance on the phased implementation of reentry during the Contract period.
b. The Health Plan shall provide Reentry Services to eligible individuals.
c. The Health Plan shall have a process in place to identify the individuals eligible for Reentry Services and prepare eligible individuals for community transition. The Health Plan or its delegate shall:
    1) Participate in the care planning process and support the development of a person-centered care plan;
    2) Provide case management services to assess and address physical and behavioral health needs and health-related social needs. For eligible juveniles covered under Section 5121 of the Consolidated Appropriations Act, 2023 P.L. 117-328, this also includes:
        a) Coordination of dental screening and diagnostic services in the thirty (30) days prior to release or as soon as is practicable following release (see also §4.12); and
        b) Targeted Case Management services, which are encompassed in the definition of Case Management in §4.13, in the thirty (30) days prior to release and for at least thirty (30) days following release.
    3) Coordinate medication for addiction treatment, provision of a thirty (30) day supply of prescription

medications for use post-release, practitioner office visits, diagnostic services, medical equipment and supplies, and peer support services as described in the person-centered service plan;

4) Facilitate referrals and warm handoffs to community-based providers prior to or following release, including health and social service referrals and CIS+ services, as indicated by the person-centered care plan, including any necessary data or information sharing upon release to another Health Plan, DHS, or health and social service providers;
5) Provide the eligible individuals with their Health Plan Member ID Card or other Medicaid enrollment documentation, along with information on how the Member can use their coverage and access necessary services; and
6) See also §4.13 and the Health Plan Manual.

3.8 Coordination with State Programs and Other Agencies

A. In addition to the Health Coordination requirements in §3.7 and the Health Plan Manual, the Health Plan is also responsible for coordination with State and other programs as described in §3.8.

B. Coordination activities with DOH, Child and Adolescent Mental Health Division (CAMHD), Adult Mental Health Division (AMHD), and Developmental Disability Division (DDD) are described below:

a. The Health Plan shall have a process in place to identify and refer:

1) Children/youth that are unstable, of moderate-high risk, and in need of the SEBD program of CAMHD (§4.4.B); and

2) I/DD children and adults to DDD.

b. The Health Plan shall coordinate care for the Members receiving services through AMHD, CAMHD, and DDD.

c. The Health Plan shall collaborate with DHS, AMHD, CAMHD, and DDD to execute signed agreements that results in the ability for the Health Plan to exchange the Member information with AMHD, CAMHD, and DDD as appropriate.

d. The Health Plan shall collaborate with DHS, AMHD, CAMHD, and DDD to develop standardized referrals and coordination processes.

e. The Health Plan shall collaborate with CAMHD to transition services aging out of CAMHD that continue to require behavioral health services and supports.

f. The Health Plan shall collaborate with DHS, CAMHD, and CCS to transition services for children that meet CCS criteria.

C. Coordination with Other State Programs

In addition to the health coordination requirements in §3.7, the Health Plan is also responsible for coordination with other governmental programs. Data use agreements will be required for any disclosure of Medicaid data. This section describes other agencies' services and responsibilities, as well as the requirements of the Health Plan.

1. DOH – Women, Infants, and Children (WIC)

   The Health Plan shall coordinate the referral with Member consent of potentially eligible women, infants, and children to the WIC Supplemental Nutrition Program and the provision of health data required by the WIC program, within the timeframe required by WIC, from their providers. The Health Plan shall cover the cost of specialty formula when Medical Necessity is established.

2. DOH – Hawaii Immunization Registry

   a. Vaccines for Children (VFC)

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

   b. 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 capitation payment paid to the Health Plans, the Health Plan is not prohibited from allowing privately acquired vaccines and may decide who, if any, shall receive the vaccines 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 capitation

payment.

3. DOH – Children with Special Needs Branch

   a. Early intervention services (EIS) are provided to eligible children aged zero (0) to three (3) with an identified delay in development or who are at risk of developing a delay. EIS assists children in five developmental areas: physical, cognitive, communication, social/emotional, and adaptive. Detailed eligibility criteria are available through the Hawaii EIS website. DOH administers and manages the EIS.

   b. The cost of EIS services are not included in the Health Plan's capitation rate.

   c. During the EPSDT screening process, the Health Plan is responsible for identifying and referring children who may qualify for these services. The Health Plan is responsible for providing services when Medical Necessity is established prior to DOH eligibility determination and continuing to ensure provision of medically necessary services if the child is or is not found eligible for EIS.

   d. The Health Plan shall collaborate with EIS as the Members transition out of EIS. Health plans shall screen each Member for HCS and authorize continuation of medically necessary services provided by EIS when the Member transitions out of EIS.

4. DHS – State of Hawaii Organ and Tissue Transplant. (SHOTT)

   a. The Health Plan shall determine that the Member meets the transplant criteria and work with the transplant facility to

submit a request for an evaluation by the SHOTT program. The Health Plan shall follow the Health Plan Manual on submitting referral request to DHS. The SHOTT program is also described in §4.12.B.

5. DHS – Foster Care/Child Welfare Services (CWS) Children

   a. For children with active cases with CWS – In addition to providing all services when Medical Necessity is established under EPSDT, the Health Plan shall provide pre-placement physicals prior to placement and comprehensive health assessments within forty-five (45) days after placement. The Health Plan also shall cover cost of medication and dispensing for medically necessary medications prescribed by providers performing the pre-placement physical and comprehensive health assessment.

   b. The Health Plan shall have a process that details how 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 effective at the end of the month in which the request is made.

6. Department of Education – School-Based Services

   a. The costs for school-based health services are not included in the capitation rate paid to the Health Plan.

7. Department of Corrections and Rehabilitation (DCR)

   a. The Health Plan shall have a process in place to collaborate with MQD and DCR to identify individuals eligible for Reentry

Services and coordinate care pre-release and post-release of individuals eligible for Reentry Services.

8. Hawai‘i Youth Correctional Facility (HYCF)

    a. The Health Plan shall have a process in place to collaborate with MQD and HYCF to identify individuals eligible for Reentry Services and coordinate care pre-release and post-release of individuals eligible for Reentry Services.

9. Hawai‘i State Judiciary

    a. The Health Plan shall have a process in place to collaborate with MQD and Hawai‘i State Judiciary to identify the planned release dates for individuals eligible for Reentry Services and to coordinate care pre-release and post-release of individuals eligible for Reentry Services.

3.9 Coordination and Alignment with Medicare for Dual Eligibles

A. Alignment

1. Throughout the Contract term, DHS will continuously pursue opportunities to improve administrative alignments that create a more seamless experience for dual eligibles. As directed by DHS, the Health Plan shall collaborate with DHS in developing and implementing strategies to enhance alignment for dual eligibles enrolled D-SNP and companion Medicaid plans, including opportunities to create unified outreach materials and aligned grievance and appeals processes in accordance with policy options provided by CMS.

    a. The Health Plan shall enter into a Coordination of Benefits

Agreement with Medicare and submit a copy of the final fully executed agreement to DHS. The Health plan shall participate in the automated claims crossover process for dual eligibles. The Health Plan shall be responsible for a dual eligible's coordination of benefits.

B. Dual-Eligible Special Needs Plan

1. Health Plans shall provide a D-SNP for Medicare and Medicaid Members. To provide such D-SNP, the Health Plan shall enter an annual Cooperative Agreement with Hawaii Department of Human Services, Med-QUEST Division. Such agreement is also referred to as the State Medicaid Agency Contract (SMAC). The Health Plan shall provide and operate its D-SNP in compliance with the terms of the governing effective SMAC. The SMAC and QI RFP shall include terms sufficient to meet any Medicare Improvements for Patients and Providers Act of 2008 and Bipartisan Budget Act of 2018 requirements identified by CMS.

2. The Health Plan's D-SNP must adhere to MQD's phased approach which promotes access to the most integrated coverage options for dual eligible Members, in alignment with the SMAC:

   a. For Medicare Advantage Contract Year 2025, Health Plans may offer both Highly Integrated D-SNPs (HIDESNP) and Fully Integrated D-SNPs (FIDESNP) consistent with the SMAC. Dual Eligible QI Members may enroll in HIDESNPs regardless of whether the HIDESNP is offered by the same organization offering the Member's QI plan. FIDESNPs operate with exclusively aligned enrollment whereby dual eligible Members can only enroll in FIDESNPs offered by the same organization which offers the Member's QI plan.

b. For Medicare Advantage Contract Year 2026, Health Plans may offer both HIDESNPs and FIDESNPs. HIDESNPs will be prohibited from accepting any new D-SNP enrollment starting January 1, 2026. All dual eligible QI Members who seek to enroll in a Hawaii D-SNP will be limited to the FIDESNP offered by their current QI plan.

c. For Medicare Advantage Contract Year 2027, HIDESNPs will not be offered. All Health Plans shall be limited to one FIDESNP with exclusively aligned enrollment.

3. D-SNPs must ensure compliance with the most current version of the SMAC.

C. Default Enrollment

1. Health Plans are required to perform the Medicare default enrollment process as well as the SMAC for Members that are newly Medicare eligible either by age or disability in accordance with 42 CRF §422.66, 422.68.
2. Starting January 1, 2026, default enrollment is limited to FIDESNPs. HIDESNPs will not have DHS approval to conduct default enrollment.
    a. Health Plans operating a new FIDESNP as of January 1, 2026 shall be responsible for obtaining default enrollment process approval from CMS. The Health Plan shall coordinate with DHS regarding those activities in accordance with the SMAC.

D. Health Plan Request to Become a Fully Integrated Dual Eligible SNP

(FIDESNP)

1. DHS may support a Health Plan's request to be a FIDESNP beginning January 1, 2024. A Health Plan's request to DHS to pursue FIDESNP status, must be received by DHS no later than sixteen (16) months prior to the start of the intended FIDESNP contract year. To be considered for FIDESNP, the Health Plan shall adhere to Medicare timelines and requirements for meeting this level.

2. Upon DHS request, the Health Plan will submit additional reporting of encounter data elements, quality performance information, or Medicare changes. In addition, DHS will coordinate with the FIDESNP to ensure alignment of services, MOC, and health risk assessments as referenced in §3.7.

E. Medicare Supplemental Benefits

1. Medicare supplemental benefits are meant to bridge Medicare and Medicaid services, but not to supplant otherwise available Medicaid services. The Health Plan may, in adherence with Medicare requirements, provide supplemental services that support statewide efforts to address SDOH.

F. Model of Care (MOC)

1. To the extent possible, DHS shall work with CMS to jointly review and provide input on a Health Plan's MOC requirements for submission and approval to NCQA. This may include collaborating with CMS to develop review criteria. Based on DHS direction, the Health Plan shall develop a MOC that includes LTSS and coordinates the provision of all Medicare and Medicaid services. The Health Plan shall provide the MOC for DHS review

no later than forty-five (45) days prior to the required submission for approval to NCQA.

2. In the event that the Health Plan receives a score below 70 percent on its initial MOC submission to NCQA, the Health Plan shall provide DHS the opportunity to review the second draft, prior to re-submission to NCQA.

G. Star Quality Rating

1. The Health Plan shall notify DHS if it receives less than a 3.0 overall Star Quality Rating from CMS, including for either its Part C or Part D scores. The notification shall be provided to DHS within fifteen (15) calendar days of receiving the score notification from CMS. The Health Plan shall provide a mitigation plan outlining the steps proposed or implemented and timeline to improve the score.
2. The Health Plan shall maintain a minimum 3.0 overall plan Star Quality Rating as assigned by CMS to implement the default enrollment process. The Health Plan's default enrollment process shall be revoked by CMS if a minimum 3.0 overall plan Star Quality Rating is not maintained, and default enrollment cannot be re-applied for with CMS until the Health Plan has subsequently achieved this minimum Star Quality Rating.

3.10 Future Services

A. In order to accomplish the stated goals for care delivery and health coordination, DHS may seek authority from CMS to add or revise Covered Services during the Contract period. Health Plans will be responsible for covering any services where benefits are added or modified during the Contract period. Examples of services that DHS

may add or enhance include, but are not limited to:

1. Specialized health home (Hale Ola) services;
2. Preventive services provided by community health workers and other paraprofessionals;
3. Services provided by Community Paramedicine programs;
4. Services provided in Institutions for Mental Disease (IMD);
5. Medication therapy management; and
6. Prevention and health promotion education, classes, and coaching for chronic diseases and the Members at risk of chronic disease, including but not limited to such programs as:
    a. CDC-recognized Diabetes Prevention Program.
    b. CDC-recommended Asthma Self-Management Education programs.

B. E-consultations and/or E-referrals – An e-consultation or e-referral is an asynchronous, non-face-to-face consultation between a PCP and a specialist using a secure electronic communication platform;

C. Telehealth consultations – The use of telecommunications and information technology (IT) to provide access to health assessment, diagnosis, intervention, consultation, supervision, and information across distance;

D. Transportation benefit expansion – for example, coverage for the Members to receive transportation services to and from pharmacy visits.

E. CIS+ benefit expansion – for example, coverage for new services such as

short-term rental assistance, utility assistance, medically necessary or environmental accessibility home modifications, and other housing transition supports such as coverage of moving costs.

F. Contingency management services – The use of motivational incentives to support Members with substance use disorders to meet treatment goals.

G. Assisted Living Facility (ALF) services for the at-risk population – Coverage for ALF services for Members who are at risk of deteriorating to the nursing facility LOC.

H. Nutrition supports – Services and interventions for Members experiencing food insecurity – for example, nutrition instruction, home delivered meals, pantry restocking, medically tailored meals, nutrition prescriptions, or cooking supplies.

SECTION 4 – Covered Benefits and Services

4.1 Overview of Covered Benefits

A. Overview of Medical Necessity and Amount, Duration, and Scope Requirements

1. The Health Plan shall be responsible for providing all Covered Services when Medical Necessity is established 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 FFS. 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.

2. The Health Plan that would otherwise be required to provide, reimburse for, or provide coverage of a counseling or referral service is not required to do so if the Health Plan objects to the service on moral or religious grounds in accordance with Section 1932(b)(3)(B)(i) of the Act and 42 CFR §438.102(a)(2).

B. Overview of Utilization Controls

1. The Health Plan may incorporate utilization controls as described in §5.2 as long as the medically-necessary services furnished to the Member can be reasonably expected to achieve its purpose.

2. The Health Plan may place appropriate limits on a service for utilization control, provided the services supporting individuals with ongoing or chronic conditions or who require LTSS are authorized in a manner that reflects the Member's ongoing need

for such services and supports.

3. The Health Plan may place appropriate limits on a service for utilization control in accordance with §5.2.

4. The Health Plan may place appropriate limits on a service on the basis of criteria applied under the Medicaid State Plan (MSP), such as Medical Necessity.

5. The Health Plan shall ensure services are provided in a manner that facilitates maximum community placement for the Members that require LTSS.

6. A Member's access to behavioral health services shall be no more restrictive than for accessing medical services. The Health Plan shall not apply any financial requirement or treatment limitation to mental health or SUD benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to Members, whether or not the benefits are furnished by the same Health Plan.

C. Overview of Coverage of Additional Services

1. With the exception of services specifically excluded by the federal Medicaid requirements, the Health Plan may, at its own option and as an administrative expense, choose to provide value-added services and/or in lieu of services, as described in §4.11. These services are provided to all Members or on an individual consideration basis. These services can include:

   a. Non-covered services;

b. Additional services; and/or
c. Services in excess of the required Covered Services or benefit limits.

2. Any additional services offered by the Health Plan shall be approved by DHS at least thirty (30) days before such services are implemented. The Health Plan shall also include in its request to DHS any benefit limits, the process it will use to notify the Members about new services and the process it will use to update program materials to reflect new services.

3. Members may be billed directly by the rendering provider for any non-covered services and for Covered Services exceeding any established limits, as applicable. The Health Plan shall inform the Members that they may be billed directly by the rendering provider for any non-covered services and for Covered Services exceeding any established limits, as applicable. The Health Plan shall instruct providers to explain the billing and obtain written consent from the Members prior to rendering the services.

4.2 Coverage Provisions for Preventive Services

A. Fluoride Varnish

1. Topical fluoride varnish application by qualified primary care providers will be covered for children beginning at age one year until reaching six years of age if they have not received a topical fluoride treatment in the previous six months. Qualified PCPs include physicians and nurse practitioners. These qualified PCPs may delegate under direct supervision to a PA, RN, LPN, or certified medical assistant.

2. Prior to performing topical fluoride varnish applications, qualified

PCPs shall receive either continuing medical education (CME) or CME-equivalent training in fluoride varnish application approved by either the American Academy of Pediatrics or the American Academy of Family Physicians. Documentation of approved training shall be provided by the qualified PCP to the Health Plan, as well as by the Health Plan to DHS upon request.

B. Immunizations

1. Health Plans shall provide recommended vaccinations, including those recommended by the CDC's Advisory Committee on Immunization Practices, as well as those recommended by other advisory bodies recognized by the State or state authorities such as the Hawaii State Department of Health. Refer to §3.8.C.2 for Health Plan responsibilities regarding the Hawaii Immunization Registry and VFC Program.

2. DHS may provide additional guidance on Health Plan and Provider participation in the DOH Hawaii Immunization Registry during the Contract period. The Health Plan shall transmit any provider-specific guidance from DHS to providers, as appropriate, and align its protocols as needed.

C. Nutrition Counseling

1. This service is provided by a licensed dietitian. This preventive health service includes nutrition counseling for diabetes, obesity, and other metabolic conditions, and when Medical Necessity is established for other medical conditions. Nutrition counseling requires a physician's order and shall be part of a treatment program to mitigate the effects of a medical condition.

D. Preventive Services

1. The Health Plan is required to cover preventive services for adult health, pediatrics, and adolescent health as defined in §2.6. The Health Plan is responsible for monitoring and maintaining current knowledge of these guidelines and standards. DHS will provide monitoring and oversight to ensure the Health Plan implemented the latest guidelines and standards.

E. Diabetes Self-Management Education (DSME)

1. The Health Plan shall cover American Diabetes Association-recognized or American Association of Diabetes Educators-accredited DSME programs for qualifying Members with diabetes or gestational diabetes. DSME programs shall be encouraged to make education and marketing materials culturally relevant by incorporating local languages and reflecting the Members' values, attitudes, practices, and beliefs.

F. Smoking Cessation Services

1. The Health Plan shall make available a comprehensive smoking cessation treatment program for all Members who smoke.

2. Services shall be accessible statewide and include tobacco cessation medications approved by the U.S. Food and Drug Administration (FDA) and counseling, preferably in a combined approach. No prior authorization or step therapy shall be required for treatment.

3. 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 be consistent with the treating tobacco use and dependence

practice guidelines issued by the AHRQ, and consist of:

a. Counseling: at least four (4) counseling sessions of at least ten (10) minutes each per quit attempt, including individual, group, or phone counseling. Two (2) effective components of counseling, practical counseling (problem-solving/skills training), and social support delivered as part of the treatment, shall be emphasized.

b. Smoking cessation counseling services shall be provided by the following licensed providers who have been trained on this service and are functioning within their scope of practice:

    1) Physician;

    2) Dentist;

    3) Psychologist;

    4) Clinical social worker in behavioral health;

    5) APRNs;

    6) Mental health counselor; and

    7) Certified tobacco treatment specialists under the supervision of a licensed provider.

c. Medications: The Health Plan shall cover all tobacco cessation medications approved by the FDA as effective treatments for smoking cessation, including both nicotine and non-nicotine agents. Effective medication combinations shall also be covered.

d. No out-of-pocket cost or co-payments shall be required for

tobacco cessation counseling or medications.

4.3 Coverage Provisions for Early and Periodic Screening, Diagnostic, and Treatment Services for Children

A. The Health Plan shall provide EPSDT services to the Members younger than twenty-one (21) years of age, including foster children and adopted children receiving subsidies. 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, diagnostic, and treatment services.

B. The Health Plan shall cover services when Medical Necessity is established under EPSDT to treat a condition detected at an EPSDT screening visit or other medical appointment.

C. The Health Plan shall provide additional medical services to correct or ameliorate defects of physical, mental/emotional, or dental illness, and conditions discovered as a result of EPSDT screens when Medical Necessity is established. Examples of additional services include, but are not limited to, prescription drugs not on the Health Plan's formulary if approved by the FDA for the indication for which prescribed, DME typically not covered for adults, and certain non-experimental medical and surgical procedures.

D. The Health Plan shall be responsible for medical services related to dental needs as described. The Health Plan shall provide all diagnostic and treatment services when Medical Necessity is established to correct or ameliorate a medical, dental, or behavioral

health problem discovered during an EPSDT screen or other visits as described in the Health Plan Manual.

E. Screening for developmental delays and behavioral health conditions shall be done using standardized, validated screening tools as recommended by current national guidelines, DOH pediatric guidelines, and the Health Plan Manual.

F. 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 ensure 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 §4.2.

G. The Health Plan is not responsible for providing health interventions when Medical Necessity is not established or is deemed experimental as defined in HAR 17-1700.2.

H. The Health Plan shall be responsible for training providers on EPSDT program requirements.

I. The Health Plan shall develop an EPSDT plan that includes, but is not limited to, written policies and procedures for outreach, informing, tracking, and compliance monitoring. The Health Plan shall submit its EPSDT plan in accordance with §13.3.B to DHS upon request.

4.4 Coverage Provisions for Behavioral Health

A. Health Plan Coverage Responsibilities

1. General Requirement for Behavioral Health Integration

a. For both adult and child Members, the Health Plan shall provide integrated physical and behavioral healthcare as described in §3.2. Some of the integrated models and services include:

1) The Collaborative Care Model is a specific model for behavioral health integration that typically is provided by a primary care team consisting of a primary care provider and a care manager who works in collaboration with a psychiatric consultant, such as a psychiatrist.

2) Medication-assisted treatment is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-person approach to the treatment of SUDs. Medications used are approved by the FDA and are clinically driven and tailored to meet each patient's needs.

3) SBIRT is an evidence-based approach to delivering early intervention treatment services for persons with SUDs, and those at risk for developing a SUD.

2. Standard Behavioral Health Services for Adults and Children

a. The Health Plan shall be responsible for providing standard behavioral health services to all Members, both adults and children. The Health Plan is not responsible for standard behavioral health services for the Members that are receiving their behavioral health services from the CCS program as described in §4.4.B. The Health Plan shall follow the financial responsibility guideline in the Health Plan manual. The Health Plan shall provide behavioral health services to persons who have been involuntarily committed for evaluation and treatment under the provisions of HRS Chapter 334 when Medial Necessity is established by the Health Plan's utilization

review procedures. Even if court ordered diagnostic, treatment, or rehabilitative services are not determined to meet Medical Necessity criteria, the costs of continuing care under court order shall be borne by the Health Plan.

b. A Member's access to behavioral health services shall be no more restrictive than for accessing medical services (§4.4.A.9). The Health Plan shall make available triage lines or screening systems, and allow the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions, when applicable. The Health Plan shall not apply any financial requirement or treatment limitation to mental health or SUD benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to the Members, whether or not the benefits are furnished by the same Health Plan.

c. 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 HRS §706-607, or individuals who are committed to the Hawaii Youth Correctional Facility.

d. The psychiatric evaluation and treatment of the Members who have been criminally committed to ambulatory mental healthcare settings, including those with legal encumbrances to DOH, shall be the clinical responsibility of the appropriate state agency. The Health Plan shall remain responsible for providing medical services to these

criminally committed Members. In addition, the Health Plan may be billed for standard behavioral health services provided to these Members.

e. 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.

3. Ambulatory Mental Health Services

a. The Health Plan shall provide coverage for ambulatory mental health services, which includes twenty-four (24) hour access line, mobile crisis response, crisis stabilization, crisis management, and crisis residential services. Health Plans shall have a contract for crisis services with the DOH, AMHD.

4. Psychotropic Medications and Medication Management

a. The Health Plan shall provide coverage for medications and medication management, which includes the evaluation, prescription, maintenance of psychotropic medications, medication management/counseling/education, promotion of algorithms, and guidelines.

5. Inpatient Psychiatric Hospitalizations

a. The Health Plan shall provide coverage for inpatient psychiatric hospitalization which includes room/board, nursing care, medical supplies, equipment, medications and medication management, diagnostic services, psychiatric and other behavioral health practitioner services, ancillary

services, and other services when Medical Necessity is established.

6. Psychiatric or Psychological Evaluation and Treatment

   a. The Health Plan shall be responsible for providing coverage for psychiatric or psychological evaluation and treatment and 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.

7. SUD Treatment

   a. The Health Plan shall provide coverage for both inpatient and outpatient SUD treatment when Medical Necessity is established. A Member's access to SUD treatment shall be no more restrictive than for accessing medical services. SUD treatment shall be provided in a treatment setting accredited according to the standards established by the ADAD.

   b. The Health Plan shall maintain a robust provider network that includes treatment providers that are closely aligned with the currently existing community-based providers that are accredited and monitored by ADAD to the extent possible.

   c. The availability and accessibility of inpatient and outpatient substance use treatment for pregnant and parenting women

and their children.

d. The Health Plan shall contract with SUD treatment providers that are closely aligned with the currently existing community-based providers that are accredited and monitored by ADAD to the extent possible.

e. Certified Substance Abuse Counselors (CSACs) shall be certified by ADAD.

f. The Health Plan shall provide coverage to its Members for all medication the FDA has approved for specific SUDs. The Health Plan may develop its own payment methodologies in accordance with §7.2.D for FDA-approved medications.

1) Methadone, Opioid Medication, and Other Medication to Treat SUD – The Health Plan shall support practice utilization of medication-assisted treatment for substance use conditions across the continuum of services from primary care to specialty behavioral health services as described in §4.4.A.1.a.2. The Health Plan shall provide coverage for Methadone/Levomethadyl acetate services for the Members for acute opiate detoxification as well as maintenance.

8. Covered Benefit Requirements for Parity in Mental Health and Substance Use Disorders

a. In addition to services under the state plan, the Health Plan shall provide coverage for any services necessary for compliance with the requirement for parity in mental health and SUD benefits in 42 CFR Part 438, Subpart K.

b. If the Health Plan does not include an aggregate lifetime or annual dollar limit on any medical/surgical benefits or includes an aggregate lifetime or annual dollar limit that applies to less than one-third of all medical/surgical benefits provided to the Members through a contract with the State, it may not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or SUD benefits in accordance with 42 CFR §438.905(b).

c. If the Health Plan includes an aggregate lifetime or annual dollar limit on at least two-thirds of all medical/surgical benefits provided to the Members through a contract with the State, it shall either apply the aggregate lifetime or annual dollar limit both to the medical/surgical benefits to which the limit would otherwise apply and to mental health or SUD benefits in a manner that does not distinguish between the medical/surgical benefits and mental health or SUD benefits; or not include an aggregate lifetime or annual dollar limit on mental health or SUD benefits that is more restrictive than the aggregate lifetime or annual dollar limit, respectively, on medical/surgical benefits in accordance with 42 CFR §438.905(c).

d. If the Health Plan includes an aggregate lifetime limit or annual dollar amount that applies to one-third or more, but less than two-thirds of all medical/surgical benefits provided to the Members, it shall either impose no aggregate lifetime or annual dollar limit on mental health or SUD benefits; or impose an aggregate lifetime or annual dollar limit on mental health or SUD benefits that is no more restrictive

than an average limit calculated for medical/surgical benefits in accordance with 42 CFR §438.905(e)(ii).

e. The Health Plan shall not apply any financial requirement or treatment limitation to mental health or SUD benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to Members, whether or not the benefits are furnished by the same Health Plan.

f. If a Member is provided mental health or SUD benefits in any classification of benefits, inpatient, outpatient, emergency care, or prescription drugs, mental health or SUD benefits shall be provided to the Health Plan Member in every classification in which medical/surgical benefits are provided in accordance with 42 CFR §438.910(b)(2).

g. The Health Plan may not apply any cumulative financial requirements for mental health or SUD benefits in a classification, inpatient, outpatient, emergency care, prescription drugs, that accumulates separately from any established for medical/surgical benefits in the same classification.

h. The Health Plan may not impose Non-Quantitative Treatment Limits (NQTL) for mental health or SUD benefits in any classification unless, under the policies and procedures of the Health Plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or SUD benefits in the classification are comparable to, and are

applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification.

i. The Health Plan shall use processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for mental health or SUD benefits that are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for medical/surgical benefits in the same classification.

B. DHS and DOH Specialized Behavioral Health Benefits

1. The State provides for specialized behavioral health benefits in addition to the benefits the Health Plan shall cover in §4.4.A. While these benefits are not the responsibility of the Health Plan, the Health Plan does have coordination requirements for specialized behavioral health benefits as described in §3.8.B. This section describes the services themselves for the Health Plan's reference.

2. Behavioral Health Services for Children/Support for Emotional and Behavioral Development Program

a. While the Health Plan is responsible for providing coverage for behavioral health services set forth in §4.4.A, 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 CAMHD SEBD program. The CAMHD program is carved out of the Health Plan responsibilities. The services covered,

eligibility criteria, and requirements for the Health Plan to coordinate services with CAMHD are included in the Health Plan Manual.

b. The Health Plan shall provide medically necessary behavioral health services when medical necessity is established if the child does not meet the CAMHD eligibility criteria.

3. Comprehensive Behavioral Health Services for Adults

a. Adult Members age eighteen (18) years or older with a diagnosis of SMI or SPMI are eligible for comprehensive additional behavioral health services within the CCS program separate from this Contract. Those Members determined eligible by DHS shall receive their behavioral health services from the CCS program. DHS shall oversee all activities related to the CCS program.

b. CCS shall provide to its adult Members a full range of specialized behavioral health services including inpatient/outpatient therapy and tests to monitor the Member's response to therapy and intensive case management. Adult Members who are receiving services through CCS that require SUD treatment may also receive these services through CCS.

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

d. DHS has the sole authority to dis-enroll the Members from CCS. Reasons for disenrollment are included in the Health

Plan Manual.

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

f. DHS may enact joint Health Plan and CCS performance incentives for their Members with SMI or SPMI.

4.5 Coverage Provisions for Primary and Acute Care Services

A. 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 §4.1. The Health Plan shall comply with all state and federal laws pertaining to the provision of such services.

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

1. Cognitive Rehabilitation Services

a. The Health Plan shall provide coverage for cognitive rehabilitation services. Cognitive rehabilitation services are services provided to cognitively impaired persons, most commonly those with traumatic brain injury, that assess and treat communication skills, cognitive and behavioral ability, and cognitive skills related to performing ADLs. Additional information is included in the Health Plan Manual.

2. Diagnostic Testing

a. The Health Plan shall provide diagnostic testing to include, but is not limited to, screening and diagnostic radiology and imaging; screening and diagnostic laboratory tests; and other screening or diagnostic radiology or laboratory services when Medical Necessity is established.

b. Health Plans shall not require prior authorization of any laboratory, imaging, or diagnostic services other than the following:

1) Magnetic resonance imaging;

2) Magnetic resonance angiogram;

3) Positron emission tomography;

4) Reference lab tests that cannot be done in Hawaii and not specifically billable by clinical laboratories in Hawaii;

5) Disease-specific new technology lab tests;

6) Genetic test;

7) Psychological testing;

8) Neuropsychological testing;

9) Cognitive testing; or

10) Computerized tomography.

3. Dialysis

a. The Health Plan shall provide coverage of dialysis services when provided by participating Medicare-certified hospitals and Medicare-certified end stage renal disease (ESRD)

providers. The Health Plan shall ensure that services, equipment, supplies, diagnostic testing (including laboratory tests), and drugs for the dialysis treatment that are approved by Medicare are also covered by Medicaid provided when Medical Necessity is established. The Health Plan shall allow for dialysis treatments in all the following settings: hospital inpatient, hospital outpatient, non-hospital renal dialysis facility, or Members' homes. The Health Plan shall structure the provision of home dialysis to include those items in Medicare's global reimbursement for home dialysis. All facilities providing maintenance renal dialysis treatments to the Members shall be certified as meeting the conditions for compliance with Medicare health, safety, and other Medicare requirements. The Health Plan shall include the following as part of dialysis services:

1) Laboratory Tests including Hepatitis B surface antigen and Anti-HB testing for patients on hemodialysis, intermittent peritoneal dialysis, and continuous cycling peritoneal dialysis;
2) Hepatitis B vaccines;
3) Alfa Epoetin when provided during dialysis and the Health Plan is encouraged to follow evidence-based best practices about target hemoglobin/hematocrit levels;
4) Other drugs related to ESRD;
5) Home dialysis equipment and supplies prescribed by

a physician;

6) Continuous ambulatory peritoneal dialysis, a variation of peritoneal dialysis, that is an alternative mode for dialysis for home dialysis patients;

7) Physician's services; and

8) Inpatient hospitalization when the hospitalization is for an acute medical condition requiring dialysis treatments; or when a patient receiving chronic outpatient dialysis is hospitalized for an unrelated medical condition, or for placement, replacement, or repair of the chronic dialysis route.

4. Dental Services to Treat Medical Conditions

a. The Health Plan shall provide dental services to treat medical conditions when Medical Necessity is established. The Health Plan shall also be responsible for providing referrals, follow-ups, coordination, and provision of appropriate medical services related to dental needs when Medical Necessity is established.

b. The Health Plan shall provide coverage for 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 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 the Health Plan Manual.

c. Specifically, the Health Plan shall be responsible for:

1) Providing referral, follow-up, coordination, and provision of appropriate services, 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 and 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;

2) Providing sedation services associated with dental treatment, when performed in an acute care setting, by a physician anesthesiologist. 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;

3) Providing dental services performed by a dentist or physician that are needed due to a medical emergency, for example, car accident, where the services provided are primarily medical; and

4) 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.

d. 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.

e. In cases of medical disputes regarding coverage, the Health Plan's Medical Director shall consult with DHS' Medical Director to assist in defining and clarifying the respective responsibilities. DHS may make the final decisions if the issues are unclear or the dispute continues.

5. Durable Medical Equipment and Medical Supplies

a. The Health Plan is responsible for providing DME and medical supplies which include, but are not limited to, the following: oxygen tanks and concentrators; ventilators; wheelchairs; crutches and canes; eyeglasses; orthotic devices; prosthetic devices; hearing aids; pacemakers; medical supplies such as surgical dressings, continence supplies and ostomy supplies; foot appliances (orthoses, prostheses); orthopedic shoes and casts; orthodigital prostheses and casts; and other DME when Medical Necessity is established.

6. Emergency and Post Stabilization Services

a. 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.

b. The Health Plan shall establish a twenty-four (24) hour triage phone line in accordance with §9.4.I.

c. The Health Plan shall provide education to its Members on the appropriate use of emergency services, the availability of the twenty-four (24) hour triage phone line, and alternatives for the Members to receive non-emergent care outside of the emergency department.

d. Through the requirements of §8.1.C, Member access to providers through extended office hours or after-hours access will increase and is expected to decrease inappropriate emergency department usage. The Health Plan is encouraged to expand access beyond the minimum requirements of §8.1 to promote utilization of urgent care centers or after-hours care in order to prevent inappropriate emergency department usage.

e. An emergency medical condition shall not be defined or limited based on a list of diagnoses or symptoms as described in §2.6.

f. Emergency services shall be provided by qualified providers.

g. 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 to be provided on an emergent basis until the Member is stabilized when Medical Necessity is established. The Health Plan shall also pay any screening examination

services to determine whether an emergency medical condition exists.

h. 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. The Health Plan 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.

i. The emergency department physician, or the provider actually treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Health Plan, such that it shall be responsible for coverage and payment. The Health Plan is responsible for coverage and payment of emergency services when Medical Necessity is established. The Health Plan shall not refuse to cover emergency services based on the emergency department provider failing to notify the Member's PCP or the Health Plan within ten (10) days of presentation for emergency services. However, the Health Plan may deny reimbursement for any services provided on an emergent basis to an individual after the provider could reasonably

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

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

k. If an emergency screening examination leads to a clinical determination by the examining physician that an 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.

l. If a Member's PCP or other Health Plan representative instructs the Member to seek emergency services, then 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.

m. The Member who has an emergency medical condition shall not be liable for payment of a subsequent screening and treatment needed to diagnose the specific condition or

stabilize the Member.

n. Once the Member's condition is stabilized, the Health Plan may require pre-certification for hospital admission or prior authorization for follow-up care.

o. The Health Plan shall be responsible for providing post-stabilization care services twenty-four (24) hours a day, seven (7) days a week, as described in §2.6. Post-stabilization services include follow-up outpatient specialist care.

p. In the following situations, the Health Plan shall pay for post-stabilization services either pre-certified by a health plan provider or organization representative, or provided without authorization, regardless of whether the provider is within the Health Plan's provider network:

1) The Health Plan does not respond to the provider's request for pre-certification or prior authorization within one (1) hour;

2) The Health Plan cannot be contacted; or

3) 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.

a) The Health Plan's responsibility for post-stabilization services that it has not approved shall end when:

i. An in-network provider with privileges at thetreating hospital assumes responsibility for the Member's care;

ii. An in-network provider assumes responsibility for the Member's care through transfer;

iii. The Health Plan's representative and the treating physician reach an agreement concerning the Member's care; or

iv. The Member is discharged.

q. 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.

7. Family Planning Services

a. 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 may not restrict a Member's free choice of family planning services, supplies, or providers. Family planning

services include family planning drugs, supplies, and devices to include, but not be limited to, any FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling for all individuals with reproductive capacity. Same day access to family planning services shall be provided, as needed, with no prior authorization.

b. The Health Plan shall furnish all services on a voluntary and confidential basis to all Members.

8. Habilitation Services

a. The Health Plan shall be responsible for coverage of habilitative services and devices. Habilitative services and devices develop, improve, or maintain skills and functioning for daily living that were never learned or acquired to a developmentally-appropriate level. Skills and functioning for daily living, such as basic ADL, are typically learned or acquired during childhood development.

b. Habilitative Services and Devices include:

1) Audiology services;

2) Occupational therapy;

3) Physical therapy;

4) Speech-language therapy;

5) Vision services, and

6) Devices associated with these services including augmentative communication devices, reading devices, and visual aids but exclude those devices

used solely as school-based services or for activities at school when Medical Necessity has not been established.

c. If not otherwise covered in the benefits package, habilitative services and devices are covered when Medical Necessity is established.

d. Habilitative services do not include routine vision services that are found in §4.5.B.22.

9. Home Healthcare

a. The Health Plan shall provide coverage for home healthcare. Home health services are part-time or intermittent care for the 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 shall meet Medicare requirements.

b. Home health services include, but are not limited to:

1) Skilled nursing;

2) Home health aides;

3) Medical supplies and DME;

4) Therapeutic services such as physical and occupational, therapy; and

5) Audiology and speech-language pathology.

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

a. The Health Plan shall be responsible for coverage of inpatient hospital services for medical, surgical, maternity/newborn care, and rehabilitation services. These services include the cost of room and board for inpatient stays. The services include:

1) Nursing care;

2) Medical supplies, equipment, and drugs;

3) Diagnostic services, physical therapy, occupational therapy, audiology; and

4) Speech-language pathology services and other services in this category when Medical Necessity is established.

11. Other Practitioner Services

a. The Health Plan shall be responsible for coverage of other practitioner services. Other practitioner services include, but are not limited to:

1) Certified nurse midwife services;

2) Licensed APRN services;

3) Family, pediatric, and psychiatric health specialists;

4) Paraprofessionals including peer support specialists; and

5) Other practitioner services provided by a licensed or certified healthcare provider to include behavioral health providers such as psychologists, marriage and family therapists, mental health counselors, and

CSACs when Medical Necessity is established.

12. Outpatient Hospital Services

    a. The Health Plan shall be responsible for coverage of outpatient hospital services. These services include:

    b. Twenty-four (24) hours a day, seven (7) days per week, emergency services;

    c. Outpatient surgical or other interventional procedures; urgent care services;

    d. Medical supplies, equipment, and drugs;

    e. Diagnostic services and therapeutic services including chemotherapy and radiation therapy; and

    f. Other services in this category when Medical Necessity is established.

13. Physician Services

    a. The Health Plan shall be responsible for coverage of physician services as described in Section 3 when Medical Necessity is established and provided at locations including, but not limited to:

        1) Physician's office;

        2) Clinic;

        3) Private home;

        4) Licensed hospital;

        5) Licensed skilled nursing or intermediate care facility; or

6) Licensed or certified residential setting.

14. Podiatry Services

a. The Health Plan shall be responsible for coverage of podiatry services. Podiatry services shall include, but are not limited to, the treatment of conditions of the foot and ankle such as:

1) Professional services not involving surgery that are provided in an office or clinic;

2) Professional services not involving surgery related to diabetic foot care in the outpatient and inpatient hospital;

3) Surgical procedures that are limited to those involving the ankle and below;

4) Diagnostic radiology procedures limited to the ankle and below;

5) Foot and ankle care related to the treatment of infection or injury is covered in an office or outpatient clinic setting; and

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

15. Pregnancy-Related Services – Services for Pregnant Women and Expectant Parents

a. The Health Plan shall provide pregnant women with any pregnancy-related services for the health of the woman and her fetus without limitation, during the woman's pregnancy

and up to sixty (60) days post-partum when Medical Necessity is established.

b. The following services are covered under pregnancy-related services:

1) Prenatal care;

2) Radiology, laboratory, and other diagnostic tests;

3) Treatment of missed, threatened, and incomplete abortions;

4) Delivery of the infant and post-partum care;

5) Prenatal vitamins;

6) Screening, diagnosis, and treatment for pregnancy- related conditions, to include SBIRT, screening for maternal depression, and access to necessary behavioral and substance use treatment orsupports

7) Lactation support for at least six months;

8) Breast pump, purchased or rented for at least six months;

9) Educational classes on childbirth, breastfeeding, and infant care;

10) Counseling on healthy behaviors, to include prevention and harm reduction; and

11) Inpatient hospital services, physician services, other practitioner services, and any other services that impact pregnancy outcomes.

c. The Health Plan is prohibited from limiting benefits for post-partum 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.

d. The Health Plan is prohibited from:

1) 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);

2) Penalizing, reducing, or limiting the reimbursement of an attending provider because the provider provided care in a manner consistent with NMHPA; or

3) Providing incentives, including monetary or otherwise, to an attending provider to induce the provider to provide care inconsistent with NMHPA.

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

1) Access to appropriate levels of care based on medical, behavioral, or social need, including emergency care;

2) Transfer and care of pregnant or post-partum women,

newborns, and infants to tertiary care facilities when necessary;

3) Availability and accessibility of:

a) Appropriate outpatient and inpatient facilities capable of assessing, monitoring, and treating women with complex perinatal diagnoses; and

b) Obstetricians/gynecologists, including maternal fetal medicine specialists and neonatologists capable of treating the Members with complex perinatal diagnoses.

4) Perinatal care coordination for high-risk pregnant women provided through either a contracted community partner or through the Health Plan health coordination program.

16. Prescription Drugs

a. The Health Plan shall cover medications when Medical Necessity is established to optimize the Member's medical condition, including behavioral health prescription drugs for children receiving services from CAMHD. The Health Plan shall cover medication management and patient counseling that is included in this service. DHS allows and encourages the Health Plan to mail prescription medications.

b. For all covered outpatient drugs, as described in 42 CFR §438.3(s)(1), the Health Plan shall:

1) Provide coverage of outpatient drugs as defined in Section 1927(k)(2) of the Social Security Act, that

meets the standards for such coverage imposed by Section 1927 of the Act as if the standards applied directly to the Health Plan;

2) Establish procedures to exclude utilization data for covered outpatient drugs that are subject to discounts under the 340B drug pricing program form the reports required under Section 1927(s)(2) of the Act when states do not require submission of managed care drug claims data from covered entities directly;

3) Operate a drug utilization review (DUR) program that includes prospective drug review, retrospective drug use review, and an educational program as required in Section 1927(g) of the Act and 42 CFR part 456, subpart K; and

4) Conduct a prior authorization program that complies with the requirements of Section 1927(d)(5) of the Act.

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

d. The Health Plan shall develop a common formulary drug list for its program available in electronic and paper form. The Health Plan's formulary drug list shall include medications that covered both generic and name brand, over-the-counter medications included in the MSP, and a medication tier list.

e. The Health Plan shall make available the formulary drug list on their website in a machine-readable file and format as specified by CMS. In accordance with HRS §346-59.9, the 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 anti-depressant and anti-anxiety medications prescribed by a licensed psychiatrist or physician duly licensed in the state for an FDA-approved indication as treatment of a mental or emotional disorder. Similarly, in accordance with HRS §346-352, any physician licensed in the state who treats the Member suffering from the human immunodeficiency virus, acquired immune deficiency syndrome, or hepatitis C, or the 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 pre-authorization procedures.

f. The Health Plan shall inform its providers in writing, at least thirty (30) days in advance, of any drugs deleted from its formulary. The Health Plan shall establish and inform providers of the process for obtaining coverage of a drug not on the Health Plan's formulary. At a minimum, the Health Plan shall have a process to provide an emergency supply of medication for at least seven (7) days to the Member until the Health Plan can make a Medical Necessity determination regarding new drugs.

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

h. Conduct a prior authorization program that complies with the requirements of Section 1927(d)(5) of the Act.

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

j. 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 the Members.

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

17. Rehabilitation Services

a. The Health Plan shall be responsible for coverage of rehabilitation services. These services include physical and occupational therapy, audiology, and speech-language pathology. These services shall be provided by licensed physical therapist (PT), licensed occupational therapist registered (OTR), licensed audiologist, and licensed speech pathologist respectively. A PT assistant or a certified occupational therapy assistant may be utilized as long as they are working under the direct supervision of either a PT or OTR, respectively.

b. Rehabilitation services are limited to those who expect to improve in a reasonable period of time. Prior authorization is required for all rehabilitation services except for the initial evaluation. Rehabilitation services for children under EPSDT have different requirements as described in §4.3.

18. Sterilizations and Hysterectomies

a. In compliance with federal regulations, 42 CFR §441.255,

the Health Plan shall cover sterilizations for both men and women only if all the following requirements are met as described in the Health Plan Manual:

1) The Member is at least twenty-one (21) years of age at the time consent is obtained;

2) The Member is mentally competent;

3) The Member voluntarily gives informed consent by completing the Sterilization Required Consent Form included in the Health Plan Manual;

4) The provider completes the Sterilization Required Consent Form included in the Health Plan Manual;

5) 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 shall have been given at least thirty (30) days before the expected date of delivery. The expected date of delivery shall be provided on the consent form;

6) An interpreter is provided when language barriers exist. Arrangements are to be made to effectively communicate the required information to the Member

who is visually impaired, hearing impaired, or otherwise disabled;

7) The Member is not institutionalized in a correctional facility, mental hospital, or other rehabilitative facility; and

8) If the Member is incapacitated pursuant to HRS §560:5-102, then a court order pursuant to HRS §§560:5-601 through 608 is required and the required amount of time shall pass pursuant to HRS §560:5-609.

b. The Health Plan shall cover a hysterectomy only if the following requirements are met:

1) The Member voluntarily gives informed consent by completing the Hysterectomy Acknowledgement Form (Health Plan Manual);

2) 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;

3) The Member has signed and dated a Sterilization Required Consent Form (Health Plan Manual), prior to the hysterectomy; and

4) An interpreter is provided when language barriers exist. Arrangements are to be made to effectively

communicate the required information to the Member who is visually impaired, hearing impaired, or otherwise disabled.

5) If the Member is incapacitated pursuant to HRS §560:5-102, then a court order pursuant to HRS §§560:5-601 through 608 is required and the required amount of time shall pass pursuant to HRS §560:5-609.

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

1) It is performed solely for the purpose of rendering the Member permanently incapable of reproducing;

2) 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

3) It is performed for the purpose of cancer prophylaxis when not medically indicated.

d. The Health Plan shall maintain documentation of all sterilizations and hysterectomies and provide documentation to DHS upon the request of DHS.

e. All financial penalties assessed by the federal government and imposed on 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.

19. Sleep Laboratory Services

    a. The Health Plan shall be responsible for coverage of 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.

    b. Sleep laboratory service providers shall be accredited by the American Academy of Sleep Medicine.

20. Transplants

    a. The Health Plan shall be responsible for coverage of cornea transplants and bone grafts. The Health Plan shall follow written standards that provide for similarly situated Members to be treated alike and for any restriction on facilities or practitioners to be consistent with the accessibility of high-quality care to the Members. The Health Plan shall make their written standards available to DHS upon DHS' request.

21. Urgent Care Services

    a. The Health Plan shall provide coverage for urgent care services as necessary. The Health Plan can require prior authorization or pre-certification.

22. Vision and Hearing Services

    a. The Health Plan shall cover a routine eye exam provided by qualified optometrist once in a twelve (12)-month period for the Members under the age of twenty-one (21) years, and once in a twenty-four (24)-month period for adults age

twenty-one (21) years and older. Visits done more frequently may be allowed if prior authorization is approved and covered when Medical Necessity is established. Emergency eye care shall be covered without prior authorization.

b. The Health Plan shall provide coverage for prescription lenses, cataract removal, and prosthetic eyes for all Members. Cornea (keratoplasty) transplants shall be provided in accordance with the Hawaii Administrative Rules. Excluded vision services include:

1) Orthoptic training;

2) Prescription fee;

3) Progress exams;

4) Radial keratotomy;

5) Visual training; and

6) Lasik procedure.

c. Visual aids prescribed by ophthalmologists or optometrists (eyeglasses, contact lenses, and miscellaneous vision supplies) are covered by the Health Plan, when Medical Necessity is established. These include costs for the lens, frames, or other parts of the glasses, as well as fittings and adjustments. Visual aids are covered once in a twenty-four (24) month period. Individuals under forty (40) years of age require a medical justification for bifocals.

d. Replacement glasses and/or new glasses with significant changes in prescription are covered within the benefit

periods for both adults and children with prior authorization. Contact lenses are only covered when Medical Necessity is established. Dispensing of the visual aids begins anew after each twenty-four (24)-month period since the prior dispensing.

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

f. Hearing services include, but are not limited to the following services detailed in Table 3: 4.5. below:

Table 3: 4.5. Hearing Services

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

Hearing aid device coverage is for both analog and digital models. Hearing aids are covered once in a twenty-four (24)-month period. Prior authorization is required for all hearing aid devices. The coverage of hearing devices shall include a service/loss/damage warranty, a trial or rental period, and reasonable reimbursement as set forth by DHS. The Health Plan shall develop a policy of providing hearing aids when medically justified. The Health Plan shall consider medically-justified requests for services outside capped

dollar amounts or frequency of replacement. The Health Plan can make exceptions for Medical Necessity as needed.

23. Palliative Care

    a. Palliative care is a specialized medical service designed for individuals with serious illnesses, provided in non-hospital, community-based settings. A serious illness is defined as a condition that carries a high risk of mortality and severely impacts daily functioning, quality of life, or places excessive strain on caregivers. The focus of palliative care is to offer relief from the symptoms and stress of serious illness, improving quality of life for both the individual and their family, and it is applicable at any stage of the illness, irrespective of curative treatment.
    b. The heath plan shall provide palliative care to members in the community as described in the Health Plan manual.

4.6 Coverage Provisions for Transportation Services

A. Non-Emergency Medical Transportation

1. The Health Plan shall provide transportation to and from Medicaid covered medical appointments when Medical Necessity is established for the Members who have no means of transportation and who reside in areas not served by public transportation or cannot access public transportation. Transportation services include both emergency and non-emergency ground and air services.
2. The Health Plan shall also provide transportation to the Members who are referred to a provider that is located on a different island or in a different service area. The Health Plan may use whatever

modes of transportation that are available and can be safely utilized by the Member. In cases where the Member is a minor or requires assistance, the Health Plan shall provide for one (1) attendant to accompany the Member to and from visits to providers when Medical Necessity is established. The Health Plan is responsible for the arrangement and payment of the travel costs (airfare, ground transportation, lodging, and meals) for the Member and the one (1) attendant (where applicable) associated with off-island or out-of- state travel due to Medical Necessity.

3. 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.
4. Should the Member be dis-enrolled from their QI Health Plan and enrolled into the Medicaid FFS program or another QI Health Plan while off-island or out-of-state, the former QI Health Plan shall be responsible for the return of the Member to the island of residence and for transitioning care to the Medicaid FFS program or the other QI Health Plan.

B. Non-medical transportation (NMT)

1. The Health Plan shall provide NMT services to and from CIS+ or HCBS services for Members receiving such services, as authorized in the Member's care plan. NMT must be provided in alignment with applicable technical specifications and safeguards required under 1915(c) waiver or 1915(i) state plan authorities.

4.7 Coverage Provisions for Community Integration Services Plus (CIS+)

A. Housing Navigation Supports, including:

1. Pre-tenancy supports – as described in §3.7 and the Health Plan Manual.
2. Tenancy sustaining services – as described in §3.7 and the Health Plan Manual.

B. Medical Respite, including:

1. Short-term pre-procedure housing – as described in §3.7 and the Health Plan Manual.
2. Short-term recuperative care – as described in §3.7 and the Health Plan Manual.
3. Short-term post-hospitalization housing – as described in §3.7 and the Health Plan Manual.

C. Non-medical transportation services may be provided to and from CIS+ services, as authorized in the Member's care plan. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the MSP, defined at 42 CFR §440.170(a), if applicable, and shall not replace them.

4.8 Coverage Provisions for Long-Term Services and Supports

A. The Health Plan shall provide coverage of the LTSS for individuals in both HCBS and institutions as part of their benefit package when meeting the health coordination requirements as described in Section 3 and the Health Plan Manual. HCBS should be provided to individuals that choose to receive their LTSS in the community instead of in an institutional setting. The Health Plan shall comply with all state and federal laws pertaining to the provision of such services, including, but not limited to, the requirement that HCBS shall be provided in a setting which complies with the 42 CFR §441.301(c)(4) requirements for home and community-based settings. All authorized LTSS shall be documented in the Member's

HAP as described in §3.7.

B. Access to LTSS Benefits

1. Access to HCBS When Not Meeting Institutional LOC

a. The Health Plan shall provide the following HCBS to individuals who are at risk of deteriorating to the institutional LOC (the at-risk population):

1) Adult day care;

2) Adult day health;

3) Home-delivered meals;

4) Personal assistance;

5) Personal emergency response system (PERS); and/or

6) PDN.

b. DHS may impose limits on the number of hours of HCBS or the budget for such services. DHS will provide the Health Plan with information on at-risk limits in the Health Plan Manual.

2. Access to LTSS When Meeting Institutional LOC

a. Once DHS approves the institutional LOC for the Member in accordance with §3.7, the Health Plan is responsible for covering the LTSS benefits when Medical Necessity is established.

C. Description of LTSS Benefits

1. The Health Plan shall provide coverage of the following services:

a. Acute Waitlisted ICF/SNF

1) Acute waitlisted ICF/SNF means either ICF or SNF LOC services provided in an acute care hospital in an acute care hospital bed. The Health Plan shall identify individuals who are acute waitlisted ICF/SNF for discharge to a more appropriate location for treatment.

b. Adult Day Care

1) Adult day care is defined as regular supportive care provided to four (4) or more disabled adult participants. Adult day care services include observation and supervision by center staff, coordination of behavioral, medical, and social plans, and implementation of the instructions as listed in the participant's HAP. Therapeutic, social, educational, recreational, and other activities are also provided as regular adult day care services.

2) Adult day care staff members may not perform healthcare-related services such as medication administration, tube feedings, and other activities which require healthcare-related training. All healthcare-related activities shall be performed by qualified and/or trained individuals only, including family members and professionals, such as an RN or LPN, from an authorized agency.

c. Adult Day Health

1) Adult day health refers to an organized day program

of therapeutic, social, and health services provided to adults with physical, or mental impairments, or both, which require nursing oversight or care. The purpose is to restore or maintain, to the fullest extent possible, an individual's capacity for remaining in the community.

2) Each program shall have nursing staff sufficient in number and qualifications to meet the needs of participants. Nursing services shall be provided under the supervision of an RN. If there are Members admitted who require skilled nursing services, the services will be provided by an RN or under the direct supervision of an RN.

3) In addition to nursing services, other components of adult day health services may include: emergency care, dietetic services, occupational therapy, physical therapy, physician services, pharmaceutical services, psychiatric or psychological services, recreational and social activities, social services, speech-language pathology, and transportation services.

d. Assisted Living Facility (ALF) Services

1) ALF services include personal care and supportive care services, including homemaker, chore, PCS, and meal preparation that are furnished to the Members who reside in an ALF. ALF services are defined in §2.6. Payment for room and board is prohibited. Members receiving ALF services shall be receiving

ongoing CCMA services.

2) CCMA services as described in §2.6 and the Health Plan Manual.

a) The Health Plan shall contract with CCMA agencies for services.

e. Attendant Care

1) Attendant care is the hands-on care, both supportive and health-related in nature, provided to children. The service includes the Member supervision specific to the needs of a medically stable, physically disabled child. Attendant care may include skilled or nursing care to the extent permitted by law. Housekeeping activities that are incidental to the performance of care may also be furnished as part of this activity. Supportive services, a component of attendant care, are those services that substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. Attendant care services may be self-directed as personal assistant delegated services.

2) CCFFH Services

a) CCFFH services, attendant care for adults, are personal care, nursing, homemaker, chore, companion services, and

medication oversight (to the extent permitted under state law) provided in a State-certified private home by a principal care provider who

lives in the home. CCFFH may accept up to three adults each.

f. Counseling and Training

1) Counseling and training activities include the following: Member care training for the Members, family and caregivers regarding the nature of the disease and the disease process; methods of transmission and infection control measures; biological, psychological care and special treatment needs/regimens; employer training for consumer-directed services; instruction about the treatment regimens; use of equipment specified in the HAP; employer skills updates as necessary to safely maintain the individual at home; crisis intervention; supportive counseling; family therapy; suicide risk assessments and intervention; death and dying counseling; anticipatory grief counseling; SUD counseling; and/or nutritional assessment and counseling on coping skills to deal with the stress caused by the Member's deteriorating functional, medical, or mental status.

2) Counseling and training is a service provided to the Members, families/caregivers, and professional and paraprofessional caregivers on behalf of the Member. Counseling and training services may be provided individually or in groups. This service may be provided at the Member's residence or an alternative site.

g. Environmental Accessibility Adaptations

1) Environmental accessibility adaptations are those physical adaptations to the Member's home, required by the individual's HAP, which are established to meet Medical Necessity criteria to ensure the health, welfare, and safety of the individual, or which enable the individual to function with greater independence in the home, without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the individual. Window air conditioners may be installed when it is necessary for the health and safety of the Member.

2) Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable state or local building codes.

h. Home-Delivered Meals

1) Home-delivered meals are nutritionally sound meals delivered to a location where an individual resides,

excluding residential or institutional settings. Per CFR §441.310, the meals shall not exceed more than two (2) meals a day. Home-delivered meals are provided to individuals who cannot prepare nutritionally-sound meals without assistance and are assessed to require the service in order to remain independent in the community and to prevent institutionalization.

i. Home Maintenance

1) Home maintenance is a service necessary to maintain a safe, clean, and sanitary environment. Home maintenance services are those services not included as a part of personal assistance and include: heavy duty cleaning, which is utilized only to bring a home up to acceptable standards of cleanliness at the inception of service to the Member; minor repairs to essential appliances limited to stoves, refrigerators, and water heaters; and fumigation or extermination services. Home maintenance is provided to individuals who cannot perform cleaning and minor repairs without assistance and are assessed, to require the service in order to prevent institutionalization.

j. Moving Assistance

1) Moving assistance is provided in rare instances when it is assessed by the Health Coordination Team that the Member needs to relocate to a new home. The following are the circumstances under which moving assistance can be provided to the Member: unsafe

home due to deterioration; the Member is wheelchair-bound, living in a multi-story building with no elevator and where the Member lives above the first floor; the home is unable to support the Member's additional needs for equipment; the Member is evicted from their current living environment; or the Member is no longer able to afford the home due to a rent increase. Moving expenses include packing and moving of belongings.

k. Non-Medical Transportation

1) Non-medical transportation is a service offered to enable individuals to gain access to community services, activities, and resources, specified by the HAP. This service is to be used only when transportation is not included in the HCBS service being accessed. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the MSP, defined at 42 CFR §440.170(a) (if applicable), and shall not replace them. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized. Members living in a residential care setting or a CCFFH are not eligible for this service.

l. Nursing Facility, Skilled Nursing Facility, or Intermediate Care Facility Services

1) Nursing facility services are provided to the Members who need twenty-four (24) hours a day assistance

with ADLs and IADLs and need care provided by licensed nursing personnel and paramedical personnel on a regular, long-term basis. Nursing facility services are provided in a freestanding or a distinct part of a facility that is licensed and certified as meeting the requirements of participation to provide skilled nursing, health-related care and rehabilitative services on a regular basis in an inpatient facility. The care that is provided in a nursing facility includes independent and group activities, meals and snacks, housekeeping and laundry services, nursing and social work services, nutritional monitoring and counseling, pharmaceutical services, and rehabilitative services.

m. PERS

1) PERS is a twenty-four (24) hour emergency assistance service which enables the Member to secure immediate assistance in the event of an emotional, physical, or environmental emergency. PERS are individually designed to meet the needs and capabilities of the Member and includes training, installation, repair, maintenance, and response needs.

2) A Member may access PERS using an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The Member may also wear a portable "help" button to allow for mobility. The system is connected to the

person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. The following are allowable types of PERS items:

a) 24-hour answering or paging;
b) Beepers;
c) Med-alert bracelets;
d) Medication reminder services;
e) Intercoms;
f) Life lines;
g) Fire/safety devices, such as fire extinguishers and rope ladders;
h) Monitoring services;
i) Light fixture adaptations (e.g., blinking lights, etc.);
j) Telephone adaptive devices not available from the telephone company; and
k) Other electronic devices or services designed for emergency assistance.

3) All types of PERS, described above, shall meet standards of manufacture, design, and installation. Repairs to and maintenance of such equipment shall be performed by the manufacturer's authorized dealers whenever possible.

4) PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, have no regular caregiver for extended periods of time, and who would otherwise require extensive

routine supervision. PERS services will only be provided to the Member residing in a non-licensed setting except for an ALF.

n. Residential Care Services

1) Residential care services are PCS, nursing, homemaker, chore, companion services, and medication oversight (to the extent permitted by law) provided in a licensed private home by a principle care provider who lives in the home.

2) Residential care is furnished:

a) In a Type I E-ARCH, allowing five (5) or fewer residents provided that up to six (6) residents may be allowed at the discretion of DHS to live in a Type I home with no more than three (3) residents of whom may be NF LOC; or

b) In a Type II E-ARCH, allowing six (6) or more residents, where no more than twenty (20) percent of the home's licensed capacity may be individuals meeting a NF LOC who receive these services in conjunction with residing in the home.

3) The Members receiving residential care services shall be receiving ongoing CCMA services.

o. Respite Care

1) Respite care services are provided to individuals unable to care for themselves and are furnished on a short-term basis because of the absence of or need for relief for those persons normally providing the

care. Respite may be provided at three (3) different levels: hourly, daily, and overnight.

2) Respite care may be provided in the following locations: individual's home or place of residence; CCFFH; E-ARCH; Medicaid-certified nursing facility; licensed respite day care facility; or other community care residential facility approved by the State. Respite care services are authorized by the Member's PCP as part of the Member's HAP. Respite services may be self-directed.

p. PDN

1) PDN is a service provided to the Members requiring ongoing nursing care at home or in the community, in contrast to home health or part time, intermittent skilled nursing services under the MSP. The service is provided by licensed nurses, as defined in HRS, Section 457, within the scope of state law, consistent with physician's orders and in accordance with the Member's HAP. PDN services may be self-directed under personal assistance level II/delegated using nurse delegation procedures as outlined in HRS §457-7.5 and the Health Plan Manual.

q. Specialized Medical Equipment and Supplies

1) Specialized medical equipment and supplies entails the purchase, rental, lease, warranty costs, assessment costs, installation, repairs and removal of devices, controls, or appliances, specified in the HAP, that enable individuals to increase and/or maintain

their abilities to perform ADL, or to perceive, control, participate in, or communicate in the environment in which they live.

2) This service also includes items necessary for life support, ancillary supplies, and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the MSP. All items shall meet standards of manufacture, design, and installation and may include:

a) Specialized infant car seats;
b) Modification of parent-owned motor vehicle to accommodate the child, for example, wheelchair lifts;
c) Intercoms for monitoring the child's room;
d) Shower seat;
e) Portable humidifiers;
f) Electric utility bills specific to electrical life support devices (e.g., ventilator, oxygen concentrator);
g) Medical supplies;
h) Heavy duty items including but not limited to patient lifts or beds that exceed $1,000 per month;
i) Rental of equipment that exceeds $1,000 per month such as ventilators;
j) Emergency back-up generators specific to electrical life support devices (ventilator, oxygen

concentrator); and

k) Miscellaneous equipment such as customized wheelchairs, specialty orthotics, and bath equipment that exceeds $1,000 per month.

3) Items reimbursed shall be in addition to any medical equipment and supplies furnished under the MSP and shall exclude those items which are not of direct medical or remedial benefit to the individual.

4) Specialized medical equipment and supplies shall be recommended by the Member's PCP.

r. Subacute Facility Services

1) Subacute facility services are provided in either a licensed nursing facility or a licensed and certified hospital in accordance with Hawaii Administrative Rules. Subacute facility services provide the Member with services that meet a LOC 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 the Members in a SNF. The subacute services shall be provided in accordance with the Hawaii Administrative Rules.

s. Personal assistance, services – Level I and Level II for Adults and Children

1) Personal assistance services, are services provided in an individual's home to help them with their IADLs and ADLs.

2) Personal assistance services Level I are provided to individuals, requiring assistance with IADLs in order to prevent a decline in the health status and maintain individuals safely in their home and communities. Personal assistance services Level I is for individuals who are not living with their family who perform these duties as part of a natural support. Legally responsible individuals (LRIs) may provide personal assistance services Level I when the LRI's role as a paid provider is authorized under the self-direction option and documented in the Member's care plan, in accordance with applicable federal and state requirements and safeguards. Personal assistance services Level I is limited to ten (10) hours per week for individuals who do not meet institutional level of care. Personal assistance services Level I may be self-directed and consist of the following:

   a) Companion Services
      i. Companion services, pre-authorized by the health coordinator in the member's health action plan, means non-medical care, supervision and socialization provided to a member who is assessed to need these services. Companions may assist or

supervise the individual with such tasks as meal preparation, laundry and shopping/ errands, but do not perform these activities as discrete services. Providers may perform light housekeeping tasks that are incidental to the care and supervision of the individual.

b) Homemaker/Chore Services

i. Homemaker/Chore services means any of the activities listed below, when the individual that is regularly responsible for these activities is temporarily absent or unable to manage the home and care for himself/herself or others. Homemaker/chore services, pre-authorized by the health coordinator in the member's health action plan, are of a routine nature and shall not require specialized training or professional skills such as those possessed by a nurse or home health aide. The scope of homemaker/chore services specified in this section shall cover only the activities that need to be provided for the member, and not for other members of the household.

(1) Routine housecleaning such as sweeping, mopping, dusting, making

beds, cleaning the toilet and shower or bathtub, taking out rubbish;

(2) Care of clothing and linen by washing, drying, ironing, mending;

(3) Inventory and shopping for household supplies and personal essentials (not including cost of supplies);

(4) Light yard work, such as mowing the lawn;

(5) Simple home repairs, such as replacing light bulbs;

(6) Preparing meals;

(7) Running errands, such as paying bills, picking up medication;

(8) Escort to clinics, physician office visits or other trips for the purpose of obtaining treatment or meeting needs established in the health action plan, when no other resource is available;

(9) Standby/minimal assistance or supervision of activities of daily living such as bathing, dressing, grooming, eating, ambulation/mobility and transfer;

(10) Reporting and/or documenting observations and services provided, including observation of member

self-administered medications and treatments, as appropriate; and

(11) Reporting to the assigned provider, supervisor or designee, observations about changes in the member's behavior, functioning, condition, or self-care/home management abilities that necessitate more or less service.

3) Personal assistance services Level II are provided to individuals requiring assistance with moderate/substantial to total assistance to perform ADLs and health maintenance activities. Personal assistance services Level II shall be provided by a Home Health Aide (HHA), Personal Care Aide (PCA), Certified Nurse Aide (CNA) or Nurse Aide (NA) with applicable skills competency. LRIs may also be authorized to provide personal assistance services Level II when the LRI's role as a paid provider is authorized under the self-direction option and documented in the Member's care plan, in accordance with applicable federal and state requirements and safeguards. Personal assistance services Level II may be self-directed and consist of the following:

a) Personal hygiene and grooming, including bathing, skin care, oral hygiene, hair care, and dressing;

b) Assistance with bowel and bladder care;
c) Assistance with ambulation and mobility;
d) Assistance with transfers;
e) Assistance with medications, which are ordinarily self-administered when ordered by member's physician;
f) Assistance with routine or maintenance healthcare services by a personal care provider with specific training, satisfactorily documented performance, care coordinator consent and when ordered by member's physician;
g) Assistance with feeding, nutrition, meal preparation and other dietary activities;
h) Assistance with exercise, positioning, and range of motion;
i) Taking and recording vital signs, including blood pressure;
j) Measuring and recording intake and output, when ordered;
k) Collecting and testing specimens as directed;
l) Special tasks of nursing care when delegated by a registered nurse, for members who have a medically stable condition and who require indirect nursing supervision as defined in Chapter 16-89, HAR;
m) Proper utilization and maintenance of member's medical and adaptive equipment and supplies. Checking and reporting any equipment or supplies that need to be repaired or replenished;

n) Reporting changes in the member's behavior, functioning, condition, or self-care abilities which necessitate more or less service; and

o) Maintaining documentation of observations and services provided.

4) When personal assistance services Level II activities are the primary services, personal assistance services Level I activities identified on the health action plan, which are incidental to the care furnished or that are essential to the health and welfare of the member, rather than the member's family, may be provided.

t. CCMA Services

1) CCMA services are provided to Members living in Community Care Foster Family Homes and other community settings, as required. A health plan may, at its option, demonstrate the ability to provide CCMA services by contracting with an entity licensed under HAR Chapter 11-800 Subchapters 1 and 2.

2) The following activities are provided by a CCMA: continuous and ongoing nurse delegation to the caregiver in accordance with HAR Chapter 16-89, Subchapter 15; initial and ongoing assessments to make recommendations to health plans for, at a minimum, indicated services, supplies, and equipment needs of Members; ongoing face-to-face monitoring and implementation of the Member's care plan; and

interaction with the caregiver on adverse effects and/or changes in condition of Members. CCMAs shall: (1) communicate with a Member's physician(s) regarding the Member's needs including changes in medication and treatment orders; (2) work with families regarding service needs of Member and serve as an advocate for their Members; and (3) be accessible to the Member's caregiver twenty-four (24) hours a day, seven (7) days a week. CCMAs are agencies licensed by the DHS or its designee under HAR Chapter 11-800, Subchapters 1 and 2, to engage in locating, coordinating, and monitoring comprehensive services to residents in community care foster family homes or Members in E-ARCHS and assisted living facilities. A health plan may be a community care management agency.

2. Telehealth

   a. Members may receive certain HCBS remotely, including adult day care, adult day health, counseling, and training activities. Telehealth will be a secondary option for select services and must be at the option or preference of the Member.

   b. Members may receive level of care evaluations, assessments, and service planning telephonically or virtually. Telephonic or virtual options are available when appropriate and in accordance with the Member's service plan.

4.9 Other Services to be Provided by the Health Plan

A. Certification of Physical/Mental Impairment

1. The Health Plan shall provide coverage for all evaluations and re-evaluations of disabilities for its Members.

4.10 End of Life

A. Advance Care Planning

1. The Health Plan shall cover voluntary advance care planning services between a provider and the Member with or without completing relevant legal forms as described in 42 CFR §438.3.(j).

B. Advance Directives

1. The Health Plan shall maintain written policies and procedures for advance directives as defined in §2.6 in compliance with 42 CFR §§422.128, 438.3(j)(1) to (4), and in Subpart I of Part 489, HAR 17-1711.1-12 and HRS §§327E-3-5. For purposes of this section, the term "MA organization" in 42 CFR §422.128 shall refer to the Health Plan. Such advance directives shall be included in each Member's medical record.

2. The Health Plan shall provide these policies on their website and through paper and/or electronic Member communications to all Members eighteen (18) years of age or older and shall advise the Members of:

a. 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;

b. The Health Plan's written policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience. See 42 CFR §422.128(b)(1)(ii); and

c. The Health Plan shall inform the Members that complaints concerning non-compliance with the advance directive requirements may be filed with the State survey and certification agency found in the Office of Health Care Assurance in the DOH.

3. The information provided by the Health Plan to its Members shall include a description of current state law and shall reflect changes in state laws as soon as possible, but no later than ninety (90) days after the effective date of the change as described in HRS §§327E-3 and 327E-4.

4. The Health Plan shall not condition the provision of care or otherwise discriminate against an individual based on whether the Member has executed an advance directive. The Health Plan shall ensure compliance with requirements of the State of Hawaii law regarding advance directives as described in HRS §§327E-3 and 327E-4.

5. The Health Plan shall educate its staff about its advance directive policies and procedures, situations in which advance directives may be of benefit to the Members, and the Health Plan's responsibility to educate and assist the Members who choose to make use of advance directives. The Health Plan shall educate the 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.

6. The Health Plan shall work with providers to demonstrate achievement across the following areas:

   a. Higher rates of completion of advance directives; and

   b. Increased likelihood that clinicians understand and comply with a patient's wishes.

C. Hospice Care

1. The Health Plan shall cover hospice care for qualifying Members. 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 shall meet Medicare requirements. Children under the age of twenty-one (21) years may receive treatment to manage or cure their disease while concurrently receiving hospice services.

4.11 Optional Services Provided by Health Plans

A. Value-Added Services

1. The Health Plan may propose value-added services. Value-added services may be actual healthcare services, benefits, or positive incentives that DHS determines will promote healthy lifestyles and improved health outcomes among the Members. Best practice approaches to delivering Covered Services are

not considered value-added services.

2. Any value-added services that a Health Plan elects to provide shall be provided at no additional cost to DHS. The cost of value-added services are not reportable as allowable medical or administrative expenses, and therefore, are not factored into the capitated rate setting process. In addition, the Health Plan shall not pass on the cost of the value-added services to the Members or providers.

3. The Health Plan shall ensure providers do not charge the Members for any other cost-sharing for a value-added services, including co-payments or deductibles. The Health Plan shall specify the conditions and parameters regarding the delivery of each value-added services and shall clearly describe any limitations or conditions specific to each value-added service in the Health Plan's Member handbook. The Health Plan shall also include a disclaimer in its marketing materials and provider directory indicating that restrictions and limitations may apply.

4. A Health Plan's proposal and subsequent requests to add a value-added service shall:

    a. Define and describe the proposed value-added service;

    b. Specify the service areas and Health Plan programs for the proposed value-added service;

    c. Identify the category or group of the Members eligible to receive the value-added service if it is a type of service that is not appropriate for all Members;

d. Note any limitations or restrictions that apply to the value-added services;

e. Identify the providers or entities responsible for providing the value-added services;

f. Describe how the Health Plan will identify the value-added service in administrative data, for example, encounter data, and/or in its financial reports, as applicable;

g. Propose how and when the Health Plan will notify providers and the Members about the availability of such value-added services; and

h. Describe the process by which a Member may obtain or access the value-added services, including any action required by the Member, as appropriate.

5. The Health Plan may not offer a value-added service without DHS approval, or advertise a value-added service if DHS has not approved it. If a value-added service is no longer offered, the Health Plan shall notify each Member that the service is no longer available through the Health Plan. The Health Plan shall also revise all materials distributed to prospective Members to reflect the change in value-added services. Materials are subject to review and approval by DHS.

4.12 Covered Benefits and Services Provided by DHS

A. The Health Plan is not responsible for the benefits described in this section, but may be required to coordinate activities with the governmental agencies that are responsible for the benefits.

B. State of Hawaii Organ and Tissue Transplant Program

1. DHS shall provide transplants when Medical Necessity is established through the SHOTT program, with the exception of cornea transplants and bone grafts, which shall be provided by the Health Plan to all Members requiring such services. The SHOTT program covers adults and children. Covered transplants shall be non-experimental, non-investigational for the specific organ/tissue and specific medical condition being treated. 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 shall meet specific medical criteria as determined by the State and the SHOTT program contractor.

C. Services for Individuals with Intellectual and Developmental Disabilities

1. The DDD provides HCBS and supports to I/DD under the authority of §1915(c) of the Social Security Act, hereinafter program is referred to as the I/DD Waiver.

2. DHS oversees and monitors all I/DD Waiver implementation, administration, and operation activities delegated to the DDD. The Health Plan's coordination responsibilities are described in §3.8.B.

3. DDD provides HCBS services to the Members who are eligible for the I/DD Waiver. The Members will continue to access medical services though their health plans. The eligibility criteria for the I/DD Waiver include:

a. The Member is eligible for Medicaid long-term care services;

b. The Member meets the Medicaid ICF/IID LOC as defined in 42 CFR §440.150; and

c. The Member meets the intellectual and/or developmental disability conditions as defined by the HRS Chapter 333F-1 and detailed in the DOH HAR §11-88.1-5.

4. The HCBS services approved under the I/DD Waiver are described in Health Plan Manual.

5. HCBS services approved under I/DD Waiver are considered a wraparound to the EPSDT benefit, not a replacement. The I/DD Waiver will not supplant any service that is the responsibility of the Medicaid coverable services under the Health Plans, for example, services that are Medical Necessity under Medicaid State Plan home health benefit or the EPSDT benefit, another state agency, or other insurance. There should be no duplication of services between the Health Plan and the I/DD Waiver.

6. If the Member is no longer eligible for the I/DD Waiver, the Health Plan shall collaborate with DDD in transitioning the Members out of the I/DD Waiver to access services that meet Medical Necessity criteria. The Health Plan shall coordinate activities with DDD in accordance with DHS guidance.

D. Dental Services

1. DHS shall provide timely and preventative dental care to Health Plan Members.

2. Members under age twenty-one (21) will be covered by EPSDT.

3. DHS shall provide dental screening and diagnostic services for eligible juveniles covered under Section 5121 of the Consolidated Appropriations Act, 2023, P.L. 117-328. See §4.13 in this section for Health Plan responsibilities for coordinating access to such dental screening and diagnostic services.

E. Intentional Termination of Pregnancies (ITOPs)

1. 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.

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

3. All financial penalties assessed by the federal government and imposed on 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.

4.13 Coverage Provisions for Reentry Services

A. Reentry Services

1. The Health Plan shall provide the following Reentry Services:

a. Case Management – Assessment and periodic reassessment of Member needs, including:
    1) Medical, educational, social, or health-related social needs;
    2) Development and periodic revision of a specific transition care plan based on information collected through the assessment(s);
    3) Making referrals and related activities to programs or services to address identified needs in the person-centered care plan;
    4) Monitoring and follow-up activities to ensure the person-centered care plan is effectively implemented and adequately addresses identified needs; and
    5) Case management services for eligible juveniles covered under Section 5121 of the Consolidated Appropriations Act, 2023, P.L. 117-328 also include:
        a) Coordination of dental screening and diagnostic services in the thirty (30) days prior to release or as soon as is practicable following release; and
        b) Targeted Case Management services, which are encompassed in the definition of Case Management in §4.13, in the thirty (30) days prior to release and for at least thirty (30) days following release.

b. Medication for Addiction Treatment Services – Medication Assisted Treatment for all types of Substance Use Disorders,

as clinically appropriate, including coverage for medications in combination with any necessary counseling and behavioral therapies.

c. Thirty (30) Day Supply of Prescription Medications – A minimum of thirty (30) day supply of prescription medications to be provided upon release from incarceration, including prescribed over-the-counter drugs, as clinically appropriate, for use post-release in the community.
d. Practitioner Office Visits – Physical and behavioral health clinical consultation services, including screenings, diagnostic services, referrals, and other practitioner orders, provided by carceral or in-reach community-based providers who enter carceral settings to initiate or continue clinical care rather than carceral facility-employed providers.
e. Diagnostic Services – Laboratory and radiology services, consistent with State Plan coverage.
f. Medical Equipment and Supplies – Durable Medical Equipment (DME) for use post-release in the community, consistent with State Plan coverage.
g. Peer Support Services – Peer Support Services may include educational skill-building groups, activities, and coaching to support participation in treatment and transitions; and structured non-clinical activities to promote recovery, wellness, self-advocacy, and other activities to support recovery within the community.

SECTION 5 – Quality, Utilization Management, and Administrative Requirements

5.1 Quality

A. Quality Strategy and Quality Program Background

DHS developed an updated Medicaid Managed Care Quality Strategy, also known as DHS Quality Strategy, in accordance with 42 CFR §438.340 that details goals, strategies, objectives for quality management and improvement, as well as specific foundational building blocks to develop a transformational healthcare system that focuses on healthy families and healthy communities. DHS' Quality Strategy addresses the health needs of the entire Member population. DHS' Quality Strategy includes the development of the SDOH Transformation Plan and leverages evidence-based and nationally-recommended approaches to address the desired goals and objectives.

1. DHS' Quality Strategy will be reviewed and updated periodically as necessary.

2. In order to achieve the objectives of DHS Quality Strategy, the Health Plan shall collaborate with DHS, other state agencies, and as needed with other Health Plans, to:

    a. Develop and implement a data-driven, outcomes-based, continuous QAPI plan focused on rigorous outcome measurement against relevant targets and benchmarks, and that appropriately supports providers and beneficiaries for advancing quality goals and health outcomes. This process will include considerations for tracking outcomes

and addressing deficiencies when improvement is not occurring.

b. Develop and adopt an SDOH work plan within its QAPI that adopts a whole person care approach throughout the QAPI through the provision of SDOH resources at the community and Member levels.

c. Develop and adopt a comprehensive cultural competency plan within its QAPI that allows the Health Plan to effectively provide services to its diverse membership, with targeted efforts to address and mitigate disparities and cultural gaps.

3. In close alignment with DHS Quality Strategy, DHS shall lead, and the Health Plan shall participate in, a comprehensive quality program that will hereafter be referred to as the "Quality Program". The Quality Program may include one or more work groups tasked with systematically addressing, reporting on challenges with, and participating in a collaborative approach to advance the goals and objectives of DHS' Quality Strategy, including the SDOH Transformation Plan.

4. The Health Plan shall participate in Rapid Cycle Assessments of its CIS program by DHS.

5. Pursuant to General Condition 2.2, DHS shall own any reports, studies, or data that the Health Plan produces in accordance with this RFP.

6. The SDOH Transformation Plan will represent DHS' plan to identify, evaluate, and reduce, to the extent practicable, health

disparities based on factors such as age, race, ethnicity, gender, primary language, and disability status. The SDOH Transformation Plan is expected to develop a shared DHS and Health Plan road map to comprehensively and systematically address health disparities. This will include the use of analytic methods to identify, monitor, and address unmet social needs, such as:

a. Collection of new, or collation of existing SDOH data, at the community and individual levels;

b. Enhanced use of SDOH data as inputs in predictive and actuarial models, as well as in hot spotting and other advanced analytic methods, leading in turn to:

    1) Improved identification of Members and Member communities disproportionately impacted by SDOH and at high risk for poor health outcomes; and

    2) Improved application of SDOH-based adjustment factors into VBP arrangements.

c. Enhancing awareness of and access to community-based SDOH supports and resources;

d. Addressing social needs in the delivery of care and resources provided to beneficiaries;

e. Adapting the delivery of care and resources provided to beneficiaries based on their SDOH needs;

f. Developing targeted strategies to addressing the SDOH needs of special populations disproportionately impacted by SDOH and at high risk for adverse health outcomes;

g. Promoting statewide collaboration with the other Health Plans, DHS and other state agencies and/or partners in implementing SDOH strategies; and

h. Collecting and incorporating community input in establishing effective partnerships with existing community resources in the implementation of SDOH strategies.

7. The SDOH Transformation Plan will outline the supports, resources, and improvements DHS will make to support the Health Plan's SDOH work plan and facilitate shared learning and statewide collaboration.

8. The SDOH Transformation Plan will be reviewed and updated as part of DHS Quality Strategy. The Health Plan shall align its SDOH work plan to describe the on the ground community and Member-level activities that will realize the overall goals and strategies of the SDOH Transformation Plan.

B. Quality Assessment and Performance Improvement Program

1. QAPI Plan – General Requirements

a. The Health Plan shall develop and implement a comprehensive QAPI program that is focused on improving health outcomes through collaborative opportunities and use of evidence-based approaches to achieve quality assurance and improvement.

b. The QAPI shall meaningfully demonstrate alignment with the DHS SDOH Transformation Plan.

c. The QAPI Program shall cover all demographic groups, care settings, and types of services. It shall address the delivery

and outcomes of clinical medical care, behavioral healthcare, Member safety, and non-clinical aspects of service, including the availability, accessibility, coordination, and continuity of care. The principles of continuous quality improvement shall be applied throughout the plan and process described, from developing, implementing, monitoring, and evaluating the QAPI program to identifying and addressing opportunities for improvement.

d. Health Plans will collaborate with DHS, other state agencies such as DOH, and other Health Plans, to develop aligned, collaborative strategies.

e. The QAPI program shall, at a minimum, address the following elements and requirements:

    1) A detailed description of the QAPI program addressing all required program elements;

    2) A discussion of how the Health Plan will operate the program to implement innovative approaches to support DHS in achieving improved outcomes;

    3) Clearly defined evidence-based approaches to performance improvement projects (PIPs) and other quality improvement efforts that the Health Plan will implement;

    4) A proposed plan for collaboration across Health Plans where expected;

    5) A process to continually evaluate the impact and effectiveness of the QAPI Plan;

6) The approach to modifying the QAPI program to address deficiencies where identified;

7) A detailed plan for conducting and assessing PIPs, including a demonstration of the alignment between the Health Plan's PIPs with other Health Plans for DHS-specified PIPs, as further described in §5.1.B.4;

8) Collecting and submitting to DHS performance measurement data, including outputs, process and outcome measures, and other qualitative data, as required by DHS;

9) Submitting data as required by DHS that enables DHS to validate and contextualize the Health Plan's performance on required measures;

10) Submitting a report that identifies disparities in health services and health outcomes between sub-populations/groups including, but not limited to, race/ethnicity and language. The report shall be submitted along with a plan of action and a timeline to remediate the SDOH and health disparities identified through targeted interventions. The plan of action should include a performance measurement and evaluation component;

11) Establishing mechanisms for detecting and addressing both under-utilization and over-utilization of services;

12) Establishing mechanisms for detecting and addressing both under-utilization and over-utilization

of prescription drugs including controlled substances;

13) Establishing a PMP to improve patient care and stop prescription misuse for controlled substances;

14) Establishing mechanisms for assessing and addressing the quality and appropriateness of care furnished to special populations across care settings, including:

    a) Members with SHCN, including those needing LTSS; and
    b) Members enrolled in D-SNP.

15) Participating in DHS efforts to prevent, detect, and remediate critical incidents, consistent with ensuring Member health and welfare per 42 CFR §441.302 and 441.730(a), that are based, at a minimum, on the requirements for home and community-based waiver programs per 42 CFR §441.302(h);

16) Establishing mechanisms to assess the quality and appropriateness of care furnished to Members using LTSS, including assessment of care between care settings and a comparison of services and supports received with those set forth in the Member's treatment/service plan, if applicable;

17) Establishing mechanisms to assess and address the quality and appropriateness of care furnished to Members receiving any type of specialized coordinated services, including but not limited to: children receiving services through DOH CAMHD,

Members enrolled in the DD/ID 1915(c) waiver, those receiving specialized behavioral health services

through CCS, and beneficiaries receiving services from other DHS programs, such as Child Welfare and Adult Protective Services.

18) Establishing mechanisms to deliver culturally competent services to Members as described further in §5.1.B.6;

19) Methods for seeking and incorporating input from, and working with, Members, providers, DHS staff and its designees, community agencies, other state agencies such as DOH, to actively improve the quality of care provided to Members;

20) Methods for improving health outcomes across the continuum of care for the Medicaid Member population in general using evidence-based and nationally recommended quality improvement approaches;

21) Practice guidelines as described in §5.1.B.5;

22) Methods to improve the provider grievances and appeals process;

23) Methods for meaningfully incorporating a whole person approach through SDOH interventions; and

24) Use of sophisticated IT infrastructure and data analytics to support DHS' vision and goals for quality improvement, measurement and evaluation,

including the capability to identify sub-populations by age, race, ethnicity, primary language, special populations, or other demographics experiencing disparities. The Health Plan shall also use predictive analytics to identify populations at risk for poor health outcomes and high cost, stratify and report metrics at the state and regional or service area level, and by sub-population, and be able to report data at the patient or provider level to DHS as required.

2. QAPI Plan – Submission Requirements

   a. The Health Plan shall submit an annual QAPI Plan for review and approval by DHS.

   b. The QAPI Plan shall include a narrative description and a detailed work plan of activities for operationalizing all elements of the QAPI Plan that demonstrably reflect its alignment with DHS Quality Strategy.

   c. The Health Plan shall review DHS Quality Strategy regularly for any updates, evaluate its QAPI Plan for alignment, and update it as needed. The Health Plan shall submit updated QAPI Plans to DHS for review and approval.

   d. Each subsequent year's QAPI Plan will be submitted along with a progress report on the current year's QAPI Plan to document the QAPI activities implemented and outcomes achieved for the year, along with remaining gaps and plan of action for the subsequent year as the QAPI Progress Report and Annual Plan Update. The QAPI Plan for each subsequent contract year should be adjusted to address the

challenges identified in the prior QAPI report. The final year's QAPI report will not include the subsequent year's QAPI Plan, and will be submitted by the Health Plan within a period of six (6) months of completion or termination of the contract, whichever occurs first.

e. The Health Plan's initial QAPI Plan shall be submitted for DHS review in accordance with §13.3.B, Readiness Review.

f. In addition to the annual progress report and annual plan update, the Health Plan shall also submit quarterly reports providing QAPI Plan updates and changes to the work plan in the QAPI as the QAPI Quarterly Progress and Work Plan Update.

g. Upon request by DHS, the Health Plan shall submit other information about its QAPI Plan. Participation in the Quality Program will include informal updates and progress reports, and discussions on strategies, successes, and challenges across various QAPI areas; it will provide an opportunity for engagement and collaboration across Health Plans for planning purposes, and an avenue to seek input from DHS. DHS may ask Health Plans to participate in training opportunities.

h. When establishing its QAPI Plan standards, the Health Plan shall comply with applicable provisions of federal and state laws and current NCQA standards/guidelines for accreditation of MCOs.

i. 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 to clarify and address identified needs for improvement.

3. SDOH Work Plan

   a. The Health Plan will develop a SDOH work plan as a component of its QAPI that is informed by the statewide SDOH Transformation Plan.

   b. The Health Plan's SDOH work plan shall be submitted as a sub-component of the QAPI plan, and include its own timelines, benchmarks, milestones, and deliverables. The Health Plan's initial SDOH work plan, which will be prepared prior to the completion of the SDOH Transformation Plan, should include:

      1) Plans for increasing the systematic collection and documentation of Member-level SDOH data through screening;

      2) Plan for promoting the use of ICD-10 Z codes for SDOH documentation;

      3) Plan to increase provider understanding of SDOH;

      4) Plan for incorporating SDOH strategies into the overall QAPI by:

         a) Linking beneficiaries to identified SDOH needs; and
         b) Providing relevant SDOH value-added services offerings;

      5) Description of how the Health Plan will directly

address and adapt its QAPI to accommodate SDOH needs for the following target populations:

a) SHCN, EHCN, and LTSS populations, including adults and children, on whom social needs have been identified through the SHCN, EHCN, and LTSS assessment;
b) CIS+ populations; and
c) Other populations with complex physical, behavioral, and social conditions.

c. In the first year of the contract, the Health Plan shall only be responsible for activities related to §5.1.B.3.b.1 and §5.1.B.3.b.2. In Year 2, the Health Plan shall additionally incorporate activities related to §5.1.B.3.b.3. The Health Plan shall be fully responsible for implementing activities related to §5.1.B.3.b, in alignment with the SDOH Transformation Plan, by Year 3. The Health Plan is encouraged to expand upon its SDOH strategy beyond the minimum required elements for the initial plan. Each subsequent year's SDOH work plan is expected to iteratively build upon the accomplishments of the previous year's plan.

d. The Health Plan shall report on its progress on the SDOH work plan and describe its updated SDOH work plan quarterly and annually as part of the QAPI Quarterly Progress and Work Plan Update and QAPI Progress Report and Annual Plan Update. DHS may amend the required elements of the SDOH Transformation Plan on an annual basis as progress is made on existing gaps, and as new gaps are identified. The Health Plan's SDOH work plan should

accordingly be updated recognizing that transformation is a continuous process and that a Health Plan's SDOH work plan should evolve over time.

4. Performance Improvement Projects

   a. As part of its QAPI program, the Health Plan shall conduct a minimum of three (3) PIPs at all times in accordance with 42 CFR §438.330(d). PIP topics may vary from one cycle to the next, and PIP cycles may not coincide with contracting cycles.

   b. The PIPs shall be designed to achieve significant improvement sustained over time in clinical care and non-clinical care areas, including SDOH, that are expected to have a favorable effect on health outcomes and Member satisfaction.

   c. PIPs shall be designed as iterative implementations of evidence-based interventions using data-driven quality improvement methods, and ongoing tracking and measurement of both outputs and outcomes.

   d. Each PIP shall include a measurement strategy of performance using objective quality indicators.

   e. Each PIP shall include implementation of interventions to achieve improvement in the access to and quality of care.

   f. The PIPs shall follow the Plan, Do, Study, Act cycle, hereafter referred to as the PDSA cycle, or other evidence-based methods. The study topics shall be approved by DHS. The studies should follow standard quality improvement methods such as having a clearly identified study question

and objective; a description of the methods that include the appropriate evidence-based intervention planned and the evidence-based approach for conducting quality

improvement; clear implementation plan; measurable indicators of output, process, and outcomes; valid sampling techniques, where applicable, and accurate data collection, including qualitative data collection where needed; data analysis; and a description of the findings, areas in need of improvement or refinement, and recommendations. The PIP should describe the iterative PDSA cycles and the lessons learned in each cycle that were implemented into the plan for the next cycle.

g. The PIP plan shall include a detailed description of the study question, approach, planned evaluation, and strategy for incorporation of findings into future PDSA cycles; be included in the QAPI plan; and is subject to review and approval by DHS prior to implementation. Updates on PIP activities, including results and outcomes, shall be provided quarterly and annually, as part of the QAPI Quarterly Progress and Work Plan Update and QAPI Progress Report and Annual Plan Update.

h. The Health Plan shall report the status and results of each project to the State as requested. The Health Plan shall complete each PIP in the time period determined by DHS to allow information on the progress of all PIPs in aggregate to produce new information periodically on quality of care according to 42 CFR §438.330(d)(3). The Health Plan shall not consider PIP methodology and findings to be

proprietary.

i. PIPs may be specified by DHS. All DHS-selected PIPs shall have aligned interventions and quality improvement approaches across Health Plans, and be included as part of the Health Plan's overall QAPI plan. In these cases, the Health Plan shall meet the goals and objectives specified by DHS. The Health Plan may also submit recommended PIP topics, PIP standards, and proposed PIPs for the selected topics to DHS. DHS has final approval for selected PIP topics and methods.

j. The Health Plan shall submit to 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 include in its submission the planned approach to sustaining or increasing improvements.

5. Practice Guidelines

a. The Health Plan shall include, as part of its QAPI program, practice guidelines that meet the following requirements as stated in 42 CFR §438.236 and current NCQA standards. Each adopted practice guidelines shall be:

1) Relevant to the needs of the Health Plan's Membership;

2) Based on valid and reliable clinical evidence, national recommendations, or a consensus of healthcare professionals in a particular field;

3) Aligned with the goals of this Contract, DHS Quality Strategy, and the Health Plan's QAPI;

4) Designed as systematic strategies to enhance use and implementation of evidence-based practices in support of addressing disparities, improving quality, enhancing adoption of evidence-based models and practices, and increased adoption of HIT-based strategies;

5) Adopted in consultation with in-network healthcare professionals;

6) Reviewed and updated periodically as appropriate;

7) Disseminated broadly to all affected providers, and upon request, to Members and potential Members;

8) Evaluated for adoption and implementation through provider-based reporting;

9) Promoted by the Health Plan for adoption and implementation through provider-based education activities; practice transformation support including HIT-based strategies; and other incentives.

10) The Health Plan shall report data on implementation and adoption of each practice guideline across its provider network to DHS quarterly and annually, as part of the QAPI Quarterly Progress and Work Plan Update and QAPI Progress Report and Annual Plan Update. Where there are gaps in adoption or implementation, the subsequent quarter or year's

QAPI plan will include plans for continued support from the Health Plans towards greater adoption and implementation.

b. Practice guidelines policies and procedures and a list of all current practice guidelines shall be submitted to DHS for review as requested.

c. Additionally, in compliance with 42 CFR §438.236, the Health Plan shall ensure decisions for utilization management, Member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

d. The Health Plan shall disseminate practice guidelines to Members and potential Members upon request.

e. DHS shall issue guidance, as needed, and additionally develop practice guidelines based on emerging and evolving clinical practice. DHS may also specify topics for practice guidelines that Health Plans shall work collaboratively to develop.

f. The Health Plan may additionally issue its own practice guidelines. Health Plans shall follow current NCQA and Balanced Budget Act standards for adopting and disseminating guidelines. DHS may periodically review the clinical practice guidelines adopted by the Health Plan, request additional information, as needed, and promulgate one or more clinical practice guidelines as a standard of practice.

g. For each practice guideline adopted, the Health Plan shall:

1) Describe the clinical, evidentiary, and strategic basis upon which the practice guideline is chosen;

2) Describe how the practice guideline takes into consideration the needs of the Members;

3) Describe how the Health Plan shall ensure practice guidelines are reviewed in consultation with healthcare Providers;

4) Describe the process through which the practice guidelines are reviewed and updated periodically;

5) Describe how the practice guidelines are disseminated to all relevant providers and, upon request, to potential Members;

6) Describe the Health Plan's strategies to promote adoption and implementation, as well as processes for monitoring; and

7) Describe how the Health Plan shall ensure decisions for utilization management, Member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

6. Cultural Competency Plan

a. The Health Plan shall have a comprehensive written cultural competency plan that shall:

1) Design programs, interventions, and services, which effectively address cultural and language barriers to the delivery of appropriate and necessary health services, and address cultural disparities identified

via the Disparities Report in §5.1.B.1.e.10;

2) Describe how the Health Plan will ensure 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;

3) 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

4) Comply with, and ensure providers participating in the Health Plan's provider network comply with, Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d, 45 CFR Part 80 and 42 CFR §§438.6(d)(4), 438.6(f), 438.100(d), and 438.206(c)(2).

b. 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.

7. Delegation

a. Contingent upon approval from DHS, the Health Plan may be permitted to delegate certain QAPI program activities

and functions. However, the Health Plan shall remain responsible for the QAPI program, even if portions are delegated to other entities. Any delegation of functions requires:

1) A written delegation agreement between the delegated organization and the Health Plan, describing the responsibilities of the delegation and the Health Plan. If applicable, the written delegation agreement shall include a Business Associate Agreement (BAA) or other data use agreement to protect and secure PHI or other personally identifiable information of Members; and

2) 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:

   a) 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;
   b) An annual on-site visit and/or documentation/record reviews to monitor/evaluate the quality of the delegated organization's assigned processes;
   c) The annual on-site visit may be deemed to have occurred if the delegate is accredited by NCQA; and
   d) Evaluation of the content and frequency of

reports from the delegated organization.

b. QAPI delegations shall be subject to review and approval by DHS. The Health Plan shall submit any QAPI delegation at the start of the contract for DHS review in accordance with §13.3.B, Readiness Review.

8. DHS Review of Health Plan QAPI Activities

a. In accordance with 42 CFR §438.330(e), Program Review by the State, DHS shall review, at least annually, the impact and effectiveness of the Health Plan's QAPI. The scope of 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 plan and to effectuate necessary improvements.

1) The Health Plan shall actively participate in DHS' review of its QAPI activities and provide requested materials within an agreed-upon timeframe. The Health Plan shall also facilitate DHS requests for on-site visits to support the review.

2) DHS shall evaluate the Health Plan's QAPI activities utilizing a variety of methods, including but not limited to:

a) Reviewing QAPI documents;

b) Reviewing, validating, and evaluating the QAPI reports regularly required by DHS, for example, Member grievances and appeals reports, provider complaints and claims reports, reports of

suspected cases of fraud and abuse, performance measures reports, PIP reports, QAPI description, etc.;

c) Meeting with Health Plans regularly as part of the Quality Program activities, and gathering information on activities, progress, and challenges;

d) Reviewing, evaluating, or validating implementation of specific policies and procedures or special reports relating to areas such as:

   i) Member rights and protections;

   ii) Services provided to Members with SHCN, receiving LTSS, enrolled in D-SNPs, identified as having Special Health Care Needs, or requiring other types of specialized coordination;

e) Evaluating the Health Plan's utilization management (e.g., under-utilization and over-utilization of services);

f) Reviewing and validating the Health Plan's access to care standards, including:

   i) Availability of services;

   ii) Adequate capacity and services;

   iii) Continuity and coordination of care; and

iv) Coverage and authorization of services.

g) Reviewing and validating the Health Plan's Structure and Operation Standards, including:

i) Provider selection;

ii) Member information;

iii) Confidentiality;

iv) Enrollment and dis-enrollment;

v) Grievance and Appeal System; and

vi) Subcontractor relationships and delegation.

h) Reviewing and validating the Health Plan's measurement and improvement standards;

i) Reviewing and validating the Health Plan's practice guidelines;

j) Reviewing and validating the Health Plan's approach to identifying addressing health disparities and proposed SDOH interventions;

k) Reviewing and validating the Health Plan's health information systems;

3) Conducting on-site reviews to interview Health Plan staff for clarification, to review records, or to validate implementation of processes/procedures; and

4) Reviewing medical records.

b. 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 DHS. Upon completion of its review, DHS or its designee may submit a report of its findings to the Health Plan and to DHS. At the request of DHS, the Health Plan shall develop corrective actions for any identified areas of deficiency.

C. Quality Rating System

1. The Health Plan shall participate in any activities needed to support DHS in the design and implementation of a managed care quality rating system in accordance with 42 CFR §438.334.

D. Performance Measures

1. The Health Plan shall comply with all 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. Performance measures will be aligned with DHS Quality Strategy and shall represent the key metrics that serve as the outputs and outcomes of the Health Plan's overall QAPI activities.

2. Clinical measures, utilization measures, and other measures of program cost may be included, in addition to process measures. DHS may require reporting of performance measure at any level of granularity including Member, Provider, practice, health system, or plan level. The types of

performance measures that the Health Plan shall be required to track and provide to DHS include:

a. Clinical and utilization quality measures – A set of clinical and utilization measures are required from the Health Plan each year. DHS shall provide a list of the performance measures each calendar year for the next year's required measures. The measures may be HEDIS measures.

b. HEDIS-like measures – A set of measures, including both clinical and utilization measures, that are based on HEDIS measure definitions, but modified, as needed, to achieve such goals as alignment with the CMS Medicaid Core Set, or alignment with DHS priorities. DHS shall provide a list of the HEDIS-like performance measures each calendar year for the next year's required measures.

c. Other nationally-developed quality measures – A set of measures, including both clinical and utilization measures, with various measure stewards nationally that may or may not be endorsed by NCQA. DHS shall provide a list of nationally developed performance measures each calendar year for the next year's required measures.

d. Other DHS-developed quality measures – A set of measures, including clinical, utilization, or cost-based measures, that are defined by DHS to track DHS priorities for which a HEDIS, HEDIS-like, or other nationally defined measure is unavailable, inadequate, or inappropriate. DHS will design these measures, as needed, and provide Health Plans with a format and frequency for reporting.

e. Utilization dashboard – The Health Plan shall supply information that may include a variety of output measures and performance metrics designed to track volumes of patients or services, including hospital admissions and readmissions, call center statistics, provider network, Member demographics, etc. DHS shall provide a list of the measures and a format and frequency for submission.

f. 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.

g. DHS shall identify the measures that may be used to support auto-assignment algorithms as described in §9.1.C.

h. DHS shall also identify the measures that may be eligible for performance incentives.

3. The Health Plan shall submit to DHS and the EQRO any and all Member data necessary to enable validation of the Health Plan's performance under this section.

E. Accreditation

1. The Health Plan shall be accredited by NCQA for its QI program. The Health Plan shall be accredited prior to beginning service delivery to Members and maintain continuous accreditation throughout the Contract period, with no lapse in accreditation. The Health Plan shall proactively seek reaccreditation, as needed, to prevent lapses.

2. The Health Plan shall notify DHS of any changes in its accreditation status within seven (7) days of the change.

3. In accordance with 42 CFR §438.332(b)(1), the Health Plan shall submit and/or authorize NCQA to submit accreditation review information to the State, including:

   a. Accreditation status, survey type, and level;

   b. Accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings; and

   c. Expiration date of the accreditation.

4. The Health Plan shall submit proof of accreditation for DHS review in accordance with §13.3.B, Readiness Review.

F. Non-Duplication Strategy

1. In accordance with 42 CFR §438.360, DHS may use information from a Medicare and/or a private accreditation review to avoid duplication with the review of select standards required under an EQR. This option may be used at the discretion of DHS. DHS will define the use of this option in DHS policies and in DHS' Quality Strategy if DHS decides to use this option. DHS may waive certain EQRO validation activities based on the Health Plan's NCQA accreditation.

G. External Quality Review/Monitoring

1. DHS contracts with an EQRO to perform, on an annual basis, an external, independent review of the quality outcomes of, timeliness of, and access to the services provided for QI Members by the Health Plans.

2. The Health Plan shall cooperate with DHS' contracted EQRO in the 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.

3. The EQRO shall monitor the Health Plan's compliance with all applicable provisions of 42 CFR §438, Subpart E. Specifically, the EQRO may provide the following activities as described in 42 CFR §438.358 and 42 CFR §438.602(e):

   a. Validation of network adequacy during the preceding twelve (12) months to comply with requirements set forth in this Contract, §§438.68, and 438.14(b)(1);

   b. Validation of PIP required by DHS;

   c. Validation of Health Plan performance measures required by DHS; and

   d. A review, conducted within the previous three (3)-year period, to determine compliance with standards established by DHS concerning access to care, structure and operations, and quality measurement and improvement.

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

5. The Health Plan shall participate in any additional activities undertaken by the EQRO for DHS, which may include but are not limited to:

a. Administration, analysis, and reporting the results of the CAHPS® Consumer Survey. The survey shall be conducted annually and be administered to an NCQA-certified sample of Members enrolled in each health plan and analyzed using NCQA guidelines. Adult and child surveys are conducted in alternate years using the most current CAHPS® survey for managed care plans. A CHIP-specific CAHPS® Consumer Survey is conducted annually to meet federal requirements. DHS may modify this schedule based on the needs of the Department; and add additional CAHPS or other nationally-accredited surveys as needed. The EQRO shall provide an overall report of survey results to DHS. DHS and the Health Plan shall receive a copy of their health plan-specific data by island;

b. 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. DHS may modify this schedule based upon the needs of the Department. The EQRO shall assist DHS in developing a survey tool to gauge PCP and specialist 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 DHS with a report of findings, including the data stratified by island. Each Health Plan shall receive an electronic version of the report with its plan-specific data

per island from the EQRO;

c. Providing technical assistance to the Health Plan to assist them in conducting activities related to the mandatory and optional EQR activities according to 42 CFR §438.310(c)(2);

d. Assisting with the quality rating of the Health Plans consistent with 42 CFR §438.334;

e. Administration, analysis, and reporting of the results of the encounter data validation, per 42 CFR §438.358(c)(1), and optional activities related to EQR. The EQRO is responsible for auditing and validating encounter data by using information derived during the preceding twelve (12) months reported by the Health Plans. The EQRO will be responsible for developing the methodology, generating and issuing the questionnaires, collecting data, and conducting a comparative analysis. Finally, the EQRO shall furnish a special report that summarizes the results to the State and the Health Plans; and

f. Assisting with the quality rating of Health Plans, Prepaid Inpatient Health Plans, and Prepaid Ambulatory Health Plans consistent with §438.334.

H. Case Study Interviews

1. 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.

5.2 Utilization Management

A. Utilization Management Program

1. The Health Plan shall have in place a 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 and maximize appropriate use of resources.

2. As part of the UMP, the Health Plan shall define its implementation of medically-necessary services in a manner that:

   a. Is no more restrictive than services determined to be a Medical Necessity as defined in §2.6; and

   b. Addresses the extent that the Health Plan covers services related to the following:

      1) The prevention, diagnosis, and treatment of health impairments;

      2) The ability to achieve age-appropriate growth and development; and

      3) The ability to attain, maintain, or regain functional capacity.

   c. The Health Plan shall have a written UMP description, a

corresponding work plan, UMP policies and procedures, and mechanisms to implement all UMP activities. The UMP description and work plan may be separate documents or may be integrated as part of the written QAPI program description and work plan. The description, work plan, policies, and procedures shall be submitted for DHS review in accordance with §13.3.B, Readiness Review.

d. The Health Plan's UMP shall include structured, systematic processes that employ objective evidenced-based criteria to ensure qualified licensed healthcare professionals make utilization decisions regarding Medical Necessity and appropriateness of medical, behavioral health, and LTSS in a fair, impartial, and consistent manner.

e. The Health Plan shall ensure applicable evidence-based criteria are applied with consideration given to the 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.

f. 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.

g. 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 Members and providers seeking information about the UMP process and the authorization of care/services have access to UMP staff.

h. The Health Plan's utilization review/management activities shall include:

1) Prior authorization/pre-certifications;

2) Concurrent reviews;

3) Retrospective reviews;

4) Discharge planning;

5) Care coordination;

6) Service coordination; and

7) Pharmacy management.

3. The Health Plans shall conduct a concurrent review process. The Health Plans shall proactively work with provider(s) to ensure Member's timely access to care, inclusive of a Member's continuation of care not limited to hospital services, post-acute services, transitional services, and DME and supplies.

4. 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:

a. Routine, systematic monitoring of relevant utilization data;

b. Routine analysis of all data collected to identify causes of inappropriate utilization patterns;

c. Implementation of appropriate interventions to correct any patterns of potential or actual under-utilization or over-utilization; and

d. Systematic measurement of the effectiveness of interventions aimed at achieving appropriate utilization.

5. 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.

6. The Health Plan shall ensure pharmaceutical management activities promote the clinically appropriate use of pharmaceuticals and align with the PMP as described in §5.1.B. There shall be policies, procedures, and mechanisms to ensure the Health Plan has criteria for adopting pharmaceutical management procedures and that there is clinical and Medical Necessity-based evidence for all decisions. The policies shall include an explanation of any limits or quotas and an

explanation of how prescribing practitioners shall provide information to support an exceptions request.

7. The Health Plan shall ensure 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 it has processes for generic substitution, therapeutic interchange, and step-therapy protocols.

8. The Health Plan shall not develop a compensation structure that creates incentives for the individuals or entities conducting UMP, and/or care coordination activities, to deny, limit, or discontinue medically-necessary services to any Member.

B. Authorization of Services

1. The Health Plan shall have in place written prior authorization/pre-certification policies and procedures for processing requests for initial and continuing authorization of services in a timely manner. The procedures shall be developed to reduce administrative burden on the providers. The Health Plan shall utilize any DHS-required standardized format for authorization of services. The Health Plan shall submit the policies and procedures for DHS review in accordance with §13.3.B, Readiness Review.

2. A Member shall be able to make a request to the Health Plan for the provision of a service. As part of these prior authorization policies and procedures, the Health Plan shall have in effect mechanisms to:

   a. Ensure consistent application of review criteria for

authorization decisions;

b. Consult with the requesting provider when appropriate;
c. Authorize service coordination/LTSS based on a Member's assessment and consistent with the person-centered service plan; and

d. Authorize care coordination services based on a SHCN/EHCN Member's assessment and consistent with the person-centered care plan.

3. The Health Plan shall ensure 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 healthcare professional who has appropriate clinical expertise in addressing the Member's medical, behavioral health, or LTSS needs.

4. Medical Necessity approvals may be made by licensed clinical staff or unlicensed staff under the supervision of licensed staff. Medical Necessity denials shall be made by licensed clinical staff. All denials of medical, behavioral health, and LTSS for adults age twenty-one (21) and older shall be reviewed by the designated Health Plan physician reviewers. All denials for children under the age of twenty-one (21) years shall be reviewed by Health Plan Medical Director.

5. The Health Plan shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. The Health Plan may

reduce or place appropriate limits on a service based on criteria such as Medical Necessity, or for utilization control provided that:

a. The services furnished can reasonably be expected to achieve their purpose; and

b. The services supporting Members with ongoing or chronic conditions or who require LTSS are authorized in a manner that reflects ongoing need for such services and supports.

6. 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 §4.5.B.6 and §4.5.B.21.

7. The Health Plan shall notify the provider of prior authorization/pre-certification determinations in accordance with the following timeframes:

a. For standard authorization decisions, the Health Plan shall provide notice as expeditiously as the Member's health condition requires but no longer than seven (7) calendar days following the receipt of the written request for service. An extension may be granted for up to fourteen (14) additional calendar days if the Member or the provider requests the extension, or if the Health Plan justifies a need for additional information and the extension is in the Member's best interest. If the Health Plan extends the timeframe, it shall give the Member written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file a grievance if he or she

disagrees with that decision. The Health Plan shall issue and carry out its determination as expeditiously as the Member's health condition requires and no later than the date the extension expires.

b. In the event a provider indicates, or the Health Plan determines, that following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, the Health Plan shall make an expedited authorization determination and provide notice as expeditiously as the Member's health condition requires but no later than seventy-two (72) hours after receipt of the request for service. The Health Plan may extend the seventy-two (72) hour timeframe by up to an additional fourteen (14) calendar days if the Member or provider requests an extension, or if the Health Plan justifies to DHS a need for additional information and the extension is in the Member's best interest. If the Health Plan extends the timeframe, it shall give the Member written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file a grievance if he or she disagrees with that decision. The Health Plan shall issue and carry out its determination as expeditiously as the Member's health condition requires and no later than the date the extension expires.

c. Authorization decisions related to coverage of: 1) environmental accessibility adaptations; 2) moving assistance; 3) specialized medical equipment, orthotics, or prosthetics that require personalized fitting or customization

specific to the Member; or 4) out-of-network non-emergent procedures, including out-of-state procedures, shall be provided within the standard authorization timeframes set forth in §5.2.B.7.a. The Health Plan will follow DHS policy guidance regarding implementation of authorization for these services. DHS may monitor timely provision of implementation of these services through an LTSS report that shall be designed in accordance with standards identified in §6.2.B.

8. Service authorization decisions not reached within the timeframes specified above and in accordance with DHS policy guidance shall constitute a denial and thus an adverse benefit determination, on the date that the time frames expire.

9. The Health Plan shall notify the Member and provider of the concurrent review determination within seventy-two (72) hours from the time of request receipt.

10. The Health Plan's prior authorization requirements shall comply with the requirements for parity in mental health and SUD benefits in 42 CFR §438.910(d).

C. Administrative Simplification Initiative

1. DHS is committed to increasing standardization and decreasing administrative burden for providers, Health Plans, and DHS, and consequently established the Administrative Simplification Initiative. The Health Plan shall actively participate in efforts that are led by DHS and DHS' Medical Director. The Health Plan may also be required to submit best practice recommendations to DHS upon request.

5.3 Administrative Requirements

A. Medical Records Standards

1. In alignment with its QAPI program, the Health Plan shall establish medical records standards, as well as a record review system to assess and ensure conformity with standards. These standards shall be consistent with the minimum standards established by DHS identified below:

   a. Require that the medical record is maintained by the provider;

   b. Ensure DHS personnel or personnel contracted by DHS 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 QI program for information released or exchanged pursuant to 42 CFR §431.300. The Health Plan shall be responsible for being in compliance with any and all state and federal laws regarding confidentiality;

   c. Provide DHS or its designee(s) with prompt access to Members' medical records;

   d. Inform Members of their right to request and receive a copy of their medical records, and to request they be amended, as specified in 45 CFR Part 164; and

   e. Allow for paper or electronic record keeping.

2. As part of the record standards, the Health Plan shall require that providers adhere to the requirements described in Health Plan Manual.

3. As part of its medical records standards, the Health Plan shall

ensure providers facilitate the transfer of the Member's medical records, to the new PCP within seven (7) business days from receipt of the request.

4. As part of its medical records standards, the Health Plan shall comply with medical record retention requirements in § 14.5.

5. The Health Plan shall submit its medical records standards to DHS for review in accordance with §13.3.B, Readiness Review.

B. Second Opinion

1. 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 healthcare team, a parent(s) or legal guardian(s), or a DHS social worker exercising custodial responsibility. A qualified healthcare 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.

C. Out-of-State/Off-Island Coverage

1. The Health Plan shall provide any medically-necessary services that are required by the Member. If these services are not available on the island where the Member resides, the Health Plan shall provide for these services whether off-island or out-of-state if Telehealth is not feasible or available. This includes referrals to an out-of-state or off-island specialist or facility, transportation to and from the referral destination for an off-island or out-of-state destination, lodging, and meals for the

Member and one (1) attendant, if applicable. However, if the service is available on a Member's island of residence, the Health Plan may require the Member to obtain the needed services from specified providers as long as the provider is in the same geographic location as the Member and the Member can be transferred.

2. The Health Plan shall provide out-of-state and off-island emergency medical services and post-stabilization services within the United States for all Members, as well as all out-of-state and off-island medically-necessary EPSDT Covered Services to Members under age twenty-one (21) years. The Health Plan may require prior authorization for non-emergency out-of-state or off-island services.

3. The Health Plan shall be responsible for the transportation costs to return the individual and their one (1) attendant, if applicable, to the island of residence upon discharge from an off-island or out-of-state facility when services were approved by the Health Plan or from an out-of-state or off-island facility for 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 dis-enrolled from the Health Plan during the out-of-state or off-island stay.

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

SECTION 6 – Health Plan Reporting and Encounter Data Responsibilities

6.1 Overview

A. The Health Plan shall comply with all reporting requirements established by DHS. Reporting requirements include data submitted to DHS in disaggregated format, as well as aggregated reports that may include quantitative and qualitative data and identifying information.

B. With regard to aggregated reporting requirements, the Health Plan shall submit reports based on DHS reporting requirements, which are published by DHS as part of the Health Plan Manual and incorporated by reference into this Contract. When requested, the Health Plan shall participate in a collaborative process with DHS and other Health Plans to update reporting requirements in the Health Plan Manual to ensure consistent usage of reporting specifications and interpretation of data definitions for all required reports.

C. The Health Plan shall submit to DHS all requested reports by the due dates and in the submission frequencies/intervals identified in the Health Plan Manual. Reports are expected to provide detailed analysis by the Health Plan, where applicable, including identified trends, successes, risks, and mitigation.

D. DHS reserves the right to modify the required reports and report requirements in the Health Plan Manual at any time. DHS will provide the Health Plan with a minimum of one full reporting cycle to incorporate substantive changes to reporting requirements to the extent feasible. Should reporting changes or new reporting

requirements be driven by state or federal requirements, timelines may be modified to ensure compliance with established state or federal deadlines.

E. Data and reports received from the Health Plan shall be used for the administration of the Medicaid program, including but not limited to monitoring, evaluation, public reporting, capitation rate setting, releasing financial withholds, implementing financial penalties, and assessing financial incentives. DHS may also share information among Health Plans to promote transparency and sharing of benchmarks/best practices. DHS shall publicly report measures in formats such as Health Plan report cards or score cards that include a variety of metrics, consumer guides, public reports, or otherwise, on DHS MQD's website in accordance with 42 CFR §438.602(g).

F. Pursuant to General Condition 2.2, DHS shall own any reports, studies, or data that the Health Plan produces in accordance with this RFP.

6.2 Report Descriptions

A. The Health Plan shall provide to DHS managerial, financial, delegation, utilization, quality, program integrity, and enrollment reports in compliance with 42 CFR §438.604 and in accordance with the reporting requirements detailed in the Health Plan Manual.

B. The Health Plan shall provide reporting to meet all federal regulations for Medicaid managed care programs as set forth in 42 CFR Part 438 and comply with all revised reporting requirements implemented by CMS during the Contract period. The Health Plan shall submit to DHS all data including encounter data, data to support MLR calculation, rate certification, risk solvency, data to demonstrate provider

availability and accessibility of services, including network adequacy, ownership and control, and any other data requested by DHS. DHS shall not request individual data of non-Members.

C. Additionally, the Health Plan shall provide necessary data, other information, or documentation as required by DHS to support verification, auditing, or contextualization of information submitted in reports to DHS. Information may also be requested by DHS to support its required and ad-hoc reporting to CMS or other state or federal agencies. As needed, the Health Plan shall provide access to all Member medical records for DHS review and follow-up. Any reviews may be conducted by DHS or delegated to the EQRO. The Health Plan shall allow DHS and/or the EQRO to conduct any reviews of documentation both on-site and remotely.

D. The Health Plans shall follow the reporting requirements in the Health Plan Manual when submitting reports. DHS may add, delete, or change any reporting requirements, or reporting due dates and submission frequencies, as needed, to ensure adequate oversight of contractual and federal and state requirements.

E. Reports, at a minimum, cover the topics listed below, although additional reporting requirements may be implemented as needed. Specific federally-required reports are explicitly identified and described within each section. However, each section may include additional reports at DHS' discretion.

1. Provider Network/Services

a. Reports on provider network and services include submission of assessments of provider network adequacy, distribution, access, and capacity; provider education and

training; PCP attribution and distribution characteristics; geographic and timely access to services; FQHC or RHC services; provider and employee suspensions and terminations; provider grievances and claims; participation in and receipt of incentives related to value-based purchasing; and integration of behavioral health and primary care. Select reports within this section are described herein.

b. Provider Network Adequacy Verification Report.

1) To ensure compliance with 42 CFR §438.207 and 42 CFR §438.604, the Health Plan shall submit a Provider Network Adequacy Verification Report demonstrating that it offers an appropriate range of preventive care, primary care, specialty services, and LTSS that is adequate for the anticipated number and needs of its Members and that the network of providers is sufficient in number, mix, and geographic distribution to meet the needs of Members in the service area in accordance with DHS standards for access to care specified in §8.1. The report shall be submitted in the format specified by DHS. DHS may require both aggregate metrics and provider-level reporting for this report.

2) An adequate provider network requires an appropriate ratio of providers accepting Medicaid Members and Members residing within a given travel time or distance. However, in addition to meeting an appropriate ratio, an adequate network shall meet the

needs of all Members. Members that require care in specific languages, or those who need physical or behavioral disability accommodations, shall reside within a certain travel time or distance of a general practitioner and various specialists that can provide that accommodation. Provider decisions and limits on accepting new QI patients shall be considered in determining the true availability and the capacity of the network in serving Members. Therefore, the Health Plan is required to use Geographic Information Systems or similar software to describe the geographic distribution of its provider network, in relation to the geographic distribution of its Members.

3) The Health Plan is expected to use spatial analytics and mapping to conduct a series of analyses that are used to report on DHS–required metrics for the Provider Network Adequacy Verification Report including, but not limited to, network adequacy considering provider-to-Member ratios alone, provider-to-Member ratios after accounting for driving time requirements, provider-to-Member ratios after restricting the network to providers accepting QI patients, and provider-to-Member ratios after restricting the network to providers who offer services in specific non-English languages. Health Plans are expected to use driving distance, rather than straight-line distance, to calculate all driving times. The analytic methodology shall be submitted with the report and is subject to verification by DHS. DHS may

ask for additional supporting information such as maps and analytic outputs.

4) The Health Plan shall use the Provider Network Adequacy Verification Report to certify the adequacy of its network for the Health Plan's Members by provider type, including geographic access standards specified in §8.1. Geographic access standards may, in part, be met via Telehealth access as specified in Section 8 and reported as such by the Health Plan in the Provider Network Adequacy Verification Report.

5) The Health Plan shall also provide a narrative that describes the Health Plan's strategy to maintain or augment its provider network, that includes the following considerations:

   a) The numbers of network providers who are not accepting new patients;

   b) 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;

   c) Access to services via Telehealth, considering Members' technological and technical capacity to avail themselves of Telehealth services;

   d) Current network gaps and the methodology used to identify them;

   e) Immediate short-term interventions when a gap

occurs including expedited or temporary credentialing; and

f) Interventions to fill network gaps and barriers to those interventions.

6) The Provider Network Adequacy Verification Report shall be submitted at a minimum as specified in the reporting timetable, but shall also be submitted as an ad-hoc report under the following circumstances:

a) Upon request by DHS;

b) Upon changes in services, benefits, geographic service area, composition of, or payment methodology to its provider network; and

c) 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:

i. A decrease in the total number of PCPs by more than five (5) percent per island. For the island of Hawaii, the Health Plan shall calculate this percentage separately for East Hawaii and West Hawaii;

ii. A loss of providers in a specific specialty where another provider in that specialty is not available on the island;

iii. A loss of a hospital; or

iv. Enrollment of a new population.

c. Timely Access Report

1) To ensure compliance with Timely Access standards in §8.1, and per 42 CFR §438.206, the Health Plan shall submit a Timely Access Report that monitors the time that lapsed between a Member's initial request for care and when the care was delivered, using a DHS–approved methodology. DHS may also specify the methodology used to gather data for the report. The Timely Access Report shall independently verify the provision of timely care for each type of contractually required timeframe of care. The Health Plan may be required to submit a variety of metrics per DHS specifications; DHS may compare the Health Plan's data to national standards and benchmarks and set Health Plan targets. The Health Plan shall be required to cure deficiencies in performance when identified. If the Health Plan does not meet timely access in any one area, for a particular type of specialist, DHS may require additional data collection to support closer monitoring in that area.

2) Health Plans, in collaboration with other Health Plans and MQD, have agreed to create a shared implementation strategy to standardize data collection to support the Timely Access Report requirement explained above. That shared implementation strategy resulted in DHS contracting through DHS-22-MQD-0119 with a contractor to provide data collection for all the Health Plans. The

Health Plans shall reimburse DHS for their share of the costs of this contract as follows:

a) Per section 60.91 of RFP-MQD-2022-002, each Health Plan shall be invoiced by the contractor and each Health Plan shall process the invoices by attaching an attestation acknowledging the amounts they will reimburse DHS, and attesting to the satisfactory completion of the contractor's work;

b) Pursuant to section 40.50.G of RFP-MQD-2022-002, the Health Plans will review each invoice submitted by the contractor and authorize payments made by DHS that are attributed to the Health Plan, and

c) Pursuant to sections 40.60.C and 40.50.H of RFP-MQD-2022-002, Health Plans shall reimburse DHS for services performed by the contractor in a timely manner as agreed upon between DHS and the Health Plans.

d. Suspensions, Terminations, and Program Integrity Education Report

1) The Health Plan shall notify DHS within three (3) business days of a provider's or employee's suspension or termination, both voluntary and involuntary, because of suspected or confirmed fraud, waste and abuse. The immediate notification shall include the provider's or employee's name,

specialty, and if applicable, the reason for the action and the effective date of the suspension or termination. Per 42 CFR §438.608, the Health Plan shall also submit a Suspensions, Terminations, and Program Integrity Education Report in order for DHS to adequately monitor changes in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the Health Plan; or any compromise to the Health Plan's ability to meet contractual obligations. This report shall include information on actions taken against any providers with whom the Health Plan refuses to enter into or renew an agreement, as described in §8.2. The report shall include all provider or employee suspensions and terminations, as well as information on providers or employees who were offered education on one or more program integrity topics or who voluntarily separated from the Health Plan in lieu of suspension or termination actions.

e. Provider Grievances and Claims Report

1) Per 42 CFR §438.66(c), the Health Plan shall submit its provider grievances and appeals logs to support DHS monitoring of Health Plan performance in addressing provider complaints. The Health Plan shall provide DHS with metrics specified by DHS, and as required, record-level data on provider complaints,

grievances, and appeals. DHS shall use the data submitted to monitor a variety of contractual and federal and state requirements including, but not limited to, volume, rate, and types of grievances and appeals filed, as well as appropriate Health Plan responses and timeliness of resolution of cases. DHS shall specifically track claims processing metrics as part of this reports to monitor the Health Plan's compliance with 42 CFR §447.46.

2. Covered Benefits and Services

   a. Reports on Covered Benefits and Services include submission of comprehensive information on identification, engagement, participation, services, utilization, and quality of care delivered under special programs such as EPSDT, and to special populations such as LTSS, SHCN, EHCN, CIS+, and Going Home Plus. Select reports within this section are described below:

      1) SHCN Report

         a) Per 42 CFR §438.330, the Health Plan shall submit an SHCN Report that allows DHS to monitor and evaluate mechanisms used by the Health Plan to identify populations with SHCN, and assess the quality, quantity, appropriateness, and cost of care furnished to beneficiaries with SHCN. The Health Plan may be required to submit both process and outcome metrics. The SHCN report shall also include EHCN beneficiaries. DHS may

require both Member-level and aggregate reporting of SHCN data and EHCN data from the Health Plan in a format specified by DHS.

2) CIS+ Report

a) Per 42 CFR §438.330, and to support reporting and evaluation per Hawaii's Section 1115 demonstration project, the Health Plan shall collect and submit any data determined reasonable, appropriate, and necessary by DHS, CMS, or another legally authorized oversight body. A CIS+ report allows DHS to monitor, oversee, and evaluate the CIS+ initiative. This includes, but is not limited to, data that allows DHS to identify populations eligible for CIS+, and assess the quality, quantity, appropriateness, effectiveness, outcomes, and cost of care furnished to beneficiaries in the CIS+ program; monitor appeals and grievances; and document clinical appropriateness of CIS+ services. To fully meet reporting requirements for CIS+, the Health Plan shall participate in rapid cycle assessments and other evaluations of the CIS+ Program by DHS and collect and report on quality metrics and additional data as required by DHS. The Health Plan may be required to submit both process and outcome metrics. DHS may require both Member- level and aggregate reporting of CIS+ data from the Health Plan in a format specified by DHS, stratified by

demographic variables, such as age, sex, race, ethnicity, disability status, and preferred language, and others when requested and available.

3) Home and Community-Based Services Report

a) Per 42 CFR §438.330, and to support reporting and evaluation per Hawaii's Section 1115 demonstration project, the Health Plan shall submit an HCBS report that allows DHS to monitor and evaluate mechanisms used by the Health Plan to identify populations eligible for HCBS services, including both populations meeting NF LOC, and those qualifying for at-risk services; and assess the quality, quantity, appropriateness, and cost of care furnished to beneficiaries receiving HCBS.

b) Two types of reporting shall be required under the HCBS Report:

i) To comply with CMS requirements, Health Plans shall implement a Health and Welfare Safeguard Process for Adverse Event Reporting on Mortalities and the Use of Restrictive Interventions for populations receiving HCBS services. In addition, the Health Plans shall include different types of adverse events listed in the Health Plan manual for populations residing in nursing facilities, Long-Term

Services and Supports, Home and Community Based Services, Special Health Care Needs, and Community Integration Services. Adverse events reporting requires timely, immediate notification to DHS and may additionally be summarized in quarterly or annual HCBS reports. Specific guidance will be issued by DHS.

ii) Per CMS requirements, the Health Plan shall meet waiver assurances set forth in 42 CFR §§441.301 and 441.302, and report on these assurances regarding the care of beneficiaries receiving HCBS. Where the Health Plan fails to meet one or more assurances, the Health Plan shall submit a remediation plan as part of the HCBS report; the Health Plan shall demonstrate progress towards curing any previously noted deficiencies in future reports until complete resolution.

c) The HCBS Report may additionally include data on services provided, assessments performed, service plan updates, addition or reduction of services, authorization of services (i.e., environmental adaptations) and any other measures DHS deems necessary. DHS may require both Member-level and aggregate

reporting of HCBS data from the Health Plan in a format specified by DHS.

4) Early and Periodic Screening, Diagnostic, and Treatment Report

a) To allow for monitoring and compliance purposes, and to support CMS-416 reporting, the Health Plan shall submit the EPSDT Report to DHS. DHS shall use the report to assess the quality and quantity of EPSDT services furnished to qualifying beneficiaries. The Health Plan may be required to submit both process and outcome metrics. DHS may require both Member-level and aggregate reporting of EPSDT data from the Health Plan in a format specified by DHS, including data collected by providers using the Hawaii EPSDT Exam, DHS 8015 form. The Health Plan's Medical Director shall review this report prior to submission to DHS.

5) Reentry Services Report

a) Pursuant to 42 CFR §438.330, and to support reporting and evaluation pursuant to Hawaii's Section 1115 demonstration project, the Health Plan shall submit a Reentry Services report that allows DHS to monitor and evaluate mechanisms used by the Health Plan to identify individuals who qualify for pre-release services, and assess the quality, quantity, appropriateness, and cost of care furnished to beneficiaries in the reentry program. To fully meet reporting requirements for the reentry

program, the Health Plan shall collect and report on utilization of applicable pre-release and post-release services, provision of social service referrals pre-release, case management services provided pre-release and post-release, and any other metrics and data as required by DHS. DHS may require both Member-level and aggregate reporting of reentry data from the Health Plan in a format specified by DHS.

3. Member Services

   a. Reports on member services include submission of data on Member services such as call center statistics, PCP assignment, services provided to beneficiaries with English as a Second Language needs. The Health Plan will also report on Member grievances and appeals, information on Member eligibility for and inclusion in various programs, and demographic changes. Finally, CAHPS® Consumer Survey data will be reported. Other Member-level data shall include total cost of care indicators, total spend and spend by categories, and Member attribution to providers. Select reports within this section are described below:

      1) Member Grievances and Appeals Report

         a) Per 42 CFR §438.66(c), the Health Plan shall submit its Member grievance and appeal logs to support DHS monitoring of Health Plan compliance with 42 CFR §438 Subpart F. Health Plan shall provide DHS with metrics and record-level data on

Member grievances and appeals. DHS shall use the data submitted to monitor a variety of contractual and federal requirements including, but not limited to, volume, rate, and types of grievances and appeals filed, as well as appropriate Health Plan response including timeliness of resolution, and administrative disposition of cases.

2) Provider or Member Satisfaction Survey Report

a) The Health Plan shall provide data to enable DHS to monitor Health Plan performance, in accordance with 42 CFR §438.66(c), including results from any enrollee or Provider satisfaction survey conducted by Health Plan. The Health Plan shall provide a copy of the survey results to DHS, along with any additional information necessary to contextualize the findings of the survey. This reporting requirement is separate from any enrollee or Provider surveys, including any CAHPS® surveys, conducted by DHS.

3) Call Center Report and Remote Monitoring

a) To satisfy 42 CFR §438.66(c), the Health Plan shall provide data and access to DHS, as needed, to monitor the Health Plan's performance in providing customer service to its Members. The Health Plan shall provide DHS employees with the ability to monitor calls to the Health Plan's Member call center and 24-hour nurse call line as

described in §9.4, to ensure Health Plan performance across a number of aspects of call quality monitoring. In addition, the Health Plan shall provide required data via the Call Center Report to monitor various quality attributes such as, but not limited to: call volume, timeliness, and responsiveness. DHS may compare the Health Plan's data to national standards and benchmarks, and set Health Plan targets. The Health Plan shall be required to cure deficiencies in performance when identified.

4. Quality

a. Reports on quality include submission of quality-related plans and reports regarding the QAPI plan, SDOH, PIPs, and quality and performance metrics required by DHS. Reports on accreditation will also be submitted in this section. Select reports within this section are described below:

1) Accreditation Status Report

a) In compliance with 42 CFR §438.332(b)(1), the Health Plan shall submit an Accreditation Status Report to provide status updates on the Health Plan's accreditation status as required in Section 5. The Health Plan shall provide DHS a copy of its most recent accreditation review, including:

i) Accreditation status, survey type, and level;

ii) Accreditation results, including

recommended actions or improvements, corrective action plans, and summaries of findings; and

iii) Expiration date of the accreditation.

b) If the Health Plan is currently applying for re-accreditation, the Health Plan shall provide timely status updates on its renewal status. These updates shall detail activities undertaken and provide a synopsis of any issues that arise that may impede the accreditation process.

2) Quality Assessment and Performance Improvement Reports

a) Per 42 CFR §438.330 and as noted in §5.1, the Health Plan shall submit quarterly and annual QAPI reports as noted below:

i) QAPI Quarterly Progress and Work Plan Update; and

ii) QAPI Progress Report and Annual Plan Update.

b) The Health Plan's Medical Director shall review these reports prior to submittal to DHS. The QAPI Plan submitted at the start of the contract shall not include a progress report component, and the QAPI Progress Report submitted at end of the contract shall not include a plan update component. QAPI work plans and progress reports shall meet submission requirements

noted in §5.1, and be submitted using templates and formats specified by DHS. As noted in §5.1, the QAPI work plans and progress reports shall incorporate reports of disparities and a work plan to address identified disparities, supporting DHS compliance with 42 CFR §438.340.

3) Quality and Performance Measurement Report

   a) Per 42 CFR §438.330 and as described in §5.1, DHS shall collect performance measurement data from the Health Plan. DHS may require both Member-level and aggregate reporting of quality and performance measurement data from the Health Plan in a format specified by DHS. For each measure, DHS may require one or more rates or stratifications. These reports shall cover the period from January 1 to December 31, unless otherwise specified by DHS; DHS shall specify the list of measures to be reported for each calendar year. The EQRO shall annually perform report validation on at least six (6) DHS-selected measures. If DHS-selected measures include HEDIS measures, the validation shall also ensure the Health Plan's compliance with HEDIS methodology. The EQRO shall validate measures selected for inclusion in P4P programs, as described further in Section 7.

4) Performance Improvement Project Report

a) Per 42 CFR §438.330 and as described in §5.1, DHS shall collect reports on the Health Plan's PIPs. A PIP report shall be submitted annually for each PIP conducted by the Health Plan during the year. PIP reports shall include elements noted in §5.1, and 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 PIPs may be requested more frequently by DHS.

5. Utilization Management

a. Reports on Utilization Management include submission of data on utilization and prior authorizations, parity in provision of services, over- and under-utilization of services, and DURs. In addition, DHS shall include reporting on overall utilization and spending on primary care, and measures assessing relative utilization and spend across services, for example, nursing home versus HCBS utilization. Select reports within this section are described below:

1) Mental Health and Substance Use Disorder Parity Report

a) Per 42 CFR §438.3(n), the Health Plan shall submit documentation to demonstrate its compliance with 42 CFR §438 Subpart K, Parity in Mental Health and SUD Benefits. Accordingly, the Health Plan

shall provide an annual Mental Health and SUD Parity Report. This report is used by DHS to ensure behavioral health or mental health/SUD (MH/SUD) services are provided by the Health Plan in a manner that is comparable to, or not any more stringent than, medical/surgical services provided by the Health Plan, as per the Medicaid

Parity Final Rule and the Mental Health Parity and Addiction Equity Act of 2008.

b) The Mental Health and SUD Parity Report shall be submitted in the format provided by DHS. It shall require multiple parity analyses of MH/SUD services provided by the Health Plan compared to medical/surgical services provided. The required analyses may include, but may not be limited to, whether the Health Plan has achieved parity for MH/SUD services in the following ways:

    i) In terms of aggregate lifetime and annual dollar limits;

    ii) In any other financial requirements or treatment limitations applied by the Health Plan;

    iii) Across various care settings (e.g., inpatient, outpatient, emergency, drugs;

    iv) With regard to copayments, coinsurance, deductibles, and out-of-

pocket maximums imposed;

v) On any quantitative treatment limits (QTLs) set by the Health Plan; or

vi) On any non-QTLs (NQTL) set by the Health Plan.

c) QTLs are numerical limits on the scope or duration of a benefit (e.g., fifty [50] outpatient visits per year). NQTLs are non-numerical limits on the scope or duration of benefits, such as formularies, prior authorization, or network admission standards.

d) The Health Plan shall provide DHS any additional supporting documentation requested. Parity analyses of MH/SUD and medical/surgical services across all QI and CCS Health Plans shall be done by DHS.

6. Provider Preventable Conditions

a. To comply with 42 CFR §447.26, the Health Plan shall report all identified provider preventable conditions (PPCs) through encounter data submissions. The mechanism for reporting shall be specified by DHS; the Health Plan will be required to flag encounters associated with PPCs by claim reference numbers (CRNs).

7. Drug Utilization Review Report

a. Per 42 CFR §438.3, the Health Plan shall provide a detailed description of its DUR program activities to DHS on an

annual basis, including the mechanisms it has in place to detect the under-utilization and over-utilization of drugs.

b. Specifically, the Health Plan is required to describe:

1) The Health Plan's process for screening prescription drug claims to identify problems such as therapeutic duplication, drug-disease contraindications, incorrect dosage or duration of treatment, drug allergy, and clinical misuse or abuse;

2) The Health Plan's retrospective review of claims data to identify patterns of fraud, abuse, gross overuse, or medically-unnecessary prescription medication use; and

3) The Health Plan's protocols for implementing corrective actions when issues are identified using the screening and review processes described above.

4) In addition, for controlled substances, the Health Plan shall submit its mechanism to detect and appropriately address both underutilization and overutilization thorough its PMP, and the results of this process.

5) The DUR report shall describe the Health Plan's prescribing patterns, findings from the screenings and retrospective reviews conducted, corrective actions taken and results, and cost savings resulting from the DUR program. DHS will specify the report format and any additional metrics to be submitted. DHS may compare the Health Plan's data to national

standards and benchmarks and set Health Plan targets. The Health Plan shall be required to cure deficiencies in performance when identified.

8. Over-Utilization and Under-Utilization of Services Report

   a. The Health Plan shall submit reports on over-utilization and under-utilization of services per 42 CFR §438.66 that describe the Health Plan's required mechanism to detect and appropriately address both underutilization and overutilization of services, and the results of this process.

      The report shall trend various metrics as specified by DHS. DHS may compare the Health Plan's data to national standards and benchmarks, and set Health Plan targets. The Health Plan shall be required to cure deficiencies in performance when identified.

9. Prior Authorizations Reports – Medical and Pharmacy

   a. To enable DHS to ensure Health Plan coverage and authorization of services are compliant with 42 CFR §438.210(c) and 42 CFR §438.404, and as allowed by 42 CFR §438.66(c), the Health Plan shall provide DHS with metrics and record-level data on prior authorizations for medical and pharmacy benefits. DHS shall use the data submitted to monitor a variety of contractual and federal and state requirements including, but not limited to, number and types of requests for prior authorizations, volume and justification for denials and deferrals by the Health Plan if applicable, information on any appeals received, instances of inappropriate or inconsistent application of the prior

authorization policies, and timely decision-making and notification of decisions about prior authorization. DHS may compare the Health Plan's data to national standards and benchmarks, and set Health Plan targets. The Health Plan shall be required to cure deficiencies in performance when identified.

F. Administration, Finances, and Program Integrity

1. Reports on administration, finances, and program integrity include submissions of reports on FWA; employee suspensions and terminations; financial reporting; TPL cost avoidance;

   required Health Plan disclosures; encounter data submission; Medicaid Contract reporting, recoveries, and reconciliation of encounter data to financial summaries; MLR; mental health and SUD parity; and over-payments. Whereas, §12.1 and §12.2 describe immediate and timely reporting requirements to support program integrity investigation activities. §6.2 encompasses Health Plan reporting requirements pertaining to reports that compile, aggregate, and summarize a variety of program integrity activities completed over the reporting timeframe. Select reports within this section are described below:

   a. Medical Loss Ratio Report

      1) MLR standards are established to ensure the Health Plan is directing a sufficient portion of the capitation payments received from DHS to services and activities that improve health in alignment with DHS' mission. The Health Plan shall submit an annual MLR

report in compliance with 42 CFR §§438.74, 438.8, and 438.604. In this report, the Health Plan shall calculate and report the MLR as described below. The Health Plan shall provide data that shall be used by DHS to determine the Health Plan's compliance with the MLR requirement.

2) The Health Plan shall calculate and report the MLR in accordance with the following:

   a) The MLR experienced for the Health Plan in a reporting year is the ratio of the numerator as defined in accordance with 42 CFR §438.8(e), to the denominator as defined in accordance with 42 CFR §438.8(f);
   b) Each expense shall be included under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense shall be prorated and parsed between types of expenses;
   c) Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, shall be reported on pro rata basis;
   d) Expense allocation shall be based on a generally accepted accounting method that is expected to yield the most accurate results;
   e) Shared expenses, including expenses under the terms of a management contract, shall be

apportioned pro rata to the contract incurring the expense;

f) Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, shall be borne solely by the reporting entity and are not to be apportioned to the other entities;

g) The Health Plan may add a credibility adjustment to a calculated MLR if the MLR reporting year experience is partially credible;

h) The credibility adjustment is added to the reported MLR calculation before calculating any remittances, if applicable;

i) The Health Plan may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible;

j) If the Health Plan's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards;

k) The Health Plan will aggregate data for all Medicaid eligibility groups covered under the contract;

l) The Health Plan shall provide a remittance for an MLR reporting year if the MLR for that reporting year does not meet the minimum MLR standard of eighty five (85) percent or higher;

m) The Health Plan shall require any third-party vendor providing claims adjudication activities to

provide all underlying data associated with MLR reporting to the Health Plan within one hundred eighty (180) days of the end of the MLR reporting year, or within thirty (30) days of being requested by the Health Plan, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting; and

n) Any retroactive changes to capitation rates after the contract year end will need to be incorporated into the MLR calculation. In instances where DHS makes a retroactive change to the capitation payments for an MLR reporting year where the report has already been submitted to DHS, the Health Plan shall:

   i) Re-calculate the MLR for all reporting years affected by the change;

   ii) Submit a new MLR report for each reporting year affected by the change, meeting the applicable requirements; and

   iii) Submit a new report incorporating the change within 30 days of the capitation rate adjustment payment by DHS.

o) The Health Plan and its Subcontractors shall retain all MLR data for a period of no less than ten (10) years in accordance with 42 CFR §438.3(u). The Health Plan shall attest to the

accuracy of the calculation of the MLR in accordance with MLR standards when submitting required MLR reports.

p) The Health Plan shall exclude spread pricing, which is defined as the amount charged by a pharmacy benefit manager to a managed care organization that is in excess of the amount paid to the pharmacy for a prescription, including the ingredient cost and dispensing fee from the calculation of the MLR.

q) Expenditures for services reimbursed under non-risk payment arrangements, as described in Section 7, shall be excluded from MLR reporting and calculations.

r) The Health Plan shall impose MLR reporting and remittance requirements on subcontractors that meet DHS' definition of risk-bearing subcontractors, in accordance with DHS guidance. Subcontractor MLR requirements shall be consistent with 42 CFR § 438.8(k), 42 CFR § 438.8(j), applicable CMS guidance, and DHS policies and procedures as outlined in DHS guidance and the Health Plan Manual.

    i. Beginning with service dates on or after January 1, 2026, the Health Plan shall require all applicable subcontractors to calculate and report a MLR, and shall

incorporate subcontractor MLR information into its own annual MLR submission to DHS.

ii. Beginning with service dates on or after January 1, 2027, the Health Plan shall impose remittance requirements on all applicable subcontractors that fail to meet the DHS established MLR standard, and shall account for such remittances in its own MLR submission to DHS.

2. Overpayments Report

a. The Health Plan is required to recover and report all overpayments as noted in §12.1.D, including both overpayments made by the Health Plan to providers, and overpayments made by DHS to the Health Plan. Per 42 CFR §438.608, the Health Plan is responsible for the prompt reporting of all overpayments identified or recovered,

specifying the overpayments due to potential FWA, and reporting of all its recoveries of overpayments to DHS.

b. The overpayment shall be reported in the reporting period in which the overpayment is identified. In addition, once recovery of overpayments is completed, the Health Plan shall replace the encounter data to reflect the correct payment amounts. It is understood that the Health Plan may not be able to complete recovery of overpayment until after the reporting period. However, the Health Plan shall properly account for any outstanding recoveries in future reports so that all overpayment activities are fully disclosed

to DHS and addressed in the encounter data submitted by the Health Plan.

c. The Health Plan shall report to DHS the full overpayment identified, even if the Health Plan negotiated and retained a lesser repayment amount with the provider, as noted in §12.1.D.2.

d. The Health Plan shall also maintain documentation of the education and training provided in addition to reporting the recovered amounts. Education and training given to providers as part of the Health Plan program integrity efforts may be reported to DHS in the Provider Suspensions, Terminations, and Program Integrity Education report.

e. The Overpayments Report will document all overayments, and all recovered and pending recovery amounts. It will specify and distinguish those overpayments which were identified as FWA from all the rest of the overpayments included in the report. It will also differentiate between overpayments by the Health Plan to providers from overpayments by DHS to the Health Plan. It will additionally identify the CRNs of encounters impacted by overpayments investigations and document the Health Plan's submission of a revised encounter based on the revised paid amounts for each encounter. Where recoveries are unable to be reflected in re-processed encounter data, the Health Plan will list those specific recovery amounts as an itemized list in the report.

3. Disclosure of Information on Annual Business Transactions

a. The Health Plan shall also submit information on ownership and control described in 42 CFR §455.104, as applicable to the Health Plan, and to the Health Plan's Subcontractors as governed by 42 CFR §438.230. At its discretion, DHS may conduct an evaluation of disclosures reported for the purpose of determining their adverse impact, if any, on the fiscal soundness and reasonableness of program costs submitted to DHS.

b. Specifically, the Health Plan shall disclose information on the following types of transactions:

    1) Any sale, exchange, or lease of any property between the Health Plan and a party in interest;

    2) Any lending of money or other extension of credit between the Health Plan and a party in interest; and

    3) Any furnishing for consideration of goods, services including management services or facilities between the Health Plan and the party in interest as defined below. This does not include salaries paid to employees for services provided in the normal course of their employment.

c. The Health Plan shall include the following information regarding the transactions listed above:

    1) The name of the party in interest for each transaction;

    2) A description of each transaction and the appropriate quantities or units involved;

    3) The total dollar value of each transaction during the

fiscal year; and

4) Justification of the reasonableness of each transaction.

d. For the purposes of this section, a party in interest, as defined in Section 1318(b) of the Public Health Service Act, is:

1) Any director, officer, partner, or employee responsible for management or administration of the Health Plan; any person who is directly or indirectly the beneficial owner of more than five (5) percent of the equity of the Health Plan; any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than five (5) percent, of the Health Plan; or, in the case of a Health Plan organized as a non-profit corporation, an incorporator or Member of such corporation under applicable state corporation law;

2) Any organization in which a person described above is director, officer or partner; has directly or indirectly a beneficial interest of more than five (5) percent of the equity of the Health Plan; or has a mortgage, deed of trust, note, or other interest valuing more than five (5) percent of the assets of the Health Plan;

3) Any person directly or indirectly controlling, controlled by, or under common control with the Health Plan; or

4) Any spouse, child, or parent of an individual described in the foregoing bullets.

e. In addition, annually and within thirty (30) days after any change in ownership of the Health Plan, the Health Plan shall update DHS on the following information:

1) The name and address of any person, individual or corporation, with an ownership or controlling interest in the disclosing entity, fiscal agent, or managed care entity. The address for corporate entities shall include, as applicable, the primary business address, every business location, and P.O. Box address(es);

2) Date of birth and social security number in the case of an individual;

3) Other tax identification number in the case of a corporation with an ownership or control interest in the disclosing entity, fiscal agent, managed care entity; or in any Subcontractor in which the disclosing entity, fiscal agent, or managed care entity has a five (5) percent or more interest;

4) Whether the person, individual, or corporation with an ownership or control interest in the disclosing entity, fiscal agent, or managed care entity is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person, individual, or corporation with an ownership or control interest in any Subcontractor in which the disclosing entity, fiscal agent, or managed care entity has a five (5) percent or more interest is related to another person with ownership or control interest in the disclosing

entity as a spouse, parent, child, or sibling;

5) The name of any other disclosing entity, fiscal agent, or managed care entity in which an owner of the disclosing entity, fiscal agent, or managed care entity has an ownership or control interest;

6) The name, address, date of birth, and social security number of any managing employee of the disclosing entity, fiscal agent, or managed care entity; and

7) The identity of any individual who has an ownership or control interest in the Health Plan, or is an agent or managing employee of the provider, and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX Services Program since the inception of those programs.

4. Medicaid Contract Report

a. The Health Plan shall submit an annual Medicaid Contracting Report to DHS, the State of Hawaii, DCCA Insurance Division, and the Hawaii State Legislature, no later than one hundred eighty (180) days following the end of the SFY. The content of the Medicaid contracting report shall include the information required from the HRS §103F-107.

5. Encounter Data/Financial Summary Reconciliation Report

a. Per 42 CFR §438.604, the Health Plan shall submit encounter data to DHS as described in Section 6. Reported encounter data will be considered part of data on the basis of which DHS certifies the actuarial soundness of capitation

rates to the Health Plan. The Health Plan shall submit an Encounter Data/Financial Summary Reconciliation Report to support the State's requirement to validate the accuracy and completeness of encounter data, as required in 42 CFR §438.818, and as defined in Section 6.

6. QUEST Integration Financial Report

   a. Per 42 CFR §438.3(m) and 42 CFR §438.604, the Health Plan shall submit audited financial reports specific to the QI Contract on an annual basis. The Health Plan shall, in accordance with generally accepted accounting practices, prepare audited financial reports that adequately reflect all direct and indirect expenditures, and management and fiscal practices related to the Health Plan's performance of services under this Contract. The audit shall be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards.

   b. Financial information submitted to DHS as part of this report shall be analyzed and compared to industry standards and standards established by DHS to ensure the financial solvency of the Health Plan. Additionally, the Health Plan shall submit data to enable DHS to ensure the Health Plan has made adequate provision against the risk of insolvency as required under 42 CFR §438.116.

   c. DHS may also monitor the financial performance of the Health Plan with on-site inspections and audits, and request any other data as needed.

7. Prescription Drugs Rebates Report

a. For all covered outpatient drugs, as described in 42 CFR §438.3(s) and in accordance with §4.5.B.16, the Health Plan shall:

1) Report drug utilization data that is necessary for the State to bill manufacturers for rebates no later than 45 days after the end of each quarterly rebate period.

2) Report drug utilization information that includes, at a minimum, information on the total number of units of each dosage form, strength, and package size by National Drug Code of each covered outpatient drug dispensed or covered by the Health Plan.

3) Establish procedures to exclude utilization data for covered outpatient drugs that are subject to discounts under the 340B drug pricing program from drug utilization data reports if the State does not require submission of managed care drug claims data from covered entities directly.

8. Fraud, Waste, and Abuse Report

a. In order to comply with 42 CFR §438.608(a)(7), the Health Plan shall promptly refer to any potential or suspected FWA identified to DHS and the State Medicaid Fraud Control Unit (MFCU) as described in greater detail in Section 12.

b. In addition to providing prompt notifications to DHS, the Health Plan shall also submit FWA reports that include, at a minimum, the following information on all alleged FWA cases:

1) A summary of activities related to all FWA investigations during the reporting period, including but not limited to those that resulted in a referral to DHS;

2) For all cases referred to DHS, information on FWA detection and investigation conducted, the administrative disposition of the case(s), any disciplinary action imposed before and after the filing of the referral, the approximate dollars involved in each incident, and the total approximate dollars impacted during the reporting period;

3) For all cases referred to and subsequently disposed by DHS, and for any cases that did not rise to the level of referral to DHS, a summary of remediation and resolution activities undertaken during the period including but not limited to:

   a) The training provided;

   b) Provider monitoring and profiling activities;

   c) Review of under- and over-utilization patterns in providers' provision of services and VOS with Members to whom services were delivered and/or the Member's electronic visit verification (EVV);

   d) A summary of the results of the VOS or EVV activities performed with Members as described in §12.2;

   e) Any other steps taken to remedy the situation; and

f) Metrics to evaluate trends in program integrity activities of the Health Plan.

4) DHS reserves the right to request additional summaries or case-specific data as needed. The Health Plan and its Subcontractors shall retain all FWA data for a period of no less than ten (10) years in accordance with 42 CFR §438.3(u).

G. Medicare Alignment

1. Reports on Medicare alignment include submission of Medicare D-SNP encounter data; submission of other performance data on the Medicare population including any available Medicare Health Outcomes Survey data; and information regarding performance of the D-SNP plan, including, but not limited to, MA Star Quality Ratings, including poor performing icons, notices of non-compliance, audit findings, and corrective action plans. If a Health Plan is under a national contract number, then it shall submit data and reports specific to its Members residing in Hawaii as requested by DHS.

H. Mental Health Evidence-Based Practices

1. Reports on mental health evidence-based practices include submission of data and reports that detail the delivery of mental health evidence/research-based practices provided to Members under the age of twenty-one (21) by a qualified medical provider.

I. Other Data Collection

1. The Health Plan shall submit the following data to DHS as required to improve the performance of the Contract:

a. Enrollment and disenrollment data;

b. Member grievance and appeal logs;

c. Provider complaint and appeal logs;

d. Results of any Member satisfaction survey conducted by the Health Plan;

e. Results of any provider satisfaction survey conducted by the Health Plan;

f. Medical management committee reports and minutes from the Health Plan; and

g. Customer service performance data.

2. The Health Plan shall submit any other data, documentation, or information relating to the performance of the Health Plan's obligations under this Contract as requested by DHS or the federal government.

6.3 Specialized Reporting

A. The Health Plan may recommend other reporting that it generates for internal use that would also be useful for DHS to review.

B. DHS may require the Health Plan to prepare and submit special or ad-hoc reports for the administration of the state Medicaid program. In addition, the Health Plan shall comply with all additional requests from DHS, or its designee, for additional data, information and reports for the administration of the state Medicaid program.

C. DHS shall give the Health Plan reasonable and sufficient notice prior to the submission of ad-hoc reports to DHS. The notice shall be reasonable relative to the nature of the ad-hoc report requested by DHS. At a minimum, DHS shall give Health Plan five (5) business

days' notice prior to submission of an ad-hoc report. In the event the Health Plan is under a corrective action plan, the Health Plan may be required to submit certain reports more frequently than stated in this section.

6.4 Encounter Data Reporting

A. Encounter Data General Requirements

1. DHS collects and uses encounter data for many reasons such as audits, investigations, identifications of improper payments, and other program integrity activities; federal reporting, as described in 42 CFR §438.242(b)(1); rate setting and risk adjustment; analysis of denial patterns; verification of reported quality measure data prior to release of withhold, incentive payments; service verification, managed care quality improvement program, policy analysis, executive and legislative decision-making, and assessment of utilization patterns and access to care; hospital rate setting; pharmacy rebates; and research studies.

2. The Health Plan shall ensure data received from providers and other Subcontractors is accurate and complete by verifying the accuracy and timeliness of reported data; screening the data for completeness, logic, and consistency; and collecting service information in standardized format. The Health Plan shall make all collected data available to DHS, and upon request, to CMS.

3. The Health Plan shall maintain appropriate systems and mechanisms to obtain all necessary data from its healthcare providers and Subcontractors to ensure its ability to comply with all encounter data reporting requirements. The failure of a Healthcare Provider or Subcontractor to provide the Health Plan

with necessary encounter data shall not excuse the Health Plan's non-compliance with this requirement.

4. The Health Plan shall submit encounter data for all services rendered to Members under this Contract, including encounters where the Health Plan determined no liability exists, and whether the encounter was processed as paid or denied, along with any adjustments, or voids of encounter records previously submitted.

5. The Health Plan shall submit encounter data even if the Health Plan did not make any payment for a claim, including claims for services to Members provided under subcontract, capitation or special arrangement with another facility or program. Encounters related to value-added services or additional benefits offered by the Health Plan shall be submitted and appropriately flagged to enable them to be distinguished and parsed as necessary.

6. The Health Plan shall submit encounter data for all services provided under this Contract to Members who also have Medicare or other TPL coverage, if a claim has been submitted to the Health Plan. Encounter data for services paid by Medicare or other TPL shall be flagged to indicate source of payment.

7. The Health Plan shall submit encounter records for direct services rendered to beneficiaries by Health Plan personnel that may otherwise be delegable to providers in the community. Examples of such services include care coordination, service coordination, housing coordination, case management, outreach efforts, medication reconciliation, and quality improvement activities. These costs shall be captured by the Health Plan as

part of its general ledger. MQD will define the mechanism to submit these encounters to HPMMIS in the HPMMIS Technical Guide – Encounter.

8. The Health Plan shall submit encounter data to DHS at least once per month in accordance with the requirements and specifications defined by the State and included in the HPMMIS Health Plan Encounters Technical Guide, published by DHS as part of the Health Plan Manual and incorporated by reference into this Contract. DHS may periodically update the Health Plan Manual with ninety (90) days' written notice to the Health Plan. The Health Plan Manual may be changed with less than ninety (90) days' notice by mutual agreement of the Health Plans and DHS. The Health Plan shall, upon receipt of such notice from DHS, provide notice of changes to Subcontractors.

9. The Health Plan shall submit an encounter submission form to accompany every certified encounter submission; the template for the form shall be provided by DHS to standardize the reconciliation process; the encounter submission form will be used by the Health Plan to provide DHS with a high-level summary of submitted encounters, including total claims, total claim lines, and total paid amounts by service category for all encounters included within a certified submission. Each program, such as QI or CCS that the Health Plan provides should be listed under a separate form.

10. Encounters shall be submitted via a DHS-designated electronic mechanism such as a secure file transfer protocol (SFTP) service and will be used to create a database that may be used for purposes described previously. DHS may edit encounter records

to ensure consistency and readability.

11. Encounter data shall be submitted to DHS, at a minimum, on a monthly basis, and no later than the end of the month following the month when the financial liability was processed, paid, denied, voided, or adjusted/corrected. Health Plans shall submit one hundred (100) percent of encounter data within fifteen (15) months from the date of service, including all adjusted and resubmitted encounters.

12. 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.

13. The Health Plan and its Subcontractors shall retain all encounter data for a period of no less than ten (10) years in accordance with 42 CFR §438.3(u). Provisions shall be made by the Health Plan to maintain permanent history by service date for those services identified as once-in-a-lifetime, including examples such as hysterectomy.

14. DHS may submit the encounter data to an all-payer claims database (APCD), or require the Health Plan to directly submit encounter data for all services rendered to Members under this Contract to an APCD. Encounter data submitted by the Health Plan may additionally be submitted to other agencies including but not limited to CMS as determined by DHS to support program integrity and other reporting functions that are directly related to the administration of the state Medicaid program.

15. Pharmacy encounter data shall be submitted by the Health Plan or Pharmacy Benefit Manager reflecting the amount paid

to the pharmacy, including the ingredient cost and dispensing fee. The paid amount should be net of any cost related to spread pricing.

B. Encounter Data Submission Content and Format

1. Encounters shall be certified for completion and accuracy and submitted by the Health Plan as required in 42 CFR §§438.604 and 438.606 and as specified in §6.5.B concurrently with each upload.

2. The Health Plan and its Subcontractors shall exclusively utilize the submission formats defined in the Health Plan Manual for the electronic communication of all encounter records submitted. Additionally, the Health Plan and its Subcontractors shall follow the instructions and guidelines set forth in the most current versions of ICD-10-CM, Healthcare Common Procedure Coding System, Current Procedural Terminology, and other standard nomenclature and classification systems. When submitting encounter records, the Health Plan shall adhere to all requirements specified in the Health Plan Manual.

3. Submitted encounters shall pass all DHS HPMMIS system edits and audits as specified in the Health Plan Manual or as sent out in communications from DHS to the Health Plan. Submitted encounters shall not be a duplicate of a previously submitted and accepted encounter unless submitted as an adjustment or void. The Health Plan shall make changes or corrections to encounter data and any systems, processes, or data transmission formats as needed to comply with DHS' data quality standards.

4. The Health Plan shall develop mechanisms to flag encounters to

support a variety of reporting requirements. For example, the Health Plan will need to flag encounters tied to PPCs, as noted in §6.2. The Health Plan may be asked to flag encounters tied to specific programs or authorities to enable DHS to meet reporting and evaluation requirements.

5. The Health Plan shall make an adjustment to encounters within thirty (30) days from when the Health Plan discovers that data is missing, incorrect, no longer valid, or some element of the encounter not identified as part of the original encounter needs to be changed, except as noted otherwise. Specifically, for newborn encounters that are billed under the mother's Member ID, the Health Plan shall correct the previously submitted encounter data with the newborn's assigned Member ID within thirty (30) days of receipt of the correct ID.

6. If DHS discovers errors or a conflict with a previously adjudicated encounter claim, the Health Plan shall be required to adjust or void the encounter claim within thirty (30) days of notification by DHS, or if circumstances exist that prevent the Health Plan from meeting this timeframe, a specified date shall be approved by DHS.

7. In the event that an audit, investigation, or litigation by the Health Plan, DHS, recovery audit contractor (RAC), federal entity, other State-contracted auditor, or other agency results in a recovery payment or payments inaccurately or inappropriately made to a provider or providers, the Health Plan shall submit an amended encounter record(s) to the State within one hundred twenty (120) days of the recovery, adjudication, or adjustment or by a timeframe determined and approved by DHS if the one hundred twenty (120) days period is not operationally

feasible, as determined by DHS. In cases where overpayments are identified, the Health Plan's amended encounter record shall include a Health Plan paid amount that reflects the amount that should have been paid, regardless of the actual paid amount remaining greater than the allowed amount after recoveries.

8. The Health Plan shall uniquely identify encounters paid under FFS, capitated, and bundled arrangements for its network providers, including FQHCs and RHCs. For capitated arrangements, the Health Plan shall report each service encounter, including those that resulted in a zero payment, when applicable. For bundled payments, including but not limited to EPSDT visits, FQHC and RHC visits, and hospital stays, the Health Plan shall submit encounter details on each service provided; each service rendered during an encounter shall be parsed into service lines to enable accurate computation of service utilization in these settings. Capitation detail records shall be required for each Provider and Member combination for each time period in which a capitation payment is made to the Provider. For encounters not uniquely tied to a payment, such as encounters for services rendered under a capitation

   arrangement, the Health Plan shall submit a Medicaid FFS equivalent valued amount for the encounter. Health Plan shall refer to the Health Plan Manual for additional detail.

C. Accuracy, Completeness, and Timeliness of Encounter Data Submissions

1. The Health Plan shall submit accurate, complete, and timely encounter data to DHS in accordance with the requirements and specifications defined by DHS and included in the Health Plan

Manual, published by DHS and incorporated by reference into this Contract.

2. As noted in §6.2, DHS shall conduct encounter data validation to ensure accuracy, timeliness, and completeness for the populations served by the Health Plan under this Contract for up to the three most recent and complete years prior to the rating period.

3. The Health Plans will conduct encounter data reconciliation against their Health Plan general ledger to ensure accuracy, timeliness, and completeness using definitions, protocols, and timelines specified in the Health Plan Manual.

4. The encounter data reconciliation process interval will be set at the beginning of each contract year and be no more frequent than quarterly and no less frequent than annually. The reconciliation protocol will be described in detail in the Health Plan Manual.

5. DHS will determine the overall extent of the discrepancy between encounter data submitted and accepted within HPMMIS and the Health Plan's general ledger amounts, and determine whether the discrepancies are within the discrepancy tolerance thresholds of successfully accepted encounters captured by DHS. Discrepancy tolerance thresholds for each interval and twelve (12) months encounter data submission will be revised annually by DHS.

6. For any discrepancies noted, the Health Plan shall have the opportunity to correct errors and resubmit the encounter data, submit revised encounter and general ledger reconciliations, and additionally provide an explanation for any remaining

discrepancies during the error resolution period. DHS will review any explanations provided, conduct its reviews, and make a final determination on whether the Health Plan has exceeded the discrepancy threshold for the interval that cannot be justified for reasons other than encounter data quality and completeness.

7. Except under circumstances where DHS determines that the Health Plan has exceeded the discrepancy threshold for the interval in a manner that is justifiably unrelated to the Health Plan, DHS shall use the submitted and accepted encounter data captured within HPMMIS for rate setting and other purposes. Should DHS determine that the Health Plan has exceeded the discrepancy threshold in a manner that is justifiably unrelated to the Health Plan, the original or updated data provided in the Health Plan encounter and general ledger reconciliation summary, whichever is applicable, shall be considered.

8. In subsequent years of the contract, the error resolution period may be rescinded. If rescinded, the final determination on whether the Health Plan's encounter data submission has exceeded the discrepancy tolerance threshold shall be made based on the calculated discrepancy value for that interval

   without further opportunity for error resolution by the Health Plan, and the submitted and accepted encounter data captured within HPMMIS will be used for rate setting and other purposes.

9. DHS reserves the right to change its encounter data validation process at any time, with at least sixty (60) days' notice to the Health Plan.

10. As described in §7.1.B.1, Health Plan operational effectiveness program (OEP), withholds may be applied by DHS, as needed,

to improve operational effectiveness in one or more areas. When applied to encounter data submissions, withholds will be based on the interval(s) established for the contract year.

11. Encounter data must be submitted to DHS at a minimum monthly, no later than the end of the month following the month when the financial liability was processed (i.e. paid, voided, or adjusted/corrected). Health Plans shall submit on hundred (100) percent of encounter data within fifteen (15) months from the data of service, including all adjusted and resubmitted encounters. DHS will provide the Health Plan with error reports via the SFTP file server after each encounter submission. See the Health Plan Manual for additional detail on encounter data timelines and error reports.

6.5 Report Submission

A. Report Submission General Requirements

1. To support communication between the Health Plan and DHS, the Health Plan shall submit a listing, in writing, of the designated Health Plan staff developing and/or submitting required reporting to DHS.

2. The Health Plan agrees to provide DHS with the reports CMS has requested or requests in the future. Health Plans shall provide any additional reports requested by DHS.

3. The Health Plan shall respond to any DHS request for information or documents within the timeframe specified by DHS. If the Health Plan is unable to respond within the specified timeframe, the Health Plan shall immediately notify DHS in writing and shall include an explanation for its inability to meet the timeframe and a request for approval of an extension of

time. DHS may approve, within its sole discretion, any such extension of time upon a showing of good cause by the Health Plan. To avoid delayed responses by the Health Plan caused by a high volume of information or document requests by DHS, both parties shall devise and agree upon a functional method of prioritizing requests so that urgent requests are given appropriate priority.

4. As noted in §6.2, DHS may wish to conduct follow-up reviews of Health Plan data, documentation, or medical records, and may delegate reviews to the EQRO. For all reviews, including reviews of medical records, the Health Plan shall submit information prior to the scheduled review and arrange for DHS and/or the EQRO to access records through on-site review and provision of a copy of the requested records. The Health Plan shall submit this information within sixty (60) days of notification or sooner should circumstances dictate an expedited submission of records.

B. Health Plan Certification

1. The Health Plan shall certify the accuracy, completeness, and truthfulness of any reports and 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 as required in 42 CFR §§438.604 and 438.606. The Health Plan shall certify that it is in substantial compliance with the contract and attesting to the accuracy, completeness, and truthfulness of the data submitted based on best knowledge, information, and belief, and thereby attest that no material fact has been

omitted from the certification and submission. The Health Plan shall complete the attestation section in the report templates for the certified data and document submission. The attestation shall be based on best knowledge, information, and belief of the following Health Plan personnel.

2. The data shall be certified by:

   a. The Health Plan's Chief Executive Officer (CEO);

   b. The Health Plan's Chief Financial Officer (CFO); or

   c. An individual who has delegated authority to sign for, and who reports directly to, the Health Plan's CEO or CFO.

3. The Health Plan shall require claim certification from each provider submitting data to the Health Plan. Source, content, and timing of certification shall comply with the requirements set forth in 42 CFR §§438.604 and 438.606.

4. Health Plan non-compliance, as specified above, will be considered a breach of Contract and subject to sanctions as described in Section 14.

C. Follow-Up by Health Plans/Corrective Action Plans/Policies and Procedures

1. DHS shall provide a report of findings to the Health Plan after completion of each review, monitoring activity, etc.

2. Unless otherwise stated, the Health Plan shall have thirty (30) days from the date of receipt of a DHS report to respond to DHS' request for follow-up, actions, information, etc. The Health Plan's response shall be in writing and address how the Health Plan resolved the issue(s). If the issues(s) has/have not been resolved, the Health Plan shall submit a corrective action plan

including the timetable(s) for the correction of problems or issues to DHS. In certain circumstances, for example in cases where concerns or issues remain unresolved or repeated from previous reviews or where urgent quality issues are identified, DHS may request a ten (10) days plan of correction as opposed to the thirty (30) days response time.

3. If the Health Plan fails to cure the deficiency as ordered, DHS shall have the right to assess a remedy set forth in Section 14.

SECTION 7 – DHS and Health Plan Financial Responsibilities

7.1 DHS General Responsibilities

A. Capitation Payment

1. Overview of Capitation Rates

a. This section describes the rate structure and the guidelines for rate setting.

b. For any QI Member, DHS shall pay a capitation rate that varies by aid category, island, and age/gender cohort. Aid categories include the following:

1) Medicaid expansion;

2) ABD:

a) ABD – Medicare eligible, and
b) ABD – Medicaid only;

3) Other populations:

a) CHIP,
b) Foster care, and
c) Families and children.

c. The capitation rates shall assume an administrative load based on expected administrative costs. The administrative loads will be set separately for ABD and non-ABD populations. The administrative loads will include administrative expenses and risk margin expenses, but will not include a general excise tax and insurance premium tax, if applicable.

d. All covered benefits and services listed in §§4.2 through 4.10 shall be provided as part of the capitation rate except for COVID-19 vaccine administration fees paid to outpatient pharmacies and other outpatient vaccine providers. These services shall be paid for by the health plan and submitted to the DHS for reimbursement monthly via an invoice. DHS shall reimburse the health plan for direct services provided. No additional charges may be submitted for reimbursement.

2. Rate Development

a. DHS shall provide final actuarially sound capitation rates to all selected Health Plans as part of the Contract. All selected Health Plans shall receive the same base capitation rates as described in §7.1.A.1. Due to the lag in rate development and application of rates, further adjustments may be required before implementation. If this is the case, DHS will provide documentation of the rate change similar to that provided during a rate renewal. The allowed administrative expenditures shall be increased to an amount as described in §7.1.A.2.a for those that serve statewide. Allowed administrative expenses may vary for Health Plans that serve Oahu only and those that service all islands.

b. The capitation rates shall have three components of risk adjustment to the base rates.

1) The first part of the enhanced payment is based on FQHC and RHC use rates for enrolled Members. The enhancement is intended to provide for the additional cost for services at these facilities due to the requirement that they be reimbursed at the

prospective payment system (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.

1) The second adjustment will account for the distribution and acuity of the membership with LTSS. DHS anticipates that this will involve stratifying Members determined to be Members residing in a nursing facility, Members receiving HCBS, Members at risk of deteriorating to NF LOC and receiving HCBS, and Members without LTSS needs. DHS will further evaluate the risk within these populations. The LTSS impacted rate cells are below:

    a) ABD;

    b) ABD – Medicare eligible; and

    c) ABD – Medicaid only.

2) Third, in order to account for risk selection between

    Health Plans, DHS may perform a risk adjustment based on diagnosis, pharmaceutical use, or other factors. This risk 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. The risk adjustment process shall be refreshed each year with the target implementation for the next calendar year.

c. The capitation rates will comply with the applicable sections in 42 CFR Part 438, including but not limited to:

§§438.4(b)(7), 438.4(b)(8), 438.4(b)(9), 438.5(b), 438.5(c), 438.5(d), 438.5(e), 438.5(f), 438.6(b)(3), 438.6(c), 438.6(d), 438.7(b), 438.7(c)(1), 438.7(c)(2), 438.8, and 438.74.

3. Future Rate Setting

a. Subject to limitations imposed by CMS, legislative direction, or other outside influence for which DHS shall comply, it is the intent of DHS to publish revised rates each calendar year throughout the term of the contract. DHS specifically does not commit to any particular methodology or formula, or to any particular benchmark or objective for rate revisions.

4. Daily Membership Rosters/Health Plan Payments

a. DHS shall enroll and dis-enroll Members through the daily membership rosters file, also known as the 834 daily file. All payments and recoveries shall be detailed on the 834 daily files. The 834 daily files identify the capitated fee amounts associated with mid-month enrollment and disenrollment transactions as well as prior period coverage transactions. DHS shall also provide an end of month enrollment snapshot from the DHS enrollment system, also known as the 834

monthly file. Health Plans shall use this file as a resource for Health Plans to reconcile their internal enrollment system with the DHS enrollment system. The Health Plan agrees to accept daily and monthly 834 files from DHS as the official enrollment record.

b. DHS shall make capitation payments 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 §1.5. Capitation payments shall be in the amounts listed in the Health Plan's contract with DHS.

c. DHS shall include plan-specific capitation rates attached as an Appendix with every signed Contract. These rates shall be binding to the Health Plan subject to CMS' approval.

d. DHS shall pay the established capitation rates to the Health Plan for Members enrolled for the entire month. Capitation payments shall be paid on rate codes that reflect the risk factor adjustments. Capitation payments for Members enrolled/dis-enrolled 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.

e. DHS shall calculate and claim for the appropriate federal matching dollars amounts after IMD services are paid for and encounters are submitted to DHS, when a Member aged twenty-one (21) to sixty-four (64) years receives inpatient treatment in an IMD. This applies to IMDs as defined in 42 CFR §435.1010, so long as the facility is a hospital providing psychiatric or SUD crisis residential services, and length of stay in the IMD is for a long-term stay of more than fifteen (15) days during the period of the monthly capitation

payment.

f. DHS shall make additional capitation payments or recover capitation payments from the Health Plan as a result of retroactive enrollments, retroactive dis-enrollments, and prior period coverage.

g. DHS shall provide to the Health Plan a Monthly Payment Summary Report that summarizes capitation payments and recoveries made to the Health Plan in the 820 file.

h. DHS shall notify the Health Plan prior to making changes in the capitation amount/rate code.

5. Health Insurance Provider Fees

a. DHS shall reimburse Health Plans for Health Insurance Provider Fees (HIPF) after Health Plans submit proof of payment of HIPF and DHS reviews the submissions. This process will apply to both retrospective and prospective activities.

6. Capitation Payment for Changes in Rate Codes

a. 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.

b. Changes in the capitation payment amount/rate code paid shall become effective the next day after the enrollment change is processed.

7. Risk Share Program

a. DHS shall implement and manage a risk share program with the Health Plans. This risk share program with DHS sharing

in the risk may have any of the following characteristics, among others:

1) Include targeted risk-sharing arrangements that kick in before individual Health Plan results are calculated;

2) Involve Health Plan losses or savings;

3) Be calculated at the individual Health Plan level or in aggregate;

4) Include stepped risk-sharing percentages based on increasing levels of losses or savings; and

5) Similar or different risk share percentages between losses and savings.

b. The risk share program and parameters will be reviewed and may be adjusted each contract year.

c. The Risk Share Agreement is listed in Appendix L.

B. Incentive Strategies for Health Plans

1. Operational Effectiveness Program (OEP)

a. DHS shall implement an OEP focused on ensuring Health Plans manage operations and performance effectively based on identified areas in need of improvement which will result in system, regional, provider, or Member-level benefit.

b. DHS will define process measurement, performance measurement, and targets that will be maintained until sustained improvements are reached.

c. DHS will determine metrics for the OEP annually. DHS shall assign weights to each metric included in the OEP. The operational and performance metrics included in the OEP, the

specific targets for each metric, and the time period of assessment for each metric, shall be set annually by DHS and may vary across the Health Plans. OEP metrics may encompass items included by the Health Plan in its technical proposal and included as part of the Contract.

d. Funding for this program may be based on a withhold arrangement.

2. Quality Payment Program

a. DHS shall implement the Quality Payment Program so that Health Plans will be eligible for financial performance payments or P4P as long as the Health Plan is fully compliant with all terms of the Contract as determined by DHS. All payments shall be in compliance with the federal managed care requirements set forth in 42 CFR §438.6 and other applicable sub-regulatory guidance.

b. To be eligible to participate in the Quality Payment Program, an NCQA-licensed audit organization shall have audited the reported Health Plan rates for the performance measurements following CMS protocol for validation. DHS contracts with an EQRO for validation of performance measures. The total of all payments paid to the Health Plan under this Contract shall be pursuant to 42 CFR Part 438. At DHS' sole discretion, DHS may exempt certain measures from this audit requirement.

c. The Quality Payment Program shall be comprised of multiple performance measures. DHS shall assign weights to each performance measure; targets/floors for each performance measure may vary each year.

d. The Quality Payment Program may be implemented based on a withhold arrangement in accordance with 42 CFR §438.6(b)(3), or the Quality Payment Program may also be implemented as an incentive arrangement program in accordance with 42 CFR §438.6(b)(2).

3. Innovation Advancement Initiative

a. DHS may implement one or more Innovation Advancement Initiatives. Health Plans may be eligible for incentives under the Innovation Advancement Initiative by meeting targets for performance and process metrics tied to goals and strategies described in the Contract or Medicaid's Quality Strategy. The Innovation Advancement Initiative may be implemented as an incentive arrangement program in accordance with 42 CFR §438.6(b)(2).

4. Community Investment Program

a. DHS may, at its discretion, create a Community Investment Program made up of the remainder of the dollars allotted to the Quality Payment Program, the Innovation Advancement Initiatives, or other DHS initiatives aligned with Medicaid's Quality Strategy. DHS would consult with Health Plans and stakeholders to make grants, payments, and similar spending strategies to entities and programs that would support DHS goals.

C. Non-Risk Payment

1. In addition to risk-based capitation payments, DHS shall reimburse the Health Plan on a non-risk basis for certain benefits and populations as specified in this Contract and DHS guidance. Non-risk benefits include:

a. Reentry Services, as described in §3.7, §4.13, and the Health Plan Manual.

b. CIS+ services, as described in §3.7, §4.13, and the Health Plan Manual.

2. Non-risk payments shall be administered separately and distinctly from capitation payments and shall comply with all applicable federal guidance, including the upper payment limits described in 42 CFR § 447.362. All costs of delivering and administering services reimbursed under non-risk payment arrangements shall be excluded from the development of risk-based capitation rates.

3. The Health Plan shall administer non-risk benefits in accordance with DHS guidance. Reimbursement shall be based on encounter data and reconciled in accordance with DHS requirements.

4. Expenditures associated with services delivered under non-risk payment arrangements shall also be excluded from the Health Plan's Medical Loss Ratio reporting and calculations, as described in Section 6.2.F.1.

7.2 Health Plan General Responsibilities

A. Payment in Full

1. The Health Plan shall accept the capitation payment as payment in full for all services to be provided pursuant to this Contract and all administrative costs associated with performance of this Contract.

B. Payment Recoupment

1. The Health Plan shall not change any of the information provided by DHS on the daily or monthly 834 files. Any inconsistencies between the Health Plan and DHS information shall be reported to DHS by the Health Plan for investigation and resolution. All

payments and recoveries shall be detailed on the 834 daily file and summarized on the 820 file.

2. If the Health Plan unintentionally reports in error, fraudulently reports, or knowingly fails to report any information affecting payments to the Health Plan, and is consequently overpaid, then DHS shall request a refund of the overpayment or recoup the overpayment by adjusting payments due in any one or more subsequent months.

3. The Health Plan and any Subcontractor shall report to DHS within sixty (60) days when it has identified capitated payments or other payments in excess of amounts specified in the Contract. The Health Plan's failure to comply with this requirement may subject the Health Plan to all available remedies set forth in §14.21, in addition to any other legal remedy.

C. Provider and Subcontractor Reimbursement

1. General Provider and Subcontractor Reimbursement Strategies

a. With the exception of eligible services provided by hospice providers, FQHCs, RHCs, private hospitals, CAHs, public hospitals, nursing facilities, CCFFH and E-ARCH, and Primary care payment enhancement program, the Health Plan may reimburse its providers and Subcontractors in any manner, subject to federal rules and any directed payment policies implemented by DHS. The specifics of these reimbursement exceptions are described further in subsection of 7.2.C.1.

b. The Health Plan shall implement financial incentives for performance or value-based payment arrangements for

some providers in accordance with federal rules and this RFP.

c. FQHCs and RHCs

1) The Health Plan shall reimburse non-contracted FQHCs and RHCs at rates no less than the Medicaid fee schedule if those providers are necessary for network adequacy. The Health Plan shall not be required to cover services at an FQHC or RHC if that provider is not contracted and not required for network adequacy. The Health Plan shall reimburse contracted FQHCs or RHCs for PPS-eligible services at the PPS rate provided annually by DHS. Any other payment methodology to these providers requires prior approval by DHS.

2) DHS shall calculate and reimburse FQHCs and RHCs for any retroactive settlements involving a change in scope of services that result in an increased PPS rate that is not incorporated into the capitation rates. The Health Plans shall reimburse the FQHCs and RHCs the annual PPS increase when provided by DHS. This annual increase will be incorporated into the capitation rates. DHS shall perform reconciliation and make any necessary supplemental payments to FQHCs and RHCs.

3) The Health Plan shall report the number of unduplicated visits provided to its Members by FQHCs and RHCs and the payments made by the Health Plan to FQHCs and RHCs. The Health Plan shall report this information to DHS in accordance with the reporting

process described in §6.2.E.1.a and §6.4.B.2.

d. Hospitals

1) Health Plans shall reimburse in-state general acute hospitals and children's hospitals for inpatient services (excluding transplant services) using the Hawaii Medicaid-specific All Patient Refined Diagnosis Related Group (APR DRG) classifications and APR DRG payment methodology including rates as determined and maintained by DHS, as described in the Hawaii State Plan Attachment 4.19-A section titled: State of Hawaii Methods and Standards for Establishing Payment Rates Prospective Reimbursement System for Inpatient Services. Additional details of this program are in Appendix P1-A.

2) At a minimum, the Health Plan shall reimburse CAHs for hospital services and nursing home services at rates calculated prospectively by DHS using Medicare reasonable cost principles in accordance with HRS §346-59.

3) Health Plans shall incorporate VBP strategies for both hospitals and CAHs in accordance with §7.2.D.

4) Health plans shall participate in the DHS quality payment program for hospitals. The details of this program are in Appendix M1.

5) The Health Plan shall reimburse public and private hospitals a uniform payment increase. The details of this program are in Appendix P1-A.

e. Ke Ola Mamo

1) The Health Plans shall reimburse Ke Ola Mamo, the facility that has a grant for the American Indian and Alaska Native Healthcare in Hawaii Project, for services provided to Members who are qualified to receive services from an Indian Health Service facility as set forth in Title 42, USC, Section 1396u-2(h)(2); and Title V of the American Recovery and Reinvestment Act of 2009, Section 5006.

2) The Health Plans shall pay Ke Ola Mamo for Covered Services at a negotiated rate, or in the absence of a negotiated rate, at a rate not less than the level and amount of payment the Health Plan would make for the services provided by non-participating providers.

f. Hospice

1) The Health Plan shall pay hospice providers Medicaid hospice rates as calculated by DHS and CMS. The Health Plan shall implement these rates on October 1 of each year.

g. Nursing Facility

1) The Health Plan shall reimburse nursing facilities in accordance with HRS §§346E and 346D-1.5 utilizing an acuity-based system at rates equal to the current Medicaid fee schedule.

2) The Health Plan shall participate in the DHS nursing facility quality payment program. The details of this programs are in Appendix P2-A.

3) The Health Plan shall reimburse public nursing facilities a uniform payment increase. These payments shall be made to HHSC, who will in turn reimburse the public nursing facilities. The details of this program are in Appendix P2-A.

4) During a Public Health Emergency, DHS may include preprint language fr emergency situations.

h. COVID-19 vaccine administration fee

1) The Health Plan shall reimburse outpatient pharmacies and other outpatient vaccine providers, for COVID-19 vaccine administration fees at rates equal to $18.59/$30.68 for first/second dose and $30.68 for single dose for service dates through March 31, 2021, and at rates equal to $43.68 for any dose for service dates from April 1, 2021 through December 31, 2021.

i. Health Care Professionals

1) The Health Plan shall reimburse the following physician and behavioral health providers no less than one hundred percent (100%) of the prevailing Medicare Resource-Based Relative Value Scale professional fees in effect as of December 31 of the prior calendar year for:

a) Medical Doctors

b) Doctors of Osteopathy

c) Psychologists

d) Certified Nurse Midwives

2) The Health Plan shall reimburse the following health care professionals no less than the percentage of the prevailing Medicare RBRVS professional fees in

effect as of December 31 of the prior calendar year. These percentages are consistent with Medicare reimbursement and are detailed in the table below:

Other Professionals (and the HOKU PT)	*% of Medicare Fee Schedule*
Nurse Practitioner (PT 19)	85%
Certified Clinical Nurse Specialist (PT 19)	85%
Physician Assistant (PT 18)	85%
Mental Health Counselor (PT 51)	75%
Marriage and Family Therapist (PT 86)	75%
Licensed Clinical Social Worker (PT 75)	75%

3) For the providers listed above, exclusions to this fee increase include:
    a) Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services will continue to receive the enhanced rate of one-hundred twenty ($120.00) dollars.
    b) Procedure codes for applied behavioral analysis, hospice, home health, home and community-based services, durable medical equipment, non-emergency medical transportation, office administered drugs, ambulance, prosthetics, laboratory, radiology, and pathology.

c) Prospective Payment System (PPS) fees paid to Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC).

2. Co-Payment Responsibilities

a. The Health Plan shall pay the Medicare co-payments for dual eligible Members to providers. The Health Plan shall utilize the current Medicaid reimbursement methodology and rate structure, if applicable, for Medicare co-payments. DHS reimburses all Medicare co-payments up to one hundred (100) percent of the Medicare rate for outpatient services only.

b. The Health Plan shall pay co-payments for services covered by a TPL to include co-payments for a three (3) months' supply of maintenance medications or supplies.

3. Out-of-Network Responsibilities

a. The Health Plan shall pay out-of-network providers who deliver emergency services the same as they would have been paid if the emergency services had been provided to an individual in the Medicaid FFS program. These providers shall not balance-bill the Member.

4. Clean Claims Requirements

a. The Health Plan shall pay its Subcontractors and Providers consistent with the claims payment procedures described in Section 1902(a)(37)(A) of the Social Security Act. The Health Plans shall allow providers at least one year from date of service or discharge, whichever is the latter, to submit claims for reimbursement.

b. The Health Plan shall pay ninety (90) percent of all clean claims within thirty (30) days of the date of receipt of such claims; ninety-nine (99) percent of all clean claims within ninety (90) days of the date of receipt of such claims; and one hundred (100) percent of all clean claims within fifteen (15) months from the date of service. The calculation of clean claim percentage paid is based on total clean claim count.

c. The clean claims payment requirements described in §7.2.C.4.b apply in the aggregate but also individually for, hospital inpatient, hospital outpatient, SNFs, CCFFHs, hospices, home health agencies, and FQHCs. The date of receipt is the date the Health Plan receives the claim, as indicated by its date stamp on the claim and the date of payment is the date of the check or other form of payment. The Health Plan and the provider may, however, agree to an alternative payment schedule provided this alternative payment schedule is reviewed and approved by DHS.

d. The Health Plan shall pay interest to a provider at a rate of fifteen (15) percent a year for money owed by a Health Plan on payment of a clean claim exceeding the applicable time limitations under this section from the first calendar date after the thirty (30) days period.

5. Electronic Claims Payment

a. Health Plans shall incentivize provider electronic claim submission over paper claim submission. The Health Plan shall require that providers use HIPAA standard 837I or 837P or National Council for Prescription Drug Program transactions for electronic claims and the CMS 1500 or UB-

04 forms for paper claims.

6. Claims Payment and Remittance Requirements

a. The Health Plan shall develop and maintain a claims payment system and process capable of processing, cost avoiding, and paying claims accurately in accordance with reimbursement terms with the provider. The system shall

produce a remittance advice related to the Health Plan's payments to providers and shall contain, at a minimum:

1) An adequate description of all denials and adjustments using HIPAA standard claim adjustment reason codes. Denial and adjustment codes assigned shall provide sufficient information to fully explain a denial or adjustment without requiring additional inquiry from the provider, and shall use language that explains in adequate detail and in language that a layperson could reasonably understand. Any payer-specific or customized reason codes shall also be fully explained in the same manner;

2) The amount billed;

3) The amount paid;

4) Application of coordination of benefits and subrogation of claims; and

5) Provider rights for claim disputes.

b. The related remittance advice shall be sent with the payment, unless the payment is made by electronic funds transfer. For payments made by electronic funds transfer, the payer shall provide remittance advice via HIPAA standard

electronic remittance advice transactions, also known as the 835 file. The Health Plan may opt to also provide a paper remittance advice. The remittance advice sent related to an electronic funds transfer shall be mailed, or sent to the provider, no later than the date of the electronic funds transfer.

7. Health Plan Responsibility as Payer to Subcontractors and Providers

   a. In no event shall the Health Plan's Subcontractors and providers seek payment directly from the State.

   b. The State and 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 Members bear no liability for the Health Plan's failure or refusal to pay valid claims of Subcontractors or providers for Covered Services.

   c. Further, the State and Members shall bear no liability for Covered Services provided to a Member for which:

      1) The State does not pay the Health Plan;

      2) The Health plan or State does not pay the individual or Healthcare Provider that furnishes the services under a contractual, referral, or other arrangement; or

      3) 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.

d. The Health Plan shall indemnify and hold the State and the Members harmless from any and all liability arising from claims related to §7.2.C and shall bear all costs in defense of any action over such liability, including attorney's fees.

e. The Health Plan shall require that Subcontractors and providers not bill Members for non-covered services for any amount greater than would be owed if the entity provided the services directly.

D. Value-Based Payment

1. Background

a. VBP is an approach to payment reform that links Provider reimbursement to improved performance or that aligns payment with quality and efficiency. This form of payment holds Healthcare Providers accountable for both the cost and quality of care they provide. VBP strives to reduce inappropriate care and to identify and reward the highest performing providers.

b. DHS intends to build upon the existing VBP structure within the State and expand capacity for increased use of VBP strategies across Hawaii's healthcare system to encompass providers such as PCPs, hospitals, LTSS, behavioral health, SUD providers, rural health providers, and other specialty providers. The Health Plan shall support DHS in advancing providers along the VBP continuum toward VBP strategies that may encompass multi-payer efforts.

c. DHS may require the Health Plan to align standard metrics and reporting for providers participating in a VBP agreement with other payer, federal, or community metrics and reporting to reduce administrative burden for the provider community. Upon DHS' request, Health Plans shall submit data to DHS, including, but not be limited to, timely,

actionable reports on conditions, or other criteria as determined by DHS.

2. VBP Continuum

a. In general, provider readiness and engagement for VBP occur along a continuum. At the earliest stages, providers and payers build infrastructure and tools, develop learning and communications strategies, establish outcomes and process goals, and build systems to support data and reporting needs. At the mature levels of the continuum, healthcare systems are integrated on multiple levels, providers are accountable for population health outcomes, assume greater financial risk, and multi-payer models support providers in efforts for practice transformation. DHS intends to adopt the HCP LAN APM framework to assess VBP engagement and levels of provider readiness within QI along the VBP continuum.

b. The Table 4:7.2.D below provides a high-level illustration of the LAN framework. The Health Plan will use the LAN framework as the foundation for developing VBP strategies to meet the goals and requirements of the QI program.

Table 4: 7.2.D. LAN Framework

<table>
<tr><th>Category 1</th><th>Category 2
FFS – Link to Quality and Value</th><th>Category 3
APMs Built on FFS Architecture</th><th>Category 4
Population-Based Payment</th></tr>
<tr><td rowspan="8">FFS – No link to quality and value</td><td>A</td><td>A</td><td>A</td></tr>
<tr><td>Foundational Payments for Infrastructure and Operations
(e.g., care coordination fees and payments for HIT investments)</td><td>APMs with Shared Savings
(e.g., shared savings with upside risk only)</td><td>Condition-Specific Population-Based Payment
(e.g., PMPM payments, payments for specialty services, such as oncology or mental health)</td></tr>
<tr><td>B</td><td>B</td><td>B</td></tr>
<tr><td>Pay-for-Reporting (P4R)
(e.g., bonuses for reporting data or penalties for not reporting data)</td><td rowspan="3">APMs with Shared Saving and Downside Risk
(e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)</td><td>Comprehensive Population-Based Payment
(e.g., global budgets or full/percent of premium payments)</td></tr>
<tr><td>C</td><td>C</td></tr>
<tr><td>P4P
(e.g., bonuses for quality performance)</td><td>Integrated Finance and Delivery System
(e.g., global budgets or full/percent of premium payments integrated systems)</td></tr>
<tr><td></td><td>3N
Risk-based payments NOT linked to quality</td><td>4N
Capitated payments NOT linked to quality</td></tr>
</table>

3. Value-Driven Healthcare Schedule

a. The Health Plan shall incorporate value-driven healthcare concepts as described in this §7.2.D and into its payment strategy and be required to attain VBP targets over the course of the Contract. DHS will develop a value-driven

healthcare schedule in Year 1 of the contract and may take Health Plan feedback into account in the development of the schedule.

b. DHS will define major provider types to include in the value-driven healthcare schedule. Major provider types may include but are not limited to:

    1) Primary care providers;

    2) Hospitals, including CAHs;

    3) Behavioral health providers;

    4) Specialists; and

    5) LTSS providers.

c. The Health Plan shall conduct a comprehensive internal assessment of VBP diffusion following LAN framework definitions, including current adoption of various VBP models. The Health Plan shall report this data to DHS by the second quarter of the first contract year using a standard assessment tool provided by DHS. Subsequent VBP diffusion assessments shall be conducted at least annually by the Health Plan.

d. After a review of the Health Plan report on VBP diffusion and the major provider types to include in the value-driven healthcare schedule, DHS will develop a schedule that sets performance targets for major providers in LAN categories. An illustrative example of what the targets is detailed in Table 5: 7.2.D as follows:

Table 5: 7.2.D. Value-Driven Healthcare Schedule Example

CY 2021	CY 2022	CY 2023	CY2024	CY2025
35% of spend by major provider type in LAN Category 2A (P4I) or above.	50% of spend by major provider type in LAN Category 2A or above (P4I); 20% 2B or above (P4P); 10% 2C or above (P4P).	Increasing to over 50% of spend by major provider type in LAN Category 2A or above (P4I); 20% 2C or above (P4P); 10% 3A or above (population or condition-specific payments).	Increasing to over 55% of spend by major provider type in LAN Category 2A or above (P4I); 22.5% 2C or above (P4P); 12.5% 3A or above (population or condition-specific payments).	Increasing to over 60% of spend by major provider type in LAN Category 2A or above (P4I); 25% 2C or above (P4P); 15% 3A or above (population or condition-specific payments).

e. The Health Plan shall participate in DHS' directed payment programs for the hospital quality program and the nursing home quality program. The value-driven healthcare schedule will be aligned with these programs. Health Plans shall work with DHS and stakeholders to ensure Health Plan performance under the value-driven healthcare schedule will support hospital and nursing home performance under the hospital quality program and the nursing home quality program.

f. DHS shall ensure Health Plan incentive strategies under §7.1.B support Health Plan performance under the value-driven healthcare schedule. DHS may do so by aligning performance metrics in the Health Plan incentive strategies under §7.1.B with Health Plan initiatives under this section. DHS may specify reporting requirements, performance measures, and targets as standards to incentivize Health Plans to move along the continuum. Annually, the Health Plan shall demonstrate and report compliance with this

schedule. The specific requirements of reporting will be determined in accordance with Section 6.

g. Performance on the value-driven healthcare schedule requirement may be part of the OEP as described in §7.1.B.1, the Quality Payment Program as described in §7.1.B.2, and/or the Innovation Advancement Initiative as described in §7.1.B.3.

4. Multi-Payer VBP Initiatives

a. Health Plans are encouraged and may be required to participate in multi-payer VBP programs or initiatives through a directed payment program or other methods in accordance with other federal and state law and authorities.

5. Vertically Integrated Organizations

a. Health Plans are encouraged and may be required to pursue a shared risk and shared savings program with integrated care organizations if available. Such a healthcare delivery model may be provider led and the organization assumes responsibility, meaning the integrated care organization becomes accountable for providing at a minimum, primary, acute, and chronic care services.

6. Health Plan Support for VBP Transformation

a. To support continued provider development and system-wide capacity for VBP, the Health Plan will collaborate with DHS, stakeholders, and other Health Plans to build system wide capacity for VBP, and to attempt to avoid overwhelming providers with misaligned VBP strategies, operational components, or reporting across payers.

b. DHS intends to leverage the existing collaborative spirit within the state in addressing work force shortages and the provision of care in remote locations. DHS will lead a stakeholder process focused on the coordination of community efforts to creatively address Hawaii-specific challenges through coordinated efforts like leveraging joint data systems, aligning funding for PCP visits to rural areas, providing Telehealth services using joint technology, or other strategies.

c. The Health Plan will support providers by:

    1) Investing in infrastructure to support provider VBP engagement;

    2) Providing technical assistance to providers engaged in VBP;

    3) Adopting payment strategies and testing models that encourage specified provider participation, such as models designed around a certain specialty provider or bundled payments for episodes of care;

    4) Offering a VBP guide path for providers interested in advancing along the VBP continuum;

    5) Addressing Hawaii-specific barriers to provider VBP engagement;

    6) Supporting provider data capabilities, including collection, reporting, and analytics;

    7) Collaborating with other Health Plans to establish a provider learning network to support sharing of best practices;

8) Educating providers on VBP and opportunities to move along the VBP continuum toward multi-payer initiatives;

9) Supporting providers in understanding and assessing SDOH, and connecting with social services providers to address patient SDOH needs; and

10) Routinely collecting, updating, and reporting to DHS, data on the Health Plan's efforts and progress towards achieving the goals of the VBP advancement initiative.

E. Investing in Primary Care

1. To achieve DHS goals, the Health Plans shall support the vision of devoting resources to advancing primary care. To this end, the Health Plans shall increase investment in, support of, and incentivization of, primary care in three concentric definition:

   a. In the narrowest sense, primary care is the provision of care in the primary care setting by primary care providers.

   b. A broader definition includes the provision of preventive services, including behavioral health integration, in the primary care setting.

   c. In the broadest definition, primary care additionally includes the wraparound support services including team-based care and SDOH supports that augment and enhance the provider's capacity to manage the Member's care in the outpatient setting.

2. The Health Plans shall be responsible for tracking its primary care spend using measures corresponding to the concentric

definitions provided by DHS. The Health Plans may be engaged in providing feedback and input on the measure definitions. For each definition of primary care spend, baseline spend will be used to set annual targets to enhance spending in primary care.

3. Once primary care measure definitions have been developed, Health Plans shall be accountable for demonstrating increased investment and spending across all three definitions. Health Plan progress with meeting the spend requirements in Investing in Primary Care in this §7.2.E. may be included in the OEP as described in §7.1.B.1, the Quality Payment Program as described in §7.1.B.2, and/or the Innovation Advancement Initiative as described in §7.1.B.3.

4. DHS may modify the definitions, as needed, to accommodate initiatives that seek to expand primary care and support stabilization of Members in the ambulatory care setting.

F. Cost Share

1. The Health Plan shall collect all enrollment fees and cost sharing amounts from Members who have enrollment fees or cost-sharing requirements. The Health Plan may delegate cost-sharing collections to providers but shall be ultimately responsible for their collection.

2. Any cost-sharing imposed on the Member shall be in accordance with Medicaid FFS requirements at 42 CFR §447.50 through 42 CFR §447.82. The Health Plan shall exempt from premiums any Indian who is eligible to receive or has received an item or service furnished by an Indian healthcare provider or through referral under contract health services. The Health Plan shall exempt from all cost sharing any Indian who is currently

receiving or has ever received an item or service furnished by an IHCP or through referral under contract health services.

G. Non-Covered Services

1. The Health Plan may collect fees directly from Members for non-covered services or for services from unauthorized non-Health Plan providers. If a Member self-refers to a specialist or other provider within the Health Plan's network without following obtaining a prior authorization, the Health Plan may deny payment to the service provider.

2. The Health Plan shall educate providers about the processes that shall be followed for billing a Member when non-covered or unauthorized services are provided as described in §4.1. In addition, the Health Plan shall inform the Member of instances when they may be billed by a provider as described in §4.1.

3. If the Health Plan later determines that a Member has been billed and paid for Health Plan-covered services, the Health Plan shall refund the Member directly.

H. Co-Payments

1. Health Plans may be required to implement future co-payments for Members as determined by DHS. This process may include tracking and limiting aggregate amounts of co-payment for a household.

I. Payment for Provider Preventable Conditions

1. The Health Plan shall not pay for healthcare-acquired conditions or other PPCs identified by CMS and DHS. DHS shall update the Health Plans, as needed, of changes to the CMS and DHS-required list. A current list of PPCs is located in the Health Plan

Manual.

J. Physician Incentives

1. Additionally, in compliance with the requirements of §7.2.D, Health Plans may establish physician incentive plans and VBP arrangements pursuant to federal and state regulations, including Section 1876(i)(8) of the Social Security Act and 42 CFR §§417.479, 422.208, 422.210, and 438.6.

2. The Health Plan shall disclose any and all physician incentive arrangements to DHS for review and approval prior to implementing physician incentives. The Health Plan shall also disclose these, upon DHS request, to Members. Such disclosure shall include:

   a. The LAN category;

   b. Whether services not furnished by the physician or group are covered by the incentive plan;

   c. The type of incentive arrangement including methodology;

   d. The percent of withhold or bonus amount; and

   e. The panel size, if patients are pooled, and the method used.

3. Upon request by DHS, the Health Plan shall report adequate information specified by applicable regulations so that DHS can adequately monitor the Health Plan.

4. If the Health Plan's physician incentive plan includes services not furnished by the physician or group or physicians, the Health Plan shall:

   a. Ensure adequate stop loss protection to individual physicians and shall provide to DHS proof of such stop loss coverage,

including the amount and type of stop loss; and

b. Upon DHS request, conduct annual Member surveys, with results disclosed to DHS and to Members.

5. 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 a Member.

7.3 Third-Party Liability (TPL)

A. Background

1. TPL refers to any other health insurance plan or carrier, such as, 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 healthcare expenses of the Member.

2. Pursuant to Section 1902(a)(25) of the Social Security Act, DHS authorizes the Health Plan as its agent to identify legally liable third parties and treat verified TPL as a resource of the Member.

3. 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 DHS.

4. 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 QI Members that also have commercial insurance through the Health Plan. The Health Plan shall also comply with HRS §431L-2.5. All services provided by TPLs shall be submitted in standard encounter data format.

B. Responsibilities of DHS

1. DHS shall be responsible for coordination and recovery of accident and worker's compensation subrogation benefits;

2. DHS shall collect and provide Member TPL information to the Health Plan. TPL information shall be provided to the Health Plan via the daily TPL roster, or another reporting mechanism as established in Section 6; and

3. DHS shall conduct TPL audits every six (6) months to ensure TPL responsibilities are being completed by the Health Plan.

C. Responsibilities of the Health Plan

1. The Health Plan shall enter into a Coordination of Benefits Agreement with Medicare and participate in the automated claims crossover process for individuals dually eligible for Medicaid and Medicare. Health Plans be responsible for dually eligible individuals' coordination of benefits.

2. The Health Plan shall coordinate healthcare benefits with other coverages, both public and private, which are or may be available to pay medical expenses on behalf of any Member.

3. 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.

4. The Health Plan shall follow the mandatory pay and chase

provisions described in 42 CFR §433.139(b)(3)(i)-(ii).

5. In addition, the Health Plan shall:

   a. Continue cost avoidance of the health insurance plans accident and worker's compensation benefits;

   b. Report all accident cases incurring medical and medically-related dental expenses in excess of five hundred (500) dollars to DHS;

   c. Provide a list of medical and medically-related dental expenses in the format requested by 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;

   d. Provide copies of claim forms with similar response time as the above;

   e. Provide listings of medical and medically-related dental expenses, including adjustments, 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;

   f. Inform DHS of TPL information uncovered during the course of normal business operations;

   g. Provide DHS with monthly reports of the total cost avoidance and amounts collected from TPLs within thirty (30) days after the end of the month being reported;

   h. Develop procedures for determining when to pursue TPL recovery; and

i. Provide healthcare services for Members receiving motor vehicle insurance liability coverage at no cost through the Hawaii Joint Underwriting Plan in accordance with HRS §431:10C-401, et seq.

6. The Health Plan's failure to comply with any requirement of §7.3, Third-Party Liability, may subject the Health Plan to all available remedies set forth in §14.21, in addition to any other legal remedy.

SECTION 8 – Responsibilities and Requirements of DHS and Health Plans: Provider Networks, Provider Credentialing, Provider Contracts, and Other Functions for Providers

8.1 Provider Network

A. General Provisions

1. The Health Plan shall develop, maintain, and monitor a Provider network that is sufficient to ensure all Covered Services that are based on Medical Necessity, are accessible and available for all Members, including those with limited English proficiency or physical or mental disabilities. At a minimum, this means that the Health Plan shall have sufficient providers to ensure all access and appointment wait times defined in §8.1.C and §8.1.D are met. This network of Providers shall provide the benefits described in Section 3 and Section 4.

2. The Health Plan shall contract with an adequate number of Providers for their Members to have timely access to Covered Services that are based on Medical Necessity. The Health Plan is responsible for ensuring Members have access to providers listed in §8.1.B. If the Health Plan's network is unable to provide Covered Services that meet Medical Necessity for a particular Member within its network or on the island of the Member's residence, the Health Plan shall adequately, and in a timely manner, provide these services out-of-network or transport the Member to another island or out of state to access the Covered Services for as long as the Health Plan's network is unable to provide Covered Services based on Medical Necessity for the

Member on the Member's island of residence as described in §5.3.C.

3. The Health Plan shall notify the out-of-network Providers providing Covered Services to its Members that payment by the Health 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.

4. The Health Plan shall not discriminate with respect to participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely based on that license or certification. The Health Plan shall not discriminate against providers serving high-risk populations or those that specialize in conditions requiring costly treatments. This is not to be construed as:

   a. Requiring that the Health Plan contract with Providers beyond the number necessary to meet the needs of its Members;

   b. Precluding the Health Plan from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or

   c. 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.

5. 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 written notice of the reason for the decision.

6. If the Health Plan decides during the contract period that it no longer will include individual Provider 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 DHS at least forty-five (45) days prior to the effective date if these Providers represent five (5) percent or more of the total contracted providers in that specialty, or if it is a hospital.

7. The Health Plan shall require that all Providers that submit claims to the Health Plans have a national provider identifier number. This requirement should be consistent with 45 CFR §162.410.

8. The Health Plan shall not include in its network any Providers when a person with an ownership or controlling interest in the Provider, an owner including the Provider himself or herself, or an agent or managing employee of the Provider, has been excluded from participation by the DOH and Human Services, Office of Inspector General (OIG) under Section 1128 of the Social Security Act, or has been excluded by DHS from participating in the Hawaii Medicaid program.

9. The Health Plan shall conduct a monthly check with DHS to identify any Providers excluded from the Hawaii Medicaid program. On a monthly basis, the Health Plan shall check the federal exclusion lists, including but not limited to the Social Security Administration's Death Master File, the National Plan

and Provider Enumeration System, List of Excluded Individuals and Entities (LEIE) maintained by the OIG, and System for Award Management.

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

11. The Health Plan shall not pay for items or services, other than an emergency item or service, not including items or services furnished in an emergency room of a hospital, as described in Section 1903(i)(2)(A)-(E) of the Social Security Act or with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997.

12. The Health Plan shall immediately comply if DHS requires that the Health Plan remove a Provider from its network due to any of the following:

    a. The provider fails to meet or violates any state or federal laws, rules, or regulations; or

    b. The Provider's performance is deemed inadequate by the State based upon accepted community or professional standards.

13. The Health Plan shall have written policies and procedures for the selection and retention of Providers. These policies and procedures shall include a process for identifying and assuring that excluded providers are not part of their network. The Health

Plan shall submit these selection and retention of providers' policies and procedures in accordance with §13.3.B.

14. The Health Plan shall have an established Provider network that meets the requirements of this RFP at the time of Readiness Review, as defined in Section 13, for all Providers. In the event the Health Plan has deficiencies in its provider network, a corrective action plan shall be submitted to DHS with defined timeframes for remedying the deficiencies.

B. Specific Minimum Requirements

1. The Health Plan shall have and is solely responsible for having:

   a. The network capacity to serve the expected enrollment in the service area;

   b. The ability to offer an appropriate range of services and access to preventive, primary, acute, behavioral health, and LTSS; and

   c. The ability to maintain a sufficient number, mix, and geographic distribution of providers of Covered Services.

2. The Health Plan may submit to DHS a formal written request for a Waiver of certain DHS network adequacy standards including the driving time when there are no or a limited number of available providers. The Health Plan may leverage Telehealth, as described in §8.1.I, in its Waiver to DHS' network adequacy standards, as appropriate and approved by DHS.

3. 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 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 provider types:

a. Hospitals (a minimum of five [5] on Oahu; one [1] on Maui; one [1] on Kauai; two [2] on Hawaii (one [1] in East Hawaii and one [1] in West Hawaii)); one (1) on Lanai, and one (1) on Molokai;

b. Emergency transportation providers (both ground and air);

c. Non-emergency transportation providers (both ground and air);

d. PCPs (at least 1 per 300 Members) as described in §8.1.E;

e. Physician specialists, including but not limited to: cardiologists, endocrinologists, general surgeons, geriatricians, hematologists, infectious disease specialists, nephrologists, neurologists, obstetricians/gynecologists, oncologists, ophthalmologists, orthopedists, otolaryngology, pediatric specialists, plastic and reconstructive surgeons, pulmonologists, radiologists and urologists;

f. Laboratories which have either a Clinical Laboratory Improvement Amendments (CLIA) 1988 certificate or a waiver of a certificate of registration;

g. Optometrists;

h. Pharmacies;

i. Physical and occupational therapists, audiologists, and speech-language pathologists;

j. Licensed dietitians;

k. PAs;

l. Community health workers;

m. Behavioral health providers:

1) Psychiatrists (One [1] per one hundred fifty [150] Members with a SMI or SPMI diagnosis);

2) Other behavioral health providers to include psychologists, licensed mental health counselors, licensed clinical social workers, APRN – behavioral health (One [1] to one hundred [100] Members with a SMI or SPMI diagnosis); and

3) Licensed therapists, counselors, and CSACs, and State licensed Special Treatment Facilities for the provision of substance abuse therapy/treatment.

n. Peer Support Specialists certified by AMHD as a part of their Hawaii certified peers specialist program or a program that meets the criteria established by AMHD;

o. State licensed Special Treatment Facilities for the provision of substance abuse therapy/treatment;

p. Home health agencies and hospices;

q. DME;

r. Case management agencies;

s. LTSS (listed below);

t. State licensed special treatment facilities for the provision of substance abuse therapy/treatment;

u. Providers of lodging and meals associated with obtaining

necessary medical care;

v. Sign language interpreters and interpreters for languages other than English; and

w. CPs.

4. In geographic areas with a demonstrated shortage of qualified physicians, a psychiatric APRN-Rx may assume the role of a psychiatrist in order to meet network adequacy requirements.

5. 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 shall pay the non-participating physician specialists who provide emergency, urgent outpatient, sub-acute services, and inpatient acute services.

6. At a minimum, the network shall include the following LTSS providers:

a. Adult day care facilities;

b. Adult day health facilities;

c. Assisted living facilities;

d. CCFFH;

e. CCMA;

f. E-ARCHs;

g. Home-delivered meal providers;

h. Non-medical transportation providers;

i. Nursing facilities;

j. Personal care assistance providers;

k. PERS providers;

l. PDN;

m. Respite care providers; and

n. Specialized medical equipment and supply providers.

7. Due to the limited frequency of utilizing LTSS providers, Health Plans may contract with the following providers on an as needed basis:

a. Environmental accessibility adaptation providers; and

b. Home maintenance providers.

C. Availability of Providers

1. 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:

a. Emergency medical situations – Immediate care (twenty-four (24) hours a day, seven (7) days a week) and without prior authorization;

b. Urgent care and PCP pediatric sick visits – Appointments within twenty-four (24) hours;

c. PCP adult sick visits – Appointments within seventy-two (72) hours;

d. Behavioral Health (routine visits for adults and children) – Appointments within ten (10) working days;

e. PCP visits, routine visits for adults and children - Appointments within twenty-one (21) days; and

f. Visits with a specialist or Non-emergency hospital stays – Appointments within four (4) weeks or of sufficient timeliness to meet Medical Necessity.

2. The Health Plan shall ensure:

a. Network providers accept new Members for treatment unless the provider has requested a waiver from the Health Plan from this provision;

b. Network providers do not segregate Members in any way from other persons receiving services, except for health and safety reasons;

c. Members are provided services without regard to race, color, creed, ancestry, sex, including gender identity or expression, sexual orientation, religion, health status, income status, or physical or mental disability; and

d. Network providers offer hours of operation that are no less than the hours of operation offered to Members covered by commercial plans or comparable to hours offered to Members under Medicaid FFS, if the provider has no commercial plan Members.

3. The Health Plan shall ensure that its network includes sufficient family planning providers to ensure timely access to Covered Services.

4. 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 to DHS, in accordance with §13.3.B.

5. The Health Plan shall ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid Members with physical or mental disabilities.

6. The Health Plan shall have a sufficient provider network of LTSS Providers that travel to Members to deliver services.

7. The Health Plan shall have an adequate network of CIS+ providers to ensure Members can access services in a timely manner. The Health Plan shall develop policies and procedures outlining its approach to managing provider shortages or other barriers to timely provision of services. The Health Plan shall ensure that CIS+ providers have sufficient experience and training in the CIS+ service being provided.

D. Geographic Access of Providers

1. 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 set forth in Table 6: 8.1.D:

Table 6: 8.1.D: Geographic Access Driving Time

Provider Type	Honolulu Metropolitan Statistical Area (MSA)	Rural

PCPs (Adult and Pediatric)	30 minute driving time	60 minute driving time
Specialists (Adult and Pediatric)	30 minute driving time	60 minute driving time
OB/GYN	30 minute driving time	60 minute driving time
Adult Day Care/Adult Day Health	30 minute driving time	60 minute driving time
Hospitals	30 minute driving time	60 minute driving time
Emergency Services Facilities	30 minute driving time	60 minute driving time
Behavioral Health Provider (Adult and Pediatric)	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
LTSS Providers	30 minute driving time	60 minute driving time

2. All travel times are maximums for the 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.

3. The Health Plan may submit to DHS a formal written request for a Waiver of these requirements after contract award for areas where there are no providers within the required driving time. The Health Plan may also submit to 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, DHS may waive the requirement entirely or expand the driving time.

E. Primary Care Providers

1. The Health Plan shall implement procedures to ensure each Member is assigned a PCP who shall be an ongoing source of primary care appropriate to the Member's needs and that this

PCP is formally designated as primarily responsible for coordinating the healthcare services furnished to the Member.

2. Individuals who are enrolled in a MA plan are not required to have a PCP. However, Members with FFS Medicare shall choose a PCP. This PCP for a Medicare Member does not have to be in the Health Plan's provider network. The Health Plan shall pay their co-payments or co-insurance as described in §7.2.A.

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

   a. A physician, either an MD or a DO, and shall have one of the following classifications: family practice, general practice, internal medicine, pediatrics, obstetrics and gynecology, preventive medicine, or family practice/internal medicine providers specialized in geriatric medicine;

   b. An APRN-Rx who is a registered professional nurse authorized by the State to practice as a nurse practitioner in accordance with state law and HAR Section 16-89, Subchapter 16; or

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

4. DHS may refine or revise the provider classifications and specializations comprising the definition of a PCP. The Health Plan may allow specialists or other healthcare practitioners to serve as PCPs for Members with chronic conditions provided:

   a. The Member has selected a specialist with whom he or she has a historical relationship as his or her PCP;

   b. The Health Plan has confirmed that the specialist agrees to assume the responsibilities of the PCP. Such confirmation

may be in writing, electronically or verbally; and

c. The Health Plan submits to DHS prior to implementation of a plan, for monitoring their performance as PCPs.

5. 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.

6. 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 healthcare and maintaining the Member's medical record that includes documentation of all services provided by the PCP as well as any specialty services.

7. The Health Plan shall monitor the number of Members that are assigned to each PCP, maintaining the ratio of less than or equal to one (1) to three hundred (300), and report this information to DHS in accordance with §6.3. The Health Plan may not restrict their Members from choosing a PCP who reaches the one (1) to three hundred (300) ratio. However, the Health Plan may not auto-assign any additional Members to the PCP until the ratio has decreased below the one (1) to three hundred (300) ratio. The Health Plan shall not apply this standard to clinics.

8. The Health Plan shall require that PCPs fulfill the responsibilities as described in this section for all Members. If the PCP is unable to fulfill his or her responsibilities to the Member, the Health Plan shall transition the Member to another PCP in accordance with §9.2.C. The original PCP shall be responsible for continuing to provide services to the Member until the other PCP has accepted the Member except in situations where the PCP is terminated

from either the Health Plan or Medicaid program. The Health Plan may support the transition and coordination of care by providing the PCP with the Member's service plans and medication lists in the appropriate electronic formats.

9. The Health Plan shall notify all Members in writing within ten (10) days of selection, assignment, or processed PCP changes. Health Plan shall ensure its auto-assign algorithm includes the following:

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

   b. Geriatricians shall not be auto-assigned to anyone under the age of sixty-five (65);

   c. PCPs with a ratio of 1 to 275 Members are removed from the algorithm;

   d. The Health Plan shall establish PCP policies and procedures that shall, at a minimum:

   e. Not establish any limits on how frequently and for what reasons a Member may choose a new PCP;

   f. Allow each Member, to the extent possible and appropriate, to have freedom of choice in choosing his or her PCP;

   g. Describe the steps taken to assist and encourage Members to select a PCP;

   h. Describe the process for informing Members about available PCPs;

   i. Describe the process for selecting a PCP;

   j. Describe the process for auto-assigning a Member to a PCP

if one is not selected;

k. Describe the process for changing PCPs; and

l. Describe the process for monitoring PCPs, including specialists acting as PCPs, to ensure PCPs are fulfilling all required responsibilities described above.

10. The Health Plan shall describe the policies and procedures for selecting and changing PCPs in its Member Handbook as described in §9.4.E. The Health Plan shall also describe in its Member Handbook, how PCPs are auto-assigned, if necessary.

11. The Health Plan shall submit the PCP policies and procedures to DHS for review and approval in accordance with §13.3. If the Health Plan revises its PCP policies and procedures during the term of the contract, DHS shall be advised and copies of the revised policies and procedures shall be submitted to DHS for review and approval thirty (30) days prior to implementation of the revised policies and procedures.

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

adequate network, the Health Plan shall allow Members to continue to use that FQHC as their PCP.

F. Direct Access to Women's Health Specialists

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

G. Federally Qualified Health Centers and Rural Health Centers

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

2. The Health Plan shall allow all Members to receive Covered Services that are urgent in nature at any FQHC or RHC without prior authorization. The Health Plan shall require the FQHC to refer the patient back to and inform the assigned PCP or help the individual select a new PCP.

H. Certified Nurse Midwives, Pediatric Nurse Practitioners, Family Nurse Practitioners and Behavioral Health Nurse Practitioners

1. The Health Plan shall ensure 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, shall be provided.

2. If the Health Plan does not have these providers in its network, it may choose to arrange and to provide the service(s) through an out-of-network provider or fly the Member to another island in a timely manner. The Health Plan may also fly the providers to the island where services needed. Alternatively, if the Health Plan chooses not to use out-of-network providers, the Health Plan shall 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.

3. This provision shall in no way be interpreted as requiring the Health Plan to provide any services that are not Covered Services.

I. Telehealth Services

1. The Health Plan is encourage to use Telehealth as a tool for facilitating access to needed services in a clinically appropriate manner and in accordance with HRS §346-59.1.

2. Telehealth providers shall be licensed in Hawaii to receive reimbursement under Medicaid.

3. The Health Plan shall have and implement policies and procedures that follow all federal and State security and

procedure guidelines. The policies and procedures shall incorporate DHS' policies and procedures for the proper use and security for Telehealth, including but not limited to confidentiality and data integrity, privacy and security, informed consent, privileging and credentialing, reimbursement, and technology.

4. Telehealth shall not be provided by any providers outside United States of America.

J. Rural Exceptions

1. In the event that there are areas in which there is only one Health Plan, any limitation the Health Plan imposes on the Member's freedom to choose between PCPs may be no more restrictive than the limitation on disenrollment under 42 CFR §438.56(c) and this Contract. In this case, the Member shall have the freedom to:

   a. Choose from at least two (2) PCPs;

   b. Obtain services from any other provider under any of the following circumstances:

   c. The service or type of provider (in terms of training, experience, and specialization) is not available within the Health Plan;

   d. The provider is not part of the network but is the main source of a service to the Member, and 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;

e. 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;

f. 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

g. DHS determines that other circumstances warrant out-of-network treatment.

8.2 Provider Credentialing, Recredentialing and Other Certification

A. Credentialing and Recredentialing Requirements

1. The Health Plan shall demonstrate that its network providers are credentialed as required under 42 CFR §438.214. The Health Plan will follow the most current NCQA credentialing and re-credentialing standards including delegation and provider monitoring/oversight.

2. The Health Plan shall reserve the right to require approval of providers, with regard to standards and thresholds set by the Health Plan and/or DHS (e.g., with regards to performance standards, office site criteria, medical record keeping, complaints triggering on-site visits). The Health Plan shall also

meet requirements of the RFP related to appointment availability and medical record keeping.

3. The Health Plan shall ensure each PCP meets all applicable requirements of law and has the necessary and current license/certification/accreditation/designation approvals per State requirements.

4. The Health Plan shall ensure that each acute care provider meets all applicable requirements of law and has the necessary and current license/certification/accreditation/designation approvals per State requirements. The Health Plan shall ensure that all facilities and organizational providers including, but not limited to, hospitals, are certified or licensed as required by the State.

5. The Health Plan shall ensure that each service delivery site of each behavioral health provider meets all applicable requirements of federal and state law and has the necessary and current license, certification, accreditation, or designation approvals 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 upon applicable state licensure rules and/or program standards, that those individuals are appropriately educated, trained, qualified, and competent to perform said services and job responsibilities.

6. The Health Plan shall ensure that each service and service delivery site of each LTSS provider—meets all applicable requirements of Federal and State law and has the necessary and current license, certification, accreditation, or designation approvals per State requirements. When individuals providing

LTSS services are not required to be licensed or certified, it is the responsibility of the Health Plan to ensure, based upon applicable state licensure rules and/or program standards, that those individuals are appropriately educated, trained, qualified, and competent to perform said services and job responsibilities.

7. Health Plans shall ensure all criminal history record check requirements are conducted for all high-risk providers determined by the State.

8. The Health Plan shall ensure that all providers including, but not limited to, therapists, meet state licensure requirements.

9. The Health Plan shall comply with the provisions of the CLIA. The Health Plan shall require that all laboratory testing sites providing services under this RFP have either a current CLIA certificate of waiver, or a certificate of registration along with a CLIA identification number. Laboratories with certificates of waiver, shall provide only ~~the~~ir types of tests permitted under the terms of the waiver. Laboratories with certificates of registration, may perform a full range of laboratory tests.

10. The Health Plan shall submit its credentialing, re-credentialing and other certification policies and procedures to DHS for review and approval in accordance with §13.3.

11. The Health Plans shall participate along with DHS' centralized credentialing initiative should it occur.

B. Provider Enrollment

1. DHS shall enroll, contract with, and screen all health plan providers that furnish, bill, order, refer, and prescribe services under this Contract as described in 42 CFR Part 455 Subpart B

and applicable sub-regulatory guidance, unless an exception applies as described herein or in other memorandum.

2. The Heath Plan shall ensure all providers that furnish, bill, order, refer and prescribe services are enrolled with the state as a Medicaid provider, unless an exception applies as described herein or in other policy memorandum.

C. Program Integrity Rules Governing Provider Agreements

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

2. The Health Plan may execute network provider agreements, pending the outcome of State screening, enrollment, and revalidation for up to one hundred twenty (120) days, but shall terminate a network provider immediately upon notification from the State that the network provider cannot be enrolled, or the expiration of one hundred twenty (120) days period without enrollment of the provider, and notify affected Members.

3. The Health Plan shall notify DHS through a Provider Suspension and Termination report to be determined in the reporting package described in Section 6 of any Providers with whom the Health Plan refuses to enter into, or renew, an agreement.

8.3 Provider Contracts

A. Provider Contract Requirements

1. All contracts between Providers and the Health Plan shall be in writing. The Health Plan's written Provider contracts shall include all of the provider contract required elements described in the Health Plan Manual.

2. The Health Plan shall ensure Providers' performance and compliance with what is listed in the provider contracts. The Health Plan shall conduct periodic reviews or audits as needed to ensure that providers are in compliance with all the terms and conditions of their contracts

3. The Health Plan may agree to an addendum to an already executed provider contract if the addendum and the provider agreement together include all the provider contract requirements described in the Heath Plan Manual. The addendum shall clearly state that if the terms and conditions in the addendum and the provider agreement conflict, the terms and conditions in the addendum shall apply.

4. The Health Plan shall submit to DHS for review and approval a model for each type of provider contract thirty (30) days after the effective date of the Contract in accordance with §13.3.B.

5. In addition, the Health Plan shall submit to DHS the signature page of all finalized and executed contracts in accordance with §13.3.B.

6. The Health Plan shall continue to solicit Provider participation throughout the contract term when Provider network deficiencies are found.

7. Requirements for contracts with non-providers Subcontractors are addressed in §14.4.

8. The Health Plan shall require their providers to report adverse event related to Member's health care for various special populations including, but not limited to, Long-Term Services and Supports, Home and Community Based Services, Special Health Care Needs, and Community Integration Services.

9. Incentive payment contracts between Health Plan and network providers must meet the requirements as specified in 42 CFR §438.3(i)(3) and §438.3(i)(4).

8.4 Provider Services

A. Provider Education

1. 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 the Commencement of Services identified in §1.5. The Health Plan shall conduct education sessions at least every six (6) months for their contracted Providers after Date of the Commencement of Services identified in §1.5.

2. The Health Plan shall provide one-on-one education to providers who are not fulfilling program requirements as outlined in the provider contract agreements listed in §14.4.A and the provider manual as described in §8.4.C. One-on-one provider education includes educating providers on how to process their specific claims for payment. Specifically, the Health Plan shall educate providers on:

    a. The Health Plan's referral process and prior authorization

process;

b. The role of the PCP, if applicable;

c. Claims processing;

d. Availability of interpreter, auxiliary aids, and services for their patients;

e. Availability of service coordination services and how to access these services;

f. Role of care coordination team, service coordination team and the Hale Ola;

g. The availability of programs that support Members and providers including but not limited to CIS+, CoCM, Health Coordination, Project ECHO, and access to SDOH supports for Members. MCO shall develop a Stepped Approach to behavioral health needs;

h. The ways in which the Health Plan will support provider-level quality improvement initiatives, including practice guidelines, and available access to resources and incentives;

i. Members' rights and responsibilities, including the right to file a grievance or appeal and how a provider can assist Members;

j. Reporting requirements;

k. Circumstances and situations under which the provider may bill a Member for services or assess charges or fees;

l. The Health Plan's medical records documentation requirements including the requirement that this documentation shall be tied to claims submission or encounter data;

m. The LAN framework and opportunities available to participate

in VBP models including mechanisms to leverage Health Plan support to build capacity for VBP participation;

n. Methods the Health Plan will use to update providers on program and Health Plan changes, for example, monthly newsletters, etc.;

o. Requirements for participating in and receiving payments from, as applicable, the Health Plan's quality program; and

p. The provider grievance, complaints, and appeals process.

3. Additionally, the Health Plan shall provide the following information on the Member Grievance and Appeal System to all Providers and Subcontractors at the time they enter into a contractual relationship with the Health Plan:

a. The Member's right to file grievances and appeals and their requirements, and timeframes for filing;

b. The Member's right to a State administrative hearing, how to obtain a hearing and rules on representation at a hearing;

c. The availability of assistance in filing a grievance or an appeal;

d. 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;

e. The toll-free numbers to file a grievance or an appeal; and

f. 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.

4. The Health Plan shall ensure that the providers are aware of their responsibilities for compliance with the Americans with Disabilities Act, including how to access interpreter and sign language services as described in §9.4.D.

5. The Health Plan shall develop provider education curricula and schedules that shall be submitted to DHS for review and approval in accordance with the timeframes in accordance with §13.3.B.

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

B. Provider Grievance and Appeals Process

1. The Health Plan shall have policies and procedures for a Provider Grievance and Appeal System that includes provider grievances and provider appeals. Provider grievances and Provider appeals shall be resolved within sixty (60) days from the day following the date of submission to the Health Plan. The Health Plan shall give providers thirty (30) days from the decision of the grievance to file an appeal. Providers may utilize the Provider Grievance and Appeal System to resolve issues and problems with the Health Plan, including a problem regarding a Member.

A Provider may file a grievance or appeal on behalf of a Member

by following the procedures outlined in §9.5.

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

   a. Benefits and limits, for example, limits on behavioral health services or formulary;

   b. Eligibility and enrollment, for example long wait times or inability to confirm enrollment or identify the PCP;

   c. Member issues, including:

      1) Members who fail to meet appointments or do not call for cancellations;

      2) Instances in which the interaction with the Member is not satisfactory;

      3) Instances in which the Member is rude or unfriendly; or

      4) Other Member-related concerns.

   d. 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;

   e. 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.;

f. Issues related to the delivery of health services, for example, the PCP was unable to 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 behavior; and

g. 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 Health Plan's specialty network cannot provide adequate care for a Member.

3. The Health Plan shall log all provider grievances and appeals, and report to DHS in accordance with the report to be determined in the reporting package described in Section 6.

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

5. The Health Plan shall submit Provider Grievance and Appeal System policies and procedures to DHS for review and approval in accordance with §13.3.B.

C. Provider Manual

1. The Health Plan shall develop a Provider manual that shall be made available to all Providers. The Health Plan may provide an

electronic version, via a link to the Health Plan's website, 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 with thirty (30) days.

2. The Provider manual shall contain all the elements described in the Health Plan Manual.

3. 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 by providing a hard copy, unless the provider specifically requests a hard copy, in which case it shall be provided without charge to the provider.

4. The Health Plan shall submit the provider manual to DHS for review and approval in accordance with the timeframes in accordance with §13.3B.

D. Provider Call-Center/Prior Authorization Line

1. The Health Plan shall operate a toll-free provider call center to respond to provider questions, comments, inquiries and requests for PAs. The provider call center shall ensure PA staff is readily accessible. The toll-free provider call center shall be available and accessible to providers from all islands on which the Health Plan serves.

2. The Health Plan's provider call center systems shall have the capability to track call center metrics identified by 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.

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

4. The Health Plan shall meet the following call center standards:

   a. The call abandonment rate is five (5) percent or less;

   b. The average speed of answer is thirty (30) seconds or less;

   c. The average hold time is two (2) minutes or less;

   d. The blocked call rate does not exceed one (1) percent; and

   e. The longest wait in queue does not exceed four (4) minutes.

5. The Health Plan shall have, at a minimum, an automated system or answering service available between the hours of 4:30 p.m. HST and 7:45 a.m. HST 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 representatives return all calls by close of business the following business day. In emergency situations, the Health Plan shall ensure calls are returned to providers within thirty (30) minutes whether the message is left on the automated system or by the answering service.

6. 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.

7. The Health Plan shall submit these policies and procedures to DHS for review and approval in accordance with §13.3.B.

E. Website for Providers

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

2. Health Plans are encouraged to develop a smart PA system, such that if a provider has a certain percentage of PA requests approved for certain services or overall, that subsequent PA requests from the provider could be waived in order to reduce administrative burden on high-performing providers.

3. The Health Plan shall have policies and procedures in place to ensure the website is updated regularly and contains accurate information. The Health Plan shall submit these policies and procedures to DHS for review and approval in accordance with

§13.3.B.

4. The Health Plan shall provide DHS with access to the provider website, even if in a test environment, for review and approval in accordance with the timeframes in accordance with §13.3.B.

8.5 Provider "Gag Rule" Prohibition

A. 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:

1. The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

2. Any information the Member needs in order to decide among all relevant treatment options;

3. The risks, benefits and consequences of treatment or non-treatment; and

4. 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.

B. 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.

C. The Health Plan shall take no punitive action against a provider that requests an expedited resolution or supports a Member's appeal.

D. 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 Health Plan objects to the service on moral or religious grounds. In these cases, the Health Plan shall notify, in writing:

1. DHS within one hundred twenty (120) days prior to adopting the policy with respect to any service;

2. DHS with the submission of its proposal to provide services under this RFP;

3. Members at least thirty (30) days prior to the effective date of the policy for any particular service; and

4. Members and potential Members before and during enrollment.

SECTION 9 – Responsibilities and Requirements of DHS and Health Plans: Eligibility, Enrollment, Disenrollment, Continuity of Care, and Grievance and Appeals

9.1 DHS Eligibility and Enrollment Responsibilities

A. Eligibility Determinations

1. DHS is solely responsible for determining eligibility. Provided the individual applying for Medicaid meets all eligibility requirements, the individual shall become eligible for Medical Assistance, and be effectively enrolled in and covered by a Health Plan on one of the following dates:

   a. The date a completed application is received by the Department;

   b. If specified by the individual applying for Medicaid, any date on which Medicaid eligible medical expenses were incurred but no earlier than three (3) months immediately prior to the date of application; or

   c. The first day of the next month following the month in which all eligibility requirements are met.

B. DHS Enrollment Responsibilities

1. DHS shall provide informational notices to potential Members upon its approval of eligibility within a timeframe that allows the Member to use the information to choose a participating Health Plan. Upon notification of application approval, eligible individuals who submitted their applications electronically shall be provided the opportunity to select a participating Health Plan on the date of notification. Notices shall include:

a. The available Health Plans from which they can choose;

b. Clear instructions on how to inform DHS about their choice;

c. Implications of actively choosing or not making an active choice of a Health Plan; and

d. An explanation of the length of the enrollment period, as well as disenrollment period, of ninety (90) days without cause after initial enrollment, and all other disenrollment options.

2. Individuals who make a Health Plan selection upon eligibility notification will be enrolled in that Health Plan retroactively to date of eligibility, or prospectively, as applicable. Individuals who do not make a choice of Health Plans when notified of eligibility, and those who do not submit an application electronically, will be auto-assigned to a Health Plan retroactively to date of eligibility, or prospectively, as applicable. The following exceptions shall apply for enrollments affecting:

   a. Newborns, as described in §9.1.D.1.;

   b. New Member added to an existing case, as described in §9.1.D.2.;

   c. Foster Care Children, as described in §9.1.D,3,;

   d. Changes made during Annual Plan Change (APC) period, as described in §9.1.E,;

   e. Individuals with gaps in eligibility for a period of less than six (6) months, as described further in the current section; and

   f. Enrollment caps or limits, as identified in §9.1.F.

3. DHS shall provide new Members a Member handbook at time of approval to aid in Health Plan selection. This Member Handbook shall include information about the basics of managed care; benefits covered by the QI programs; and how to access information on the Health Plans' provider networks. The Member Handbook shall be presented in a format and timeframe prescribed by DHS and the Health Plan shall provide complete, accurate, and timely information to DHS for inclusion in the Member Handbook. DHS shall prorate the total cost of printing the Member Handbook equally among the number of Health Plans participating in the QI program.

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

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

6. In addition, DHS shall allow all Members to change Health Plans without cause for the first ninety (90) days following their enrollment in a Health Plan, regardless of whether enrollment is a result of selection or auto-assignment, and whether enrollment is from initial eligibility or from annual plan change. Members are only allowed one (1) change of Health Plan during the ninety (90) days grace period. DHS shall educate providers about the option for Members to make Health Plan changes during the ninety (90) days grace period. This applies to all

Members, including aged, blind, and disabled Members.

7. Health Plan change requests received during the ninety (90) days period following enrollment shall be effective beginning the first day of the following month in which the Health Plan change request was received by DHS. After the ninety (90) days grace period, Members shall only be allowed to change plans during the Annual Plan Change Period, except for cause, as described in §9.1.H, or as outlined in §9.1.D.

8. DHS or its agent shall provide the Member with written notification of the Health Plan in which the Member is enrolled and the effective date of enrollment each time Health Plan enrollment changes. This notice shall serve as verification of enrollment until a Membership card is received by the Member from the Health Plan.

9. The Health Plan shall receive a daily file of enrollment/disenrollment information in a HIPAA-compliant 834 file format via DHS SFTP server. The enrollment information shall include at a minimum the case name, case number, Member's name, mailing address, date of enrollment, TPL coverage, date of birth, sex, and other data that DHS deems pertinent and appropriate. The Health Plan is required to review 834 reports in a timely manner, and make prompt initial contact with the new Members on its daily report.

C. Auto-Assignment to a Health Plan

1. Responsibilities

a. DHS is responsible for the development and implementation of Auto-Assignment algorithms, policies, and procedures

and such algorithms, polices, and procedures are subjectto change at the discretion of DHS.

b. DHS reserves the right to establish Auto-Assignment algorithms that are population based, such as ABD Members.

c. The Health Plan is required to participate in Auto-Assignment unless an exception is permitted at the discretion of DHS.

2. Special Auto-Assignment Rules after Selection of Health Plans

a. DHS has established the following auto-assignment processes to enroll Members in the Health Plans selected in this RFP, as described in Section 16. These processes account for all Members in existing and returning Health Plans, if there is a reduction in the overall selected number of Health Plans, and/or the selection of one (1) or more new Health Plans:

1) Members in Returning Plans: Members shall remain with their current Health Plan if that Health Plan is selected by DHS until the next APC.

b. Members in Non-Returning Plans: If the Member's Health Plan is not selected by DHS, the Member will have the choice of selecting another participating Health Plan. Members who do not select a Health Plan will be Auto-Assigned and equitably distributed to the participating Health Plans.

c. All Members may choose to change Health Plans during the APC.

3. General Auto-Assignment Rules and Process

   a. DHS shall keep Members enrolled in the same QI Health Plan if they remain eligible for QI benefits but their eligibility category changes. DHS shall not provide a choice to the Member until the next Annual Change Period unless there is cause, as defined in §9.1.H. Nothing in this section negates the Members' rights.

   b. Members newly enrolled or re-enrolled after six (6) months lapse in eligibility in QI who are enrolled in a contracted Health Plan's MA plan including D-SNP shall be auto-assigned into the same Health Plan's QI plan. The Health Plan is not precluded from encouraging the Member to enroll into the Health Plan's D-SNP, as defined in §2.6, provided the Member is within enrollment timeframes.

4. Auto-Assignment Algorithm

   a. DHS shall determine auto-assignment based on an algorithm that may take into consideration Health Plan enrollment volume, distribution of Member sub-groups, Health Plan performance, Health Plan scorecard and quality metrics, and additional criteria to be specified. Auto-assignment methodologies, including the relative weight of each component included in the formula, may be modified as needed. DHS may incorporate enrollment caps and limits into the auto-assignment methodology.

   b. The auto-assignment algorithm to be implemented in the first Contract year shall be provided to the Health Plan within thirty (30) to sixty (60) days prior to the Commencement of Services to Members.

c. Thereafter, DHS shall notify the Health Plan at least six (6) months prior to a planned changed to the auto-assignment algorithm. DHS shall inform the Health Plan of the specifications of each performance or quality measure potentially incorporated into the auto-assign algorithm no less than six (6) months prior to the beginning of the time period from which the data is being measured.

D. Enrollment Exceptions

1. Newborn Enrollment

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

b. If the newborn mother's health insurance is unknown or the mother is not enrolled in a Health Plan offered by a health insurer that also offers a QI plan, the newborn may be auto-assigned into a QI Health Plan in accordance with §9.1.C. until the Member makes a choice of Health Plan. If auto-assignment is required, the newborn will be enrolled based on Health Plan enrollment of family Members in the case as described in §9.1.D.2.a. If the newborn does not have any family Members in QI, then the newborn is auto-assigned

based on the algorithm.

c. DHS reserves the right to dis-enroll the newborn if the newborn is later determined to be ineligible for QI or enrollment was applied incorrectly. DHS shall notify the Health Plan of the disenrollment by electronic media. DHS shall make capitation payments to the Health Plan for the months in which the newborn was enrolled in the Health Plan.

d. A newborn Member delivered by a non-Medicaid mother with commercial insurance from a health plan that participates with QI shall be enrolled in the same health plan.

2. Additions to Existing Cases

a. For any new case or new Member added to an existing case, DHS shall promote family continuity. All Members of a newly eligible case shall be auto-assigned to the same Health Plan. If the new Member is less than nineteen (19) years old, he or she will be enrolled in the same Health Plan as the youngest family Member. If the new Member is age nineteen (19) years old or older, he or she will be enrolled in the same Health Plan as the primary client.

3. Foster Children

a. Foster children, including children in the custody of DHS CWS and former Foster children, may be enrolled or dis-enrolled from a Health Plan at any time upon written request from DHS CWS staff. Disenrollment shall be at the end of the month in which the request was made and enrollment

into the new Health Plan shall be on the first day of the next month.

E. Annual Plan Change Period

1. APC Period Timeframes

a. DHS shall hold an APC period at least annually to allow Members the opportunity to change Health Plans without cause. DHS may establish additional APC periods as deemed necessary on a limited basis (e.g., termination of a Health Plan during the contract period).

2. APC Member Materials

a. At least sixty (60) days before the start of the enrollment period, DHS shall mail, to all households with individuals who are eligible to participate in the APC period, an information packet that describes the APC process, a booklet that includes the information about the Health Plans, benefits covered by the QI programs, how to select a Health Plan and a PCP, a description of Auto-Assignment, and information on how to access the Health Plans' provider networks.

3. Ongoing APC Process

a. If during any APC period within this Contract period, no Health Plan selection is made and the Member is enrolled in a returning Health Plan that has a current and new contract with DHS, the person shall remain in the current Health Plan.

b. For Members changing from one Health Plan to another

during the APC period, the effective date of enrollment shall be the first day of the second month after the APC period ends.

F. Auto-assignment, Member Enrollment Limits and Caps

1. The Health Plan shall accept all Members selecting the Health Plan or auto-assigned by DHS to the Health Plan.

2. Population-based Enrollment Caps

a. At the discretion of DHS, a population-based Membership, for example ABD Members, enrollment cap may be imposed due to Health Plan performance deficiencies or other factors as determined by DHS. DHS reserves the right to lift the population-based enrollment cap at its discretion.

b. If a Health Plan has a population-based enrollment cap, it shall not be available during the APC period or to new Members but will be available for existing Members to continue with the Health Plan. Below are exceptions to this policy:

1) Enrollment of newborns in a QI plan that have the same health insurer as their mother, whether the mother was enrolled in a QI or commercial plan, shall be exempt from the performance-based enrollment cap;

2) Newly determined eligibles that have PCPs, specialists, or behavioral health providers who are exclusive to the capped Health Plan within the previous twelve (12) months shall be allowed to enroll in the capped Health Plan. The capped Health

Plan shall provide DHS with a listing of exclusive PCP, specialist and behavioral health providers, which shall be verified with the other Health Plans;

3) Members who have lost eligibility for a period of less than six (6) months may return to the capped Health Plan;

4) Child(ren) under foster care, kinship guardianship or subsidized adoption may enroll in a capped plan;

5) If a capped Health Plan does not have a waiting list for HCBS or "at risk" services when another Health Plan in the same service area open to new Members does have a waitlist for these services, then Members shall be able to enroll in a capped Health Plan;

6) Starting January 1, 2026, dual eligible Members who seek to enroll in a D-SNP offered by a Health Plan that differs from their current QI plan must first switch their Medicaid plan to match the Health Plan of their D-SNP choice, consistent with §3.9.B.2.b; or

7) The population-based enrollment cap imposed under Hawaii's Medicaid program would not allow a current enrolled dual eligible to move his/her Medicaid portion of benefits from one plan to another, but will not limit a currently enrolled Medicare Member from switching his/her Medicare portion of benefits to another D-SNP.

3. Performance-based Enrollment Caps

a. At the discretion of DHS, a Membership enrollment cap may be imposed due to Health Plan performance deficiencies. A

performance-based enrollment cap will be reviewed at a frequency determined by DHS. At its discretion, DHS reserves the right to lift a performance-based enrollment cap based on evidence of sustained resolution of the Health Plan's performance deficiencies.

b. If a Health Plan has a performance-based enrollment cap, it shall not be available during the APC period or to new Members but will be available for existing Members to continue with the Health Plan. Below are exceptions to this policy:

    1) Enrollment of newborns in a QI plan that have the same health insurer as their mother, whether the mother was enrolled in a QI or commercial plan, shall be exempt from the performance-based enrollment cap;

c. Newly determined eligible Members that have PCPs or behavioral health providers who are exclusive to the capped Health Plan within the previous twelve (12) months shall be allowed to enroll in the capped Health Plan. The capped Health Plan shall provide DHS with a listing of exclusive PCP and behavioral health providers, which shall be verified with the other Health Plans; or

d. Members who have lost eligibility for a period of less than six (6) months may return to the capped Health Plan;

e. Child(ren) under foster care, kinship guardianship or subsidized adoption;

f. If a capped Health Plan does not have a waiting list for HCBS

or "at risk" services when another Health Plan in the same service area open to new Members does have a waitlist for these services, them Members shall be able to enroll in a capped Health Plan;

g. Starting January 1, 2026, dual eligible Members who seek to enroll in a D-SNP offered by an organization that differs from their current Medicaid plan must first switch their QI plan to match the Health Plan of their D-SNP choice, consistent with §3.9.B.2.b; orA newly eligible Medicaid individual who is already enrolled in a MA D-SNP will be able to continue enrollment in the MA plan D-SNP he/she was already enrolled in for Medicare; or

h. The enrollment cap imposed under Hawaii's Medicaid program would not allow a current enrolled dual eligible to move his/her Medicaid portion of benefits from one plan to another but will not limit a currently enrolled Medicare Beneficiary from switching his or her Medicare portion of benefits to another D-SNP.

4. Minimum Membership Levels

a. At the discretion of DHS, minimum Membership level(s) may be established by DHS based on geography or other factors as determined by DHS.

G. Member Education Regarding Status Changes

1. DHS shall educate Members concerning the necessity of providing to the Health Plan and DHS any information affecting their Member status. Events that could affect the Member's status and may affect the eligibility of the Member include but

are not limited to:

a. Change in household (movements in and out of a household);

b. Death of the Member or family Member (spouse or dependent);

c. Birth;

d. Marriage;

e. Divorce;

f. Adoption;

g. Transfer to LTSS;

h. Change in health status, for example, pregnancy or permanent disability;

i. Change of residence or mailing address;

j. Institutionalization, for example, state mental health hospital, Hawaii Youth Correctional Facility, or prison;

k. TPL coverage that includes accident related medical condition;

l. Inability of the Member to meet citizenship, alien status, photo and identification documentation requirements as required in the Deficit Reduction Act Section 6037 and in other federal law;

m. Change or addition of social security number; or

n. Other household changes.

2. The Health Plan shall collaborate and coordinate with the other

participating QUEST Integration Health Plans to maintain the health and safety of the Members and the continued access to necessary services during the disaster period.

H. Disenrollment Requirements and Limitations

1. DHS shall be the sole authority to dis-enroll a Member from a Health Plan and from the programs. DHS shall process all disenrollment requests submitted orally or in writing by the Member or his or her authorized representative.

2. Appropriate reasons for disenrollment include, but are not limited to the following items relating to program participation:

   a. Member no longer qualifies based on the medical assistance eligibility criteria or voluntarily leaves the program;

   b. Death of a Member;

   c. Incarceration of the Member;

   d. Member enters the State hospital;

   e. Member enters the Hawaii Youth Correctional Facility;

   f. Member enters the SHOTT program;

   g. Member is in foster care and has been moved out-of-state by DHS;

   h. Member becomes a Medicare Special Savings Program Member;

   i. Member provides false information with the intent of enrolling in the programs under false pretenses; or

   j. Member is a medically needy individual who is two (2) full

months in arrears in the payment of the designated spend down or cost share, unless the failure to pay occurs because:

1) The Member is not in control of their personal finances, and the arrearage is caused by the party responsible for the Member's finances, and action is being taken to remediate the situation, including but not limited to:

a) Appointment of a new responsible party for the Member's finances; or
b) Recovery of the Member's funds from the responsible party which will be applied to the Member's enrollment fee obligation.

k. The Member is in control of their finances, and the arrearage is due to the unavailability of the Member's funds due to documented theft or financial exploitation, and action is being taken to:

a) Ensure that theft or exploitation does not continue; or
b) Recover the Member's funds to pay the Member's enrollment fee obligation.

l. The member's enrollment period is within 90 days of the initial enrollment and all other disenrollment options.

3. Additional appropriate reasons for disenrollment from a Health Plan include, but are not limited to the following:

a. Member chooses another Health Plan during the annual plan change period;

b. The Member missed Annual Plan Change due to temporary loss of Medicaid eligibility and was reenrolled in their former Health Plan as described in §9.1.B.;

c. Member's PCP, behavioral health provider, specialist or LTSS residential facility is not in the Health Plan's provider network and is in the provider network of a different Health Plan;

d. Member is eligible to receive HCBS or "at risk" services and is enrolled in a Health Plan with a waiting list for HCBS or "at risk" services and another Health Plan does not have a waiting list for the necessary service(s);

e. DHS has imposed sanctions on the Health Plan as described in §14.20.A;

f. The Health Plan's contract with DHS is terminated or is suspended as described in §14.16;

g. Mutual agreement by participating Health Plans, the Member, and DHS;

h. Member requests disenrollment for cause, at any time, due to:

    1) An administrative appeal decision;

    2) Provisions in administrative rules, Federal or State statutes;

    3) A legal decision;

    4) Relocation of the Member to a service area where the Health Plan does not provide service;

5) Change in foster placement if necessary for the best interest of the child;

6) The Health Plan's refusal, because of moral or religious objections, to cover the service the Member seeks as allowed for in §8.5;

7) 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;

8) The Member does not have access to women's healthcare specialists for breast cancer screening, pap smears, or pelvic exams;

9) 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 healthcare needs, lack of direct access to but not limited to certified nurse midwives, pediatric nurse practitioners, family nurse practitioners, women's healthcare specialists for breast cancer screenings, pap smears and pelvic exams, if available in the geographic area in which the Member resides; or

10) Any Member who uses LTSS that would experience a disruption in their residence or

employment due to having to change their residential, institutional, or employment supports provider based on that provider's change in status from in-network to out- of-network.

11) When Health Plan that has an on-going sanction listed in §14.21.F and continued enrollment causes damages to a Member's health and wellness.

4. DHS shall provide daily disenrollment data to the Health Plan via disenrollment roster on DHS SFTP file server seven (7) days a week.

5. Disenrollment requests shall be determined no later than the first day of the second month following the month that the Member or the Health Plan files the request. If DHS fails to make a determination in that time frame, the transfer or disenrollment shall be considered approved and effective on that day.

6. Any Member dissatisfied with DHS' determination denying their request to disenroll from their Health Plan shall be given access to the State administrative hearing process.

7. The Health Plan shall not request disenrollment of a Member for discriminating reasons, including:

   a. Pre-existing Medical Conditions;

   b. Missed appointments;

   c. Changes to the Member's health status;

   d. Utilization of medical services;

   e. Diminished mental capacity; or

   f. Uncooperative or disruptive behavior resulting from the

Member's special needs.

8. Please refer to §4.12 for Health Plan administrative requirements for SHOTT.

I. Health Plans shall seek DHS' Disability Status Determination, for an Aid to Disabled Review Committee (ADRC) Evaluation

1. DHS, through the ADRC, determines the disability status of persons who are not in receipt of Retirement, Survivors and Disability Insurance (RSDI) or Supplemental Security Income (SSI) disability benefits. If the Health Plan has supporting documentation, copy of SSA letter, payment stub, or any other evidence of payment, that a Member is RSDI or SSI eligible, this documentation shall be sent to DHS in accordance with established procedures so that appropriate action can be taken to re-determine the Member's eligibility status without going through the ADRC process.

2. The Health Plan shall comply with the ADRC process for the following individuals who are not in the Adult group:

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

   b. Members who qualify for SHOTT.

3. When a Health Plan identifies one of their Members meeting the criteria, the Health Plan shall refer the Member to DHS for an ADRC evaluation utilizing the ADRC packet which includes DHS Forms 1180, 1128, and 1127. Specifically, the Health Plan shall submit to the ADRC Coordinator in DHS, the following completed forms and documentation:

a. A DHS 1180, "ADRC Referral and Determination";

b. A DHS 1127, "Medical History and Disability Statement";

c. A DHS 1128 "Disability Report";

d. 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, for example, clinical progress notes, history and physical reports, discharge summaries, etc.; and

e. A CMS 2728 may be substituted for DHS 1128 for ADRC referrals on clients with ESRD.

4. The Health Plan shall submit an ADRC packet for Members in the Adult group if the Member:

   a. Meets NF LOC on DHS 1147 and has chosen to receive HCBS; and

   b. Has signed their agreement to have their assets reviewed on DHS 1127.

5. If the Member is going through ADRC to obtain LTSS, then DHS shall conduct additional post-eligibility review on the approved ADRC packet.

6. If approved for SHOTT, the Member shall be dis-enrolled from the Health Plan, converted to FFS, and transitioned to SHOTT.

7. To qualify for ADRC disability determination, the disability shall be for a minimum of one year. The ADRC follows criteria outlined in the latest edition of the Disability Evaluation Under Social Security, also known as the Blue Book.

9.2 Health Plan Enrollment Responsibilities

A. General Requirements

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

2. DHS shall make every effort to ensure that individuals who are ineligible for enrollment are not enrolled in the QI program. However, to ensure that such individuals are not enrolled in QI, the Health Plan shall assist DHS in the identification of individuals who are ineligible for enrollment, as set forth in §9.1.A, should such individuals inadvertently become enrolled in the QI program. The Health Plan shall also assist DHS in the identification of individuals who become ineligible for Medicaid or CHIP, including individuals who have moved out-of-State, been incarcerated, or are deceased.

3. The Health Plan shall accept daily and monthly transaction files from DHS as the official enrollment record.

4. The Health Plan shall issue a new Member enrollment packet

within ten (10) days of receiving the notification of enrollment from DHS. The new Member packet shall include all of the elements described in the Health Plan Manual.

B. Welcome Calls and New Member Survey

1. The Health Plan shall place a welcome call within ten (10) days of receiving the notification of enrollment from DHS. The Health Plan may send the written survey in the new Member enrollment packet as described in §9.2.A. The Health Plan may choose to only utilize welcome calls instead of written surveys.

2. The Health Plan shall include standardize questions, including SHCN screening questions, at DHS discretion in the welcome calls and new Member survey, if applicable. If SHCNs are identified through the welcome call or new Member survey, the Health Plan will follow the process and requirements as described in Section 3 and the Health Plan Manual.

3. The Health Plan shall submit its welcome call script and new Member survey, if applicable, to DHS upon request.

C. Primary Care Provider (PCP) Selection

1. The Health Plan shall provide assistance in selecting a PCP and shall provide the Member ten (10) days from the date identified on enrollment packet 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 Member fails to select a PCP within ten (10) days, excluding mail time, or if the Member has been auto-assigned to the Health Plan, the Health Plan shall auto- assign a Member to a PCP based on the following algorithm:

a. The Health Plan shall auto-assign Members to the assigned

PCP of an immediate family Member enrolled in the Health Plan, if the provider is appropriate based on age and gender of the Member.

b. If no immediate family Member has an existing relationship with a PCP, the Health Plan shall auto-assign the Member based on age and gender and geographic proximity of the Member's residence.

2. The Health Plan shall follow additional requirements identified in §8.1.E when assigning a PCP.

D. Changes in Member Status

1. The Health Plan shall forward to 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 in an electronic format specified by DHS; for example, changes in address shall be communicated to DHS electronically on its SFT file server site on a monthly basis on the fifteenth (15) of the month or next business day utilizing the format provided by DHS. Where it is not feasible to submit changes in an electronic format (for example, when an urgent change is needed), information may also be submitted by phone, fax, courier services, or mail to the appropriate DHS eligibility office.

2. In addition, the Health Plan shall notify the Member that it is also his or her responsibility to provide changes and updated information to DHS. Examples of changes in the Member's status are provided in §9.1.G.

E. Notification of Newborns

1. The Health Plan shall notify 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. The change will be submitted electronically to the extent feasible in a format specified by DHS.

9.3 Health Plan Continuity of Care

A. Transition to Different Health Plan

1. In the event a Member entering the Health Plan is receiving Covered Services that meet Medical Necessity in addition to or other than prenatal services, including Members in the second and third trimester of pregnancy receiving prenatal services described in this section, the day before enrollment into the Health Plan, the Health Plan shall be responsible for the costs of continuation of such services that meet Medical Necessity, without any form of prior approval and without regard to whether such services are being provided by contract or non-contract Providers. Health Plans shall be responsible for services that meet Medical Necessity provided during prior period coverage and retroactive enrollment.

2. Health Plans shall ensure that during transition of care, its new Members:

   a. Receive all emergency services that based on Medical

Necessity;

b. Receive all prior authorized LTSS, including both HCBS and institutional services;

c. Adhere to a Member's prescribed prior authorization for services that meet Medical Necessity requirements, including prescription drugs, or courses of treatment; and

d. Provide for the cost of care associated with a Member transitioning to or from an institutional facility in accordance with the requirements prescribed in §9.2.A.

3. The Health Plan shall provide continuation of services for individuals with SHCN or who are receiving LTSS for at least ninety (90) days or until the Member has received an assessment by the new Health Plan as described in Section 3.

4. The Health Plan shall provide continuation of other services for all other Members for at least forty-five (45) days or until the Member's medical needs have been assessed or reassessed by the PCP who has authorized a course of treatment.

5. 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.

6. In the event the Member entering the Health Plan is in her second or third trimester of pregnancy and is receiving covered prenatal services based on Medical Necessity 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.

B. Transition from the Health Plan

1. 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 §9.2.A, provided to the Member, if hospitalized at the time of transition, until discharge or LOC 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.

2. 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.

3. The former Health Plan shall ensure 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.

C. Transition of Care Policies and Procedures

1. 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 in accordance with §13.3.B. The transition of care policy shall be consistent with the requirements set forth below.

2. The transition of care policy shall include the following:

   a. The Member has access to services consistent with the access they previously had, and is permitted to retain their current provider for a period of time if that provider is not in the provider network;

   b. The Member is referred to appropriate providers of service that are in the new plan's provider network;

   c. The Member's previous provider(s) shall fully and timely comply with requests for historical utilization data from Member's new provider(s) in compliance with Federal and State law.

   d. The Member's new provider(s) shall be able to obtain copies of the Member's medical records consistent with Federal and State law, as appropriate.

   e. Any other necessary procedures as specified by the Secretary of DHHS to ensure continued access to services to prevent serious detriment to the Member's health or reduce the risk of hospitalization or institutionalization.

   f. The transition of care policy shall be publicly available and provide instructions to Members on how to access continued services upon transition.

9.4 Notification to Members of Services, Responsibilities and Rights

A. General Requirements

1. The Health Plan shall have in place mechanisms to help Members

and potential Members understand the requirements and benefits of their plan.

2. The Health Plan shall ensure that Members and potential Members are provided all required information in a manner and format that may be easily understood and is readily accessible. This includes but is not limited to Members being informed 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.

3. The Health Plan shall make the following available in written format in the prevalent non-English languages in its relevant service area: provider directory, Member handbook, appeal and grievance notices, and denial and termination notices.

4. The Health Plan shall convey this information via written materials and other readily accessible methods that may include but not be limited to electronic information and services, telephone, internet, or face-to-face communications that allow the Members to ask questions and receive responses from the Health Plan.

5. When directed by DHS, and whenever there has been significant change, including network provider termination, 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 and termination or fifteen (15) days after receipt or issue termination of notice.

6. The Health Plan shall develop Member services policies and procedures that address all components of Member services. These policies and procedures shall include, but are not limited to, policies and procedures on:

   a. Member call center staffing and monitoring;

   b. Member call center activities to ensure metrics as required in §9.4.I are met;

   c. The availability and how to access interpretation services for non-English speakers, translation services, and services for individuals with visual and hearing impairments;

   d. Member rights and how they are protected;

   e. Up-dating and ensuring accuracy of information on the Member portal of the website; and

   f. Methods to ensure Member materials are mailed in a timely manner.

7. The Health Plan shall submit their Member services policies and procedures for DHS review in accordance with §13.3.B.

8. The Health Plan shall ensure Members have access to Indian Health Services pursuant to, and shall comply with all requirements of Title 42, United States Code, Section 1396o(a), and Title V of the American Recovery and Reinvestment Act of 2009, Section 5006.

9. The Health Plan shall:

   a. Mail a printed copy of the information to the Member's mailing address;

b. Provide the information by email after obtaining the Member's agreement to receive the information by email;

c. Post the information on the Website of the Health Plan and advise the Member in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that a Member with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or

d. Provide the information by any other method that can reasonably be expected to result in the Member receiving that information.

B. Member Education

1. 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 but not be limited to: the availability and benefits of preventive healthcare; the

importance and schedules for preventive services for children and adults, as defined in §2.6, including but not limited to screenings receiving an A or B recommendation from the U.S. Preventive Services Task Force; the importance of early prenatal care; and the importance of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services including timely immunizations. The Health Plan shall also provide educational programs and activities that outline the risks associated with the use of alcohol, tobacco and other substances.

2. 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 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 services and how to access 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.

3. As part of these educational programs, the Health Plan may use classes, individual or group sessions, videotapes, written material and media campaigns. All instructional materials shall be provided in a manner and format that is easily understood.

4. DHS shall review and approve all educational and program materials prior to the Health Plan or its Subcontractor distributing them or otherwise using them in educational programs. The Health Plan shall submit to DHS, for review and approval, any of its Member education materials, including but not limited to training plans and curricula, in accordance with §13.3.B.

C. Language and Format Requirements for Written Materials

1. The Health Plan shall use easily understood language and formats for all Member written materials.

2. All written materials shall use a font size no smaller than twelve

(12) point.

3. The Health Plan shall make all written materials available with taglines in the prevalent non-English languages in the state, as well as large print, explaining the availability of written translation or oral interpretation to understand the information provided and the toll-free and TTY/TDY telephone number of Health Plan. Large print shall be conspicuously visible.

4. All written materials shall also be made available in alternative formats upon request of the potential Member or Member at no cost, and in a manner that takes into consideration the Member's special needs, including those who are visually impaired or have limited reading proficiency. Auxiliary aids and services shall also be made available upon request of the potential Member or Member at no cost. The Health Plan shall notify all Members and potential Members that information is available in alternative formats at no cost and provide information on how to access those formats.

5. The Health Plan shall make all written information for Members available in languages that comply with Section 1557 of the Patient Protection and Affordable Care Act. When the Health Plan is aware that the Member needs written information in one of these alternative languages, the Health Plan shall send all written information in this language, not English, to that Member within seven (7) days of the request or within seven (7) days of the next business day following the request if the request is made outside of business hours. Small-sized publications and communications (i.e., post cards, brochures, and pamphlets) to obtain services shall include at a minimum taglines in the

following four non-English languages: Ilocano, Vietnamese, Chinese (Traditional), and Korean. The Health Plan may provide information in other prevalent non-English languages based upon its Member population, and as required in Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d, 45 CFR Part 80.

6. All written materials distributed to Members shall include a language block that informs the Member that the document contains important information and directs the Member to call the Health Plan to request the document in an alternative language or to have it orally translated. The language block shall be printed, at a minimum, in the non-English languages identified in paragraph three (3) of this section.

7. The Health Plan shall certify that a qualified individual has reviewed the translation of the information into the different languages for accuracy.

8. 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:

   a. Fry Readability Index;

   b. PROSE The Readability Analyst (software developed by Education Activities, Inc.);

   c. McLaughlin SMOG Index; or

   d. Flesch-Kincaid Index.

9. All written material including changes or revisions shall be submitted to 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.

D. Interpretation Services

1. The Health Plan shall provide oral interpretation services for any language to individuals with limited English proficiency and individuals with disabilities at no cost to the individual. The Health Plan shall notify its Members and potential Members of the availability of free interpretation services, sign language and TDD services, and inform them of how to access these services.

2. The Health Plan shall provide free language services to individuals whose primary language is not English. This can include services such as qualified interpreters.

3. Written translation is available in Ilocano, Vietnamese, Chinese (Traditional), and Korean.

4. The Health Plan shall provide free aids and services to individuals with disabilities. This shall include such services as:

   a. Qualified sign language interpreters;

   b. TTY/TDD services; and

   c. Written information in other formats (large print, audio, accessible electronic formats, other formats).

5. The Health Plan shall meet the following oral interpretation special requirements:

   a. Offer oral interpretation services to individuals with limited English proficiency (LEP) regardless of whether the individual speaks a language that meets the threshold of a

prevalent non-English language; and

b. Document the offer of an interpreter regardless of whether the Member indicated an ability to provide his or her own, and whether an individual declined or accepted the interpreter service.

6. The Health Plan is prohibited from requiring or suggesting that individuals with Limited English Proficiency (LEP) provide their own interpreters or utilize friends or family Members.

7. The Health Plan shall submit its policies and procedures on assuring both oral interpretation and written translation of materials for review and approval in accordance with §13.3.B.

E. Member Handbook Requirements

1. The Health Plan shall inform all newly enrolled Members within ten (10) days of receiving the notice of Member enrollment from DHS that the Member Handbook is available on their website. The Health Plan shall also inform enrolled Members that the Member Handbook is available in paper form without charge and will be provided upon request within five (5) business days.

2. Annually, the Health Plan shall mail or provide a web-link to the electronic form of the Member Handbook to all enrolled Members.

3. The Health Plan may consolidate the provision of Member Handbook to a family, including the parents and children, under the age of nineteen (19), as long as they are living in the same household.

4. The Member Handbook shall contain all of the elements

described in the Health Plan Manual.

5. The Health Plan shall submit the Member handbook to DHS for review and approval in accordance with §13.3.B.

F. Member Rights

1. 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:

   a. Receive information pursuant to 42 CFR §438.100(a)(1)(2) and §§9.4.C and 9.4.D of this RFP;

   b. HRS Chapter 432E, Patients' Bill of Rights and Responsibilities;

   c. Be treated with respect and with due consideration for the Member's dignity and privacy;

   d. Have all records and medical and personal information remain confidential;

   e. Receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand;

   f. Participate in decisions regarding his or her healthcare, including the right to refuse treatment;

   g. 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;

h. 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 §§164.524 and 164.526;

i. Be furnished healthcare services in accordance with 42 CFR §§438.206 through 438.210;

j. 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;

k. Have direct access to a women's health specialist within the network;

l. Receive a second opinion at no cost to the Member;

m. 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;

n. Receive services according to the appointment waiting time standards;

o. Receive services in a culturally competent manner;

p. Receive services in a coordinated manner;

q. Have his or her privacy protected;

r. Be included in service and care plan development, if applicable;

s. Have direct access to specialists (if he or she has a special healthcare need);

t. Not have services arbitrarily denied or reduced in amount, duration or scope solely because of diagnosis, type of illness, or condition;

u. Not be held liable for:

1) The Health Plan's debts in the event of insolvency;

v. The Covered Services provided to the Member by the Health Plan for which DHS does not pay the Health Plan;

w. Covered Services provided to the Member for which DHS or the Health Plan does not pay the healthcare provider that furnishes the services; and

x. 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

y. Only be responsible for cost sharing in accordance with 42 CFR §§447.50 through 447.57.

G. Provider Directory

1. The Health Plan shall make available a provider directory for DHS to assist Members in selecting a Health Plan. The provider directory shall be available online and made available to the Member in paper form upon Member request. 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:

a. The provider's name, as well as any group affiliations;

b. Street address(es);

c. Telephone number(s);

d. Website uniform resource locators, as appropriate;

e. Specialties, as appropriate;

f. Whether the provider will accept new Members;

g. Cultural and linguistic capabilities, including languages (including American Sign Language) spoken by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training; and

h. Whether the provider's facility/office has Americans with Disabilities accommodations for people with physical disabilities, including offices, exam room and equipment.

2. The provider directory shall include above information for each of the following provider types.

   a. Physicians, including specialists;

   b. Hospitals;

   c. Pharmacies;

   d. Behavioral health providers; and

   e. LTSS providers.

3. The Health Plan shall make available and maintain an updated provider directory on their website in a machine readable file and format as specified by HHS 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 website. In addition, the Health Plan shall have Member and provider service representatives who can access provider directory information for its Members, providers and the State.

a. The Health Plan shall mail a hard copy or provide a weblink of its provider directory to their Members as part of the new Member enrollment packet as described in §9.2.A.

4. The Health Plan shall update its provider directory within thirty (30) days after the receipt of updated provider information. Annually, the Health Plan shall mail or provide a weblink to the electronic form of the provider directory to all enrolled Members. The Member Handbook shall state that the provider directory is either available electronically and provide the weblink, or by hard copy upon request. The Health Plan may be required to routinely submit its provider directory electronically to DHS to support the creation of a centralized directory, and to support reporting requirements.

H. Member Identification (ID) Card

1. 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 shall, at a minimum, contain the following information:

a. Member number;

b. Member name;

c. Effective date;

d. PCP name and telephone number;

e. Third-Party Liability (TPL) information;

f. Health Plan's call center telephone number; and

g. 24-hour nurse call center telephone number.

h. Bank Identification Number/Processor Control Number (BIN/PCN), a group number and an active date.

2. The Health Plan shall reissue a Member ID card within ten (10) days of notice that a Member reports a lost card; there is a Member name change; the Member's PCP changes; or for any other reason that results in a change to the information on the Member ID card, or for renewal with continuing eligibility.

3. The Health Plan shall submit a sample Member ID to DHS for review and approval in accordance with §13.3.B.

I. Member Toll-Free Call Center

1. 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 serviced by the Health Plan.

2. 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.

3. The Health Plan's toll-free call center systems shall have the capacity to:

a. Track call center metrics identified by DHS;

b. Allow DHS to monitor remotely; and

c. Have the ability for the calling Member to receive an automatic call back so that the Member does not need to remain on hold.

4. The call center shall be fully staffed between the hours of 7:45 a.m. HST and 4:30 p.m. HST, Monday through Friday, excluding State holidays. The call center staff shall be trained to respond to Member questions in all areas, including, but not limited to, Covered Services and the provider network.

5. The Health Plan shall meet the following call center standards:

a. The call abandonment rate is five (5) percent or less;

b. The average speed of answer is thirty (30) seconds or less;

c. The average hold time is two (2) minutes or less; and

d. The blocked call rate does not exceed one (1) percent.

6. The Health Plan may have an overflow call center located outside of Hawaii within the United States. However, this call center may not receive more than five (5) percent of the calls coming into the Health Plan's call center. In addition, the overflow call center shall meet all metrics identified above.

7. The Health Plan shall have an automated system or answering service available outside of Health Plan call-center hours, Monday through Friday, and during all hours on weekends and State holidays. This automated system or answering service shall provide callers with operating instructions on what to do in

case of an emergency, shall provide an option to talk directly to a nurse or other clinician, as described below, and shall include a voice mailbox or other method for Members to leave messages. The Health Plan shall ensure that the voice mailbox has adequate capacity to receive all messages. The Health Plan shall ensure that representatives return all calls by close of business the following business day.

8. 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 shall be a RN, physician's assistant, nurse practitioner, or medical doctor. The primary intent of the toll-free nurse line is, through triage, to decrease inappropriate utilization of emergency department visits and improve coordination and continuity of care with an individual's PCP. However, having the phone line staffed by someone who is also able to provide treatment as appropriate is encouraged.

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

   a. The call abandonment rate is five (5) percent or less;

   b. The average speed of answer is thirty (30) seconds or less;

   c. The average hold time is two (2) minutes or less; and

   d. The blocked call rate does not exceed one (1) percent.

10. The Health Plan shall submit policies and procedures on the Member call center to DHS for review and approval in accordance with §13.3.B.

J. Internet Presence/Website

1. The Health Plan shall have a Member portal on its website that is available to all Members that contains accurate, up-to-date information about the Health Plan, services provided, the provider network, FAQs, and contact phone numbers and e-mail addresses.

2. The Member web portal shall allow Members to view explanation of benefits (EOB) for the past twelve (12) months, review prior authorization requests (approval or denials), contact their service coordinator, if applicable, review their service plan, if applicable, and communicate changes to the Health Plan (i.e., demographics, change in family size, change in PCP, request change in service coordinator, etc.).

3. The section of the website relating to QI shall comply with the marketing policies and procedures and requirements for written materials described in this Contract and all applicable State and Federal laws.

4. The information shall be in a format that is readily accessible.

5. The information shall be placed in a location on the Health Plan's website that is prominent and readily accessible.

6. The information shall be provided in an electronic form which can be electronically retained and printed.

7. The information is consistent with content and language requirements.

8. The Health Plan shall notify the Member that the information is available in paper form without charge upon request.

9. The Health Plan shall provide, upon request, information in

paper form within 5 business days.

10. In addition, the Health Plan shall submit access to the Member website (even if in a test environment) to DHS for review and approval.

9.5 Member Grievance and Appeals System

A. General Requirements

1. The Health Plan shall have a formal grievance and appeals system that is consistent with the requirements of the State of Hawaii and 42 CFR Part 438, Subpart F. The Member grievance and appeals system shall include an inquiry process, a grievance process and an appeals process. In addition, the Health Plan's grievance and appeals system shall provide information to Members on accessing the State's administrative hearing system. The Health Plan shall require that Members exhaust its internal grievance and appeals system prior to accessing the State's administrative hearing system.

2. The Health Plan shall use templates developed by DHS for communication to Members regarding grievance and appeal process system processes.

3. The Health Plan shall develop policies and procedures for its grievance and appeals system and submit these to DHS for review and approval in accordance with §13.3.B. The Health Plan shall submit to DHS any proposed updated copy of these policies and procedures within thirty (30) days of any modification for review and approval. Changes shall be approved by DHS prior to implementation.

4. The Health Plan shall address, log, track and trend all

expressions of dissatisfaction, regardless of the degree of seriousness and regardless of whether the Member or provider expressly requests filing the concern or requests remedial action. The formal grievance and appeals system shall be utilized for any expression of dissatisfaction and any unresolved issue.

5. The Health Plan shall give Members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, auxiliary aids and services upon request such as providing interpreter services, and toll-free numbers that have adequate TTY/TTD and interpreter capability.

6. The Health Plan shall acknowledge receipt of each filed grievance and appeal in writing within five (5)[1] business days of receipt of the grievance or appeal. The Health Plan shall have procedures in place to notify all Members in their primary language of grievance and appeal resolutions, as described in §§9.4.C and 9.4.D. These procedures shall include written translation and oral interpretation.

[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 days 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.

7. The Health Plan shall ensure that for any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, the Member shall be given a timely and accessible peer to peer option that discusses the denial and is made and reviewed by a healthcare professional that has appropriate medical knowledge and clinical expertise in treating the Member's condition or

disease.

8. The Health Plan shall ensure that individuals who make decisions on grievances and appeals were not involved in any previous level of review or decision-making, nor is a subordinate of any such individual. The individual making decisions on grievances and appeals shall be healthcare professionals who have the appropriate clinical expertise, as determined by the State, in treating the Member's condition or disease. These decision makers on grievances and appeals of adverse benefit determinations shall take into account all comments, documents, records, and other information submitted by the Member and/or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination. This requirement applies specifically to reviewers of:

   a. An appeal of a denial based on issues of medically necessary or Medical Necessity;

   b. A grievance regarding denial of expedited resolution of an appeal; or

   c. A grievance or appeal that involves clinical issues.

9. A Member, a Member's authorized representative, or a provider acting on behalf of the Member with the Member's authorization, is deemed to have exhausted the Health Plan's grievance and appeal process if the Health Plan fails to adhere to the notice and timing requirements set by DHS, and may file for a State administrative hearing.

B. Grievance and Appeal Recordkeeping

1. The Health Plan shall maintain records of its Members' grievances and appeals for a period of no less than ten (10) years in accordance with 42 CFR §438.3(u) and this RFP's requirements for recordkeeping and confidentiality of Members' medical records. Records shall be accurately maintained in a manner accessible to the State and available upon request to CMS.

2. The record of each grievance or appeal shall contain, at a minimum, all of the following information:

    a. A general description of the reason for the appeal or grievance;

    b. The date received;

    c. The date of each review or, if applicable, review meeting;

    d. Resolution at each level of the appeal or grievance, if applicable;

    e. Date of resolution at each level, if applicable; and

    f. Name of the covered person for whom the appeal or grievance was filed.

C. Inquiry Process

1. The Health Plan shall have an inquiry process to address all inquiries as defined in §2.6. As part of this process, the Health Plan shall ensure that, if at any point during the contact, the Member expresses a complaint of any kind, the inquiry becomes a grievance or appeal and the Health Plan shall give the Member, a Member’s authorized representative, or a provider acting on behalf of the Member with the Member’s consent, their

grievance and appeal rights. The inquiry can be in writing or made as a verbal request over the telephone.

D. Authorized Representative of a Member

1. Members shall be allowed to authorize another person to represent their interests during any stage of the Grievance and Appeal System process as their authorized representative.

2. Members shall be allowed, in person or by telephone, to verbally identify another person who may communicate with the Health Plan on the Member's behalf, for any matter that does not require a written request or written designation of an authorized representative under this RFP and contract.

E. Grievance Process

1. A grievance may be filed about any matter other than an Adverse Benefit Determination, as defined in §2.6. Subjects for grievances include, but are not limited to:

   a. The quality of care of a Provider;

   b. Rudeness of a Provider or a Provider's employee; or

   c. Failure to respect the Member's rights regardless of whether remedial action is requested.

2. Grievance includes a Member's right to dispute an extension of time proposed by the Health Plan to make an authorization decision.

3. A Member or a Member's Authorized Representative may file a grievance orally or in writing with the Health Plan at any time. The Health Plan shall accept any grievance filed on the Member's behalf from a Member's representative even without verbal or

written consent of the Member. However, the Health Plan shall send the outcome of any grievance filed by a Member's representative without oral or written consent, such as the Appointment of Representative form, to the Member.

4. The Health Plan shall ensure that all comments, documents, records, and other information submitted by the Members or their representative are taken into account by the grievance decision makers.

5. The Health Plan shall have in place written policies and procedures for processing grievances in a timely manner to include processes pertaining to grievances filed by a provider or a Member's authorized representative on behalf of the Member, and protocols for addressing grievances filed by a Member's representative when there is no documentation of a written form of authorization, such as an AOR form.

6. As part of the grievance policies and procedures, the Health Plan shall have in effect mechanisms to:

   a. ensure reasonable attempts were made to obtain a written form of authorization; and

   b. consult with the requesting provider when appropriate.

7. The Health Plan shall:

   a. Send a written acknowledgement of the grievance within five (5) business days of the Member's expression of dissatisfaction;

   b. Convey a disposition, in writing, of the grievance resolution as expeditiously as the Member's health condition requires,

but no later than thirty (30) days of the initial expression of dissatisfaction; and

c. Include clear instructions as to how to access the State's grievance review process if the Member is dissatisfied with the Health Plan's disposition.

8. 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.

9. The Health Plan may extend the timeframe for processing a grievance by up to fourteen (14) days if the Member requests the extension; or if the Health Plan shows that there is need for additional information and that the delay is in the Member's interest.

10. If the Health Plan extends the timeline up to fourteen (14) days for a grievance not at the request of the Member, the Health Plan shall: make reasonable efforts to give the Member prompt oral notice of the delay; give the Member written notice, within two (2) days 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.

F. State Grievance Review

1. As part of its grievance and appeals system, the Health Plan shall inform Members of their right 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:

a. Health Plan Members may request a State grievance review, within thirty (30) days from the date on the grievance resolution letter issued by the Health Plan. A State grievance review may be made by contacting DHS by phone or by mailing a request to:

Med-QUEST Division

Health Care Services Branch

P.O. Box 700190

Kapolei, Hawaii 96709-0190

Telephone: 808-692-8094

b. DHS shall review the grievance and contact the Member with a determination within ninety (90) days from the day the request for a grievance review is received; and

c. The grievance review determination made by DHS is final.

G. Notice of Adverse Benefit Determination

1. The Health Plan shall give the Member and the referring provider a written notice of an Adverse Benefit Determination, as defined in §2.6, within the time frames specified below. The notice to the Member or provider shall include the following information:

a. The adverse benefit determination the Health Plan has made or intends to make;

b. The reason for the adverse benefit determination, including the right of the Member to be provided, upon request and free of charge, with reasonable access to and copies of all

documents, records, and other information relevant to the Member's adverse benefit determination. Such information includes Medical Necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits;

c. The Member's or provider's right to an appeal with the Health Plan;

d. The Member's or provider's right to request an appeal;

e. Procedures for filing an appeal with the Health Plan;

f. The Member's right to represent himself or herself, use legal counsel, or use an authorized representative;

g. The circumstances under which an appeal process can be expedited and how to request it; and

h. The Member's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with State policy, under which the Member may be required to pay the costs of these services.

2. The notice of adverse benefit determination to the Member shall be written pursuant to the requirements in §9.4.C of this RFP.

3. The Health Plan shall mail the notice within the following time frames:

a. For termination, suspension, or reduction of previously authorized Medicaid Covered Services, at least ten (10) days prior to the date the adverse benefit determination is to start except:

1) By the date of action for the following reasons:

a) The Health Plan has factual information confirming the death of a Member;
b) 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 termination or reduction of services will occur as a result of supplying that information;
c) The Member has been admitted to an institution that makes him or her ineligible for further services;
d) The Member's address is unknown and the post office returns Health Plan mail directed to the Member indicating no forwarding address;
e) The Member has been accepted for Medicaid services by another local jurisdiction;
f) The Member's provider prescribes a change in the level of medical care;
g) 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
h) In the case of adverse actions for nursing facility transfers: the safety or health of other 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.

b. The period of advanced notice is shortened to five (5) days if there is alleged fraud by the Member and the facts have been verified, if possible, through secondary sources.

c. For denial of payment: advance notice at the time of any action affecting the claim.

d. For standard service authorization decisions that deny or limit services: as expeditiously as the Member's health condition requires, but not more than seven (7) days following receipt of request for service, with a possible extension of up to fourteen (14) additional days. The total time frame allowed with extension is twenty-one (21) days from the date of the request for services if:

    1) Member or provider requests an extension; or

    2) The Health Plan justifies a need for additional information and how the extension is in the Member's best interest.

e. If the Health Plan extends the time frame, it shall:

    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.

f. For expedited authorization decisions: as expeditiously as the Member's health condition requires but no later than seventy-two (72) hours after receipt of the request for service. The Health Plan may extend the seventy-two (72) hour timeframe by up to an additional fourteen (14) days if the Member requests an extension, or if the Health Plan justifies to DHS a need for additional information and how the extension is in the Member's best interest.

g. For service authorization decisions not reached within the time frames specified above shall constitute a denial.

H. Health Plan Appeals Process

1. An appeal may be filed when the Health Plan issues an Adverse Benefit Determination, as defined in §2.6, to a Health Plan Member.

2. A Member, a Member's authorized representative, or a provider acting on behalf of the Member with the Member's authorization, may file an appeal within sixty (60) days of the Notice of Adverse Benefit Determination. An oral appeal may be submitted in order to establish the appeal submission date. The Health Plan shall assist the Member, provider or other authorized representative in this process.

3. The Health Plan shall ensure that decision makers on appeals take into account all comments, documents, records, and other information submitted by the Member or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.

4. In addition to meeting the general requirements detailed in §9.5, the Health Plan shall:

   a. Accept all the oral inquiries seeking to appeal an action without any written requests;

   b. 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;

   c. Provide the Member and his or her authorized representative a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The Health Plan shall inform the Member about the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in 42 CFR §438.408(b) and (c) in the case of expedited resolution;

   d. Provide the Member and his or her authorized representative, upon request, the Member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the Health Plan. This information shall be provided free of charge and sufficiently in advance of the resolution timeframe for appeals; and

   e. Include as parties to the appeal, the Member and his or her authorized representative, or the legal representative in the case of a deceased Member's estate.

5. 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.

6. The Health Plan may extend the resolution timeframe by up to fourteen (14) additional days if the Member requests the extension, or the Health Plan shows, to the satisfaction of DHS, upon DHS request for review, that there is need for additional information that justifies the delay, and how the delay shall be in the Member's best interest.

7. For any extension not requested by a Member, the Health Plan shall make reasonable efforts to give the Member prompt oral notice of the delay. Within two (2) days the Health Plan 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 resolve the appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires.

8. The Health Plan shall notify the Member, provider or other authorized representative in writing within thirty (30) days of the resolution.

9. The Health Plan shall include the following in the written notice of the resolution:

   a. The results of the appeal process and the date it was completed; and

   b. For appeals not resolved wholly in favor of the Member:

      1) The right to request a State administrative hearing

with the Administrative Appeals Office (AAO), and clear instructions about how to access this process;

2) The right to request to receive benefits while the hearing is pending and how to make the request; and

3) A statement that the Member may be held liable for the cost of those benefits if the hearing decision is not in the Member's favor.

I. Expedited Appeal Process

1. The Health Plan shall establish and maintain an expedited review process for appeals. The Member, his or her Provider or other authorized representative acting on behalf of the Member with the Member's written authorization, may file an expedited appeal either orally or in writing. No additional follow-up shall be required.

2. An expedited appeal is only appropriate when the Health Plan determines, based upon a request from the Member, or the provider indicates, in making the request on the Member's behalf, that taking the time for a standard resolution could seriously jeopardize the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

3. 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.

4. The Health Plan shall inform Members of the limited time available to present evidence and testimony, in person and in writing, and make legal and factual arguments in the case of an

expedited appeal resolution. The Health Plan shall inform Members of this sufficiently in advance of the resolution timeframe for appeals.

5. For expedited resolution of an appeal, the Health Plan shall resolve the appeal and provide written notice to the affected parties as expeditiously as the Member's health condition requires, but no more than seventy-two (72) hours from the time the Health Plan received the appeal. The Health Plan shall make reasonable efforts to also provide oral notice of the appeal determination to the Member.

6. The Health Plan shall provide written notice, and make reasonable efforts to provide oral notice, of the resolution of an expedited appeal. The Health Plan shall include the following in the written notice of the resolution:

   a. The results of the appeal process and the date it was completed; and

   b. For appeals not resolved wholly in favor of the Member:

      1) The right to request a State administrative hearing as described in §9.5.J., and clear instructions about how to access this process;

      2) The right to request an expedited State administrative hearing;

      3) The right to request to receive benefits while the hearing is pending, and how to make the request; and

      4) 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.

7. 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 shows, to the satisfaction of DHS, upon DHS request for review, that there is need for additional information that justifies the delay and demonstrates to DHS how the delay shall be in the Member's best interest. For any extension not requested by the Member, or if the Health Plan denies a request for expedited resolution of an appeal, the Health Plan shall:

   a. Transfer the appeal to the time frame for standard resolution;

   b. Make reasonable efforts to give the Member prompt oral notice of the delay or denial;

   c. Within two (2) days give the Member written notice of the reason for the decision to extend the timeframe or deny a request for expedited resolution of an appeal;

   d. Within two (2) days, inform the Member orally and in writing that they may file a grievance with the Health Plan for the delay or denial of the expedited process, if he or she disagrees with that decision; and

   e. Resolve the appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires.

8. The Health Plan shall notify DHS within twenty-four (24) hours if an expedited appeal has been granted by the Health Plan or if

an expedited appeal time frame has been requested by the Member or the provider. If the Health Plan is not resolving the appeal on an expedited basis, the Health Plan shall provide the reason it is requesting a fourteen additional fourteen (14) day extension to DHS. The Health Plan shall notify DHS within twenty-four (24) hours, or sooner if possible, from the time the expedited appeal is upheld. The Health Plan shall provide information on the method of notification to the Member to DHS.

9. If the Health Plan denies a request for expedited resolution of an appeal, it shall transfer the appeal to the standard timeframe of no longer than thirty (30) days from the day the Health Plan receives the appeal, with a possible fourteen (14) days extension.

J. State Administrative Appeals Office Hearing for Regular Appeals

1. If the Member is not satisfied with the Health Plan's written notice of disposition of an appeal, the Member may file for a State administrative hearing within one hundred and twenty (120) days of the receipt of the notice of denial disposition as part of the Member's internal appeal procedure.

2. At the time of the denied appeal determination, the Health Plan shall inform the Member, the Member's provider or other authorized representative, or the legal representative of a deceased Member's estate that:

   a. He or she may request information on how to exhaust the Health Plan's one level of appeal and the right to a state administrative appeal hearing after receiving notice that the adverse benefit determination is upheld; and

b. The Member, or his or her authorized representative, may access the State administrative hearing process by submitting a letter to the AAO within one hundred and twenty (120) days from the receipt of the Member's appeal determination. A Provider may not file an appeal on behalf of a Member unless the Provider is the Member's Authorized Representative.

3. Upon request of DHS, the Health Plan's Medical Director or designee shall attend the state administrative hearing. The Health Plan's Medical Director or designee shall be a Physician with the appropriate specialization and comprehensive understanding of the issues involved in the hearing.

4. In addition to the hearing guidance listed in HAR §17-1703.1, a Member may request a hearing on the following bases in accordance with 42 CFR §431.220:

   a. Member's clean claim for services is denied or is not acted upon with reasonable promptness;

   b. Member believes the Health Plan has taken an action on covered benefits or services erroneously;

   c. Member believes a SNF or nursing facility has erroneously determined that he or she shall be transferred or discharged;

   d. Member believes the State has made an erroneous determination with regards to the preadmission and annual resident review requirement of section 1919(e)(7) of the Social Security Act.

5. Hearing Decisions shall be based exclusively on evidence

introduced at the hearing as reiterated below:

a. The transcript or recording of the testimony, information, and exhibits provided at the hearing, or an official report containing the substance of what happened at the hearing;

b. All papers and requests filed in the proceeding; and

c. The recommendation or decision of the hearing officer.

6. The Health Plan shall provide the following address to Members:

   State of Hawaii Department of Human Services

   Administrative Appeals Office

   P.O. Box 339

   Honolulu, HI 96809-0339

7. The State shall reach its decision within ninety (90) days of the date the Member filed the request for an administrative hearing with the State. The disposition of the appeal at the State administrative hearing level shall prevail.

K. Expedited State Administrative Hearings

4. The Member may file for an expedited State administrative hearing only when the Member requested or the Health Plan 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 AAO within one hundred and twenty (120) days from the receipt of the Member's appeal determination.

5. The Health Plan shall provide the following address to Members:

State of Hawaii Department of Human Services

Administrative Appeals Office

P.O. Box 339

Honolulu, HI 96809-0339

6. An expedited State administrative hearing shall 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.

7. In the event of an expedited State administrative hearing the Health Plan shall submit information that was used to make the determination, for example, medical records, written documents to and from the Member, provider notes, etc. The Health Plan shall submit this information to DHS within twenty-four (24) hours of the decision denying the expedited appeal.

L. Continuation of Benefits during an Appeal or State Administrative Hearing

4. A Member or a Member's authorized representative may request for a continuation of benefits during a Health Plan Appeal or a State Administrative Hearing process. The Health Plan shall continue the Member's benefits if the following conditions have been met:

a. an appeal was requested within sixty (60) days following the date on the adverse benefit determination notice;

b. The appeal or request for State administrative hearing involves the termination, suspension, or reduction of a previously authorized services;

c. The services were ordered by an authorized provider;

d. The original authorization period has not expired; and

e. The Member timely files for continuation of benefits on or before the later of the following:

1) Within ten (10) days of the Health Plan mailing the notice of adverse benefit determination; or

2) The intended effective date of the Health Plan's proposed adverse benefit determination.

5. If the Health Plan continues or reinstates the Member's benefits while the appeal or State administrative hearing is pending, the Health Plan shall not discontinue the benefits until one of the following occurs:

a. The Member withdraws the appeal or request for a State administrative hearing;

b. The Member does not request a State administrative hearing within ten (10) days from when the Health Plan mails a notice of an adverse benefit determination; or

c. A State administrative hearing decision unfavorable to the Member is made.

6. If the final resolution of the appeal or State administrative hearing is adverse to the Member, that is, upholds the Health Plan's adverse benefit determination, the Health Plan may,

consistent with the State's usual policy on recoveries and as specified in the Health Plan's contract, recover the cost of services furnished to the Member while the appeal and State administrative hearing were pending, to the extent that they were furnished solely because of the requirements of this section.

7. If the Health Plan or the State reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Health Plan shall authorize or provide these disputed services promptly, and as expeditiously as the Member's health condition requires, but no later than seventy-two (72) hours from the date it receives notice reversing the determination.

8. 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.

9.6 Marketing and Advertising

J. Allowable Activities

4. The Health Plan shall be permitted to perform the following marketing activities:

a. Distributing general information through mass media (i.e., newspapers, magazines and other periodicals, radio, television, the Internet, public transportation advertising, and other media outlets);

b. 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

c. Attending activities that benefit the entire community such as health fairs or other health education and promotion activities.

d. Encourage its current QI plan Members who are D-SNP eligible to enroll in the QI's Health Plan Medicare Advantage Plan.

5. If the Health Plan performs an allowable activity, the Health Plan shall conduct these activities in all of the regions in which it is operating.

6. All materials shall comply with the information requirements in 42 CFR §438.10 and as detailed in §9.4.C of this RFP.

K. Prohibited Activities

4. The Health Plan is prohibited from directly or indirectly engaging in door-to-door, telephone, mailings or other cold-call marketing activities to potential Members.

5. The Health Plan is prohibited from offering any favors, inducements or gifts, promotions, or other insurance products that are designed to induce enrollment in the Health Plan without prior approval of DHS.

6. The Health Plan is prohibited from distributing information that contains any assertion or statement, whether written or oral, that the Health Plan is endorsed by CMS, the Federal or State government, or DHS.

7. Distributing information or materials that seek to influence enrollment in conjunction with the sale or offering of any private insurance.

8. The Health Plan is prohibited from distributing information and materials that contain statements that DHS determines are inaccurate, false, or misleading. Statements considered false or misleading include, but are not limited to, any assertion or statement, whether written or oral, that the Member shall 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.

9. The Health Plan is prohibited from distributing materials that, according to DHS, mislead or falsely describe: the Health Plan's provider network, its performance/quality, the participation or availability of network providers, the qualifications and skills of network providers, including their bilingual skills, or the hours and location of network services.

10. The Health Plan is prohibited from using marketing materials that have not received DHS approval.

11. The Health Plan is prohibited from editing, modifying, or changing in any manner marketing materials previously approved by DHS without the consent and approval of DHS.

L. State Approval of Materials

4. 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 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 QI that have not been approved by DHS.

5. The Health Plan shall submit to DHS any marketing materials it has received from a Provider or Subcontractor for review and prior approval.

M. Marketing for Initial Enrollment and Annual Plan Change (APC)

4. The Health Plan shall submit all potential marketing materials to DHS for review and approval. DHS shall utilize criteria identified in §§9.6.A and 9.4.C to approve materials.

5. The Health Plan shall only use DHS approved materials for marketing during APC.

N. Non-Compliance of Marketing and Advertisement Policies

4. The Heath Plans that does not follow marketing and advertisement policies described in §9.6 shall be subject to liquidated damages as described in §14.21.E.

5. DHS may impose financial sanctions, as described in §14.21.F, up to the federal limit, on the Health Plan for any violations of the marketing and advertising policies.

SECTION 10 – Information Systems and Information Technology

10.1 DHS Responsibilities

A. Hawaii Prepaid Medicaid Management Information Systems

1. DHS operates the HPMMIS to effectively and efficiently administer the Medicaid managed care and FFS programs. HPMMIS is an integrated MMIS that supports program administration. The major functional areas of HPMMIS include:

   a. Receiving daily eligibility files from KOLEA and processing enrollment/dis-enrollment of Members into, and dis-enrollment of Members from the Health Plans based on established enrollment and dis-enrollment rules;

   b. Processing Member Health Plan choices submitted to the DHS enrollment call center;

   c. Producing daily enrollment/disenrollment rosters, monthly enrollment rosters, and TPL rosters;

   d. Processing bi-monthly encounter submissions from Health Plans and generating encounter error reports for Health Plan correction. Accepting and processing monthly Health Plan Provider network submissions to assign Medicaid Provider IDs for Health Plan use. Errors associated with these submissions are generated and returned to the Health Plans on a monthly basis for correction;

   e. Processing additional reports submitted by Health Plans;

   f. Monitoring the access and 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;

g. Monitoring the activities of the Health Plans through information and data received from the Health Plans and generating management reports;

h. Evaluating Health Plan quality and performance through a variety of metrics and analyses;

i. Calculating capitation rates and adjustments;

j. Determining the amount due to the Health Plans for the monthly capitated rate for enrolled Members;

k. Producing a monthly Provider master registry file for the Health Plans to use for tracking the assignment of Medicaid Provider IDs, Provider types, and allowable categories of services by DHS; and monitoring Provider approvals by DHS for the purpose of ensuring that Providers render services in accordance with the approvals they have received from DHS, and in preparing and submitting encounter files to DHS;

l. Generating required CMS reports and submitting data to other entities as permitted and necessary; and

m. Generating management information reports.

2. Receiving or transmitting of data files between the Health Plans and HPMMIS is done via the DHS SFTP service. The SFTP service allows DHS and Health Plans to securely transfer Member, Provider, and encounter data via the internet.

a. As specified in §6.4, the Health Plan shall include all

encounter data from any network providers the MCO is compensation on the basis of capitated payments and adjudicated claims and encounter data from any Subcontractors.

3. In addition, DHS processes Hawaii's Medicaid FFS payments utilizing HPMMIS through its fiscal agent.

10.2 Health Plan Responsibilities

A. General Requirements

1. The Health Plan shall have information management systems that enable it to meet DHS requirements, state and federal reporting requirements, all other contract requirements and any other applicable state and federal laws, rules and regulations, including HIPAA. As specified in the HPMMIS Encounter Technical Guide in the Health Plan Manual, the Health Plan is responsible for adopting national standards and code sets, and up-to-date protocols and formats for encounter data submission, validation, and adjudication.

2. The Health Plan shall maintain a written manual of its claims adjudication protocol and submit to DHS for review and approval as requested; the Health Plan shall routinely review its claims processing protocols and update the protocols and manual as needed. The Health Plan shall notify DHS of updates and revisions to its claims processing protocols at least thirty (30) days prior to implementation of the updates or revisions.

3. The Health Plan shall have a system or systems that collect, analyze, integrate, and report data and achieve the objectives of 42 CFR §438.242. The system or systems shall provide

information on areas including, but not limited to, utilization, claims, grievances, appeals, and dis-enrollments for other than loss of Medicaid eligibility.

B. Specific Requirements

1. The Health Plan shall have a system or systems able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by DHS to meet the requirements of Section 1903(r)(1)(F) of the Social Security Act.

2. The Health Plan shall have a system or systems able to collect data on Member and Provider characteristics as specified by DHS, and on all services furnished to Members through an encounter data system or other methods as may be specified by DHS.

3. The Health Plan shall have a system or systems that will ensure data received from Providers is accurate and complete by:

   a. Verifying the accuracy and timeliness of reported data, including data from network Providers the Health Plan is compensating on the basis of capitation payments;

   b. Screening the data for completeness, logic, and consistency. As specified by DHS, the Health Plan shall align its screening process and reference tables with DHS to streamline encounter data processing; and

   c. Collecting data from Providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for State

Medicaid quality improvement and care coordination efforts.

4. The Health Plan shall make all collected data available to DHS, and upon request, to CMS.

5. The Health Plan shall implement, by the compliance date identified in the CMS Interoperability and Patient Access final rule, a Fast Healthcare Interoperability Resources (FHIR)-based application programming interface to support Medicaid beneficiaries as specified in 42 CFR §431.60 that permits third-party applications to retrieve, with the approval and at the direction of a current Member or the Member's personal representative, data specified below through the use of common technologies (e.g., via smartphone and without special effort from the Member).

   a. The API shall conform to all technical, documentation, and data access standards and requirements specified or referenced within 42 CFR §431.60(c)-(g).

   b. The information shall also be accessible to its current beneficiaries or the Member's personal representative through the API, and include:

      1) All encounter data on the Member, including encounter data from any network Providers the Health Plan is compensating on the basis of capitation payments and adjudicated claims and encounter data from any Subcontractors;

      2) Encounters from Providers compensated on the basis of capitation payments posted no later than one (1) business day after receiving the data from Providers;

3) Data concerning claims data for payment decisions that may be appealed, were appealed, or are in the process of appeal, and Provider remittances and Member cost sharing pertaining to such claims, no later than one (1) business day after a claim is processed;

4) Clinical data, including laboratory results, if the Health Plan maintains any such data, no later than one (1) business day after the data is received by the Health Plan; and

5) Information about covered outpatient drugs and updates to such information, including, where applicable, preferred drug list information, no later than one (1) business day after the effective date of any such information or updates to such information.

c. As feasible, the Health Plan shall develop this functionality to also include information on Member care gap data available to the Health Plan, no later than one (1) business day after the effective date of any such information or updates to such information.

d. Data transmitted via the API shall also be made available in a DHS-specified format to DHS.

6. The Health Plan shall implement, by the compliance date identified in the CMS Interoperability and Patient Access final rule, and maintain a FHIR-based API that provides a complete and accurate directory of the Health Plan's Provider directory information specified in 1902(a)(83) of the Social Security Act,

as specified in 42 CFR §431.70.

a. The directory shall conform to all technical requirements specified in 42 CFR §431.60(c), excluding the security protocols related to user authentication and authorization and any other protocols that restrict the availability of this information to particular persons or organizations; and the documentation requirements in 42 CFR §431.60(d).

b. The directory shall be updated no later than thirty (30) days after the Health Plan receives Provider directory information or updates to Provider directory information;

c. The directory shall be accessible via a public-facing digital endpoint on the Health Plan's website.

d. The directory shall include all information specified in 42 CFR §438.10(h)(1) and (2).

7. The Health Plan shall ensure the following regarding Member encounter data:

a. Collection and maintenance of Member encounter data to identify the Provider who delivers any item(s) or service(s) to Members, including any additional information required by DHS;

b. Submission of Member encounter data to DHS at a frequency, level of detail, and formats specified in §6.4 and in the HPMMIS Encounter Technical Guide in the Health Plan Manual, based on program administration, oversight, and program integrity needs; and

c. Submission of all Member encounter data that DHS is

required to report to CMS under 42 CFR §438.818.

8. DHS shall review and validate the encounter data collected, maintained, and submitted to DHS by the Health Plan for completeness and accuracy of the representation of services provided to Members under the contract between DHS and the Health Plan. All encounter data requirements specified in §6.4 and the HPMMIS Encounter Technical Guide in the Health Plan Manual are subject to verification and validation.

9. Per 42 CFR §438.62, the Health Plan's transition of care policy shall include an electronic data exchange process to ensure continued access to services during a transition from one Health Plan to another when an Member, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization. As specified in 42 CFR §438.62(b)(1)(vi), the Health Plan shall implement, by the compliance date identified in the CMS Interoperability and Patient Access final rule, a process for the electronic payer-to-payer data exchange of, at a minimum, the data classes and elements included in the United States Core Data for Interoperability content standard adopted at 45 CFR §170.213, including the following requirements:

    a. The Health Plan shall develop mechanisms to both send and receive data from other Health Plans, including DHS;

    b. Information received by the Health Plan shall be incorporated into the Health Plan's records about the current Member;

    c. With the approval and at the direction of a current or former Member or the Member's personal representative, the

Health Plan shall receive all such data for a current Member from any other payer that has provided coverage to the Member within the preceding five (5) years, including non-Medicaid Plans and out-of-state Health Plans;

d. At any time the Member is currently enrolled in the Health Plan, and up to five (5) years after dis-enrollment, send all such data to any other payer that currently covers the Member or a payer the Member or the Member's personal representative specifically requests receive the data;

e. Send data received from another payer in the electronic form and format it was received;

f. The Health Plan shall develop this functionality in a manner that additionally facilitates data exchange with the CCS Plan for CCS beneficiaries;

g. As feasible, the Health Plan shall also develop this functionality in a manner that would facilitate data exchange to support healthcare coordination in the future with non-Health Plans including, but not limited to, DOH for beneficiaries receiving direct services from various DOH programs; Providers, care teams, and hospitals; and health homes, when implemented; and

h. To support enhanced functionality, the Health Plan is encouraged to develop this functionality to enable closed-loop, bi-directional referrals of services from the Health Plan to the Provider, and between Providers in the community.

10. The Health Plan shall comply with provisions of Section 4004 of the Cures Act (42 USC 300jj-52) and not charge beneficiaries

for access to the Patient Access API specified in §10.2.B.5, or the Provider Directory API specified in §10.2.B.6.

11. The Health Plan shall support any additional requirements implemented by DHS that will be needed for DHS to comply with the CMS Interoperability and Patient Access final rule that requires DHS to exchange certain data with CMS daily on beneficiaries who are dually eligible for Medicaid and Medicare.

12. In addition to the required health information exchange functionality specified in §10.2.B.9, the Health Plan shall participate in and support the state-designated health information exchange entity to the extent feasible.

C. Expected Functionality

1. The Health Plan shall have information systems and supports that, at a minimum, facilitate and integrate the following essential Health Plan health coordination functions:

   a. Predictive analytics to support identification of Members who are likely to benefit from special program services including but not limited to SHCN, EHCN, CIS+, LTSS, and SDOH supports;

   b. Administration of and collection of data on various Member health status screeners and assessments and data to support quality reporting;

   c. Documentation and sharing of Member's assessment, HAP(s) in a concise, understandable, and printable or electronic format;

   d. Coordination and oversight of the data elements to support

the delivery of optimal health services;

e. Provision of essential and actionable health information on Members and patient panels to Providers and service coordinators in the community to facilitate care, and to DHS as requested;

f. Support the expansion of Telehealth to enhance care and service delivery;

g. Collection and analysis of data on the health and service utilization of the Member population, including but not limited to the adoption of interoperable data exchange protocols with state public health registries, such as the immunization registry;

h. Collection, analysis, and reporting of Provider-level data to support a variety of quality, value-based purchasing, and other efforts;

i. Collection, analysis, and reporting of Member attribution information, where relevant, to contextualize differences in health outcomes; and

j. Collection, analysis, and reporting, at the Member-level, of encounter data, and additional data that extend beyond encounter submissions to support contextualization and evaluation of various DHS programs and services.

2. The Health Plan shall adhere to all reporting requirements, including those that extend beyond the required information systems functionality described herein.

3. The Health Plan shall have a system or systems capable of

adapting to DHS formats and sharing information electronically with DHS, service Providers in the community, and with other Health Plans, that are readily accessible yet secured to enable the efficient execution of the aforementioned functions.

D. Method of Data Exchange with DHS

1. DHS' SFTP service is the primary but not the only mechanism for file transfers between DHS and trading partners, including Health Plans. Technical specifications and instructions are provided in the HPMMIS Encounter Technical Guide in the Health Plan Manual, also available on the MQD website. The SFTP service allows DHS and the Health Plan to securely transfer electronic Member, Provider, and encounter data.

E. Compliance with the Health Insurance Portability and Accountability Act

1. The Health Plan shall implement the electronic transaction and code set standards and other Administrative Simplification provisions, privacy provisions, and security provisions of HIPAA, Public Law 104-191, as specified by CMS.

F. Audits of Health Plan Information Technology

1. The Health Plan shall institute processes to ensure the validity and completeness of the data submitted to DHS. DHS or its contractors may conduct general data validity and

   completeness audits using industry standard sampling techniques.

2. DHS may additionally request information from the Health Plan on its health systems, including but not limited to, system

configuration, data verification and validation processes, and processes used to prepare and submit encounters and data in other reports to DHS.

3. DHS reserves the right to have access to the Health Plan's system at any time.

G. Disaster Planning and Recovery Operations

1. The Health Plan shall have in place disaster planning and recovery operations that is consistent with the IT Disaster Recovery Plan on www.Ready.gov and comply with all applicable federal and state laws relating to security and recovery of confidential information and electronic data.
2. The Health Plan shall collaborate and coordinate with the other participating QUEST Integration health Plans to maintain the health and safety of the Members and the continued access to necessary services during the disaster period.

H. Information Systems and Information Technology Compliance

1. The Health Plan is expected to meet all requirements specified in §10.2.B prior to the start of the contract, or as applicable, by the compliance date identified in the CMS Interoperability and Patient Access final rule.

2. The Health Plan is not expected to have met the minimum functionality expectations in § 10.2.C fully prior to the execution of the contract, but is required to provide DHS with a description of what functionality requirements it has met, and an anticipated timeline of when it will meet full compliance with all expected functionality, during §13.3.B. The Health Plan is expected to

have fully met the minimum functionality

expectations of §10.2.C by Year two (2) of the contract. DHS may exempt specific functionality requirements on a case-by-case basis.

3. The Health Plan shall submit documentation of its disaster planning and recovery operations for DHS review in accordance with §13.3.B.

SECTION 11 – Health Plan Personnel

11.1 General Requirements

A. The Health Plan shall have in place the organizational, management, and administrative arrangements, procedures, and systems capable of fulfilling all contractual requirements of this RFP.

B. The Health Plan shall also have in place the organizational, management, and administrative arrangements, procedures, and systems, pursuant to 42 CFR §438.608.

C. For purposes of this Contract, the Health Plan shall not knowingly have an employment, contractual relationship, or affiliation of the types addressed in 42 CFR §438.610, involving any individual, affiliate or entity that:

1. Is debarred, suspended, or otherwise lawfully prohibited from participating in any public procurement activity 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, pursuant to 42 CFR §438.610(a)(1);

2. Is excluded from participation in any federal healthcare program under Section 1128 or 1128A of the Social Security Act, pursuant to 42 CFR §438.610(b);

3. Has been debarred, suspended, or otherwise lawfully prohibited from participating in non-procurement activities under HRS §103D-702;

4. Has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid, Title XX Services Programs, or Title XXI Program in the last 10 years; or

5. Has been excluded through federal databases including, but not limited to, LEIE, SAM, or any such databases.

D. The Health Plan shall not have a contract for the administration, management, or provision of medical services (or the establishment of policies or provision of operational support for such services), either directly or indirectly, with an individual convicted of crimes described in Section 1128(b)(8)(B) of the Social Security Act.

E. The Health Plan is responsible for operating its Health Plan in the State of Hawaii. 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 operations are located outside of the State of Hawaii.

F. The Health Plan shall have an office on each island on which it provides services to at least 5,000 Members. The office shall be open during regular business hours (i.e., Monday to Friday from 7:45 a.m. HST to 4:30 p.m. HST, excluding state holidays) to provide face-to-face customer service to Members.

11.2 Staffing Requirements

A. Staffing Table

1. Table 7: 11.2.A, below, contains a list of mandated QI staff and requirements regarding each staff position. See the following sections for requirements definitions.

Table 7: 11.2.A. QI Staffing Table

Mandated QI Staff		Requirements			
Position		FTE or # of Positions	Hawaii	Resume	Change Notification
1	Administrator/CEO/Executive Director	1.0	✓	✓	✓
2	Behavioral Health Coordinator	1.0	✓	✓	✓
3	Business Continuity Planning, Disaster Preparedness and Recovery Manager/Coordinator	Adequate to meet the Contract requirements			✓
4	CIS+ Coordinator	1.0	✓		
5	Claims Administrator/Manager (See below for Hawaii residence requirement exception)	1.0	✓		✓
6	Claims Processing Staff	Adequate to meet the Contract requirements			
7	Compliance Officer	1.0	✓	✓	✓
8	Data Analytics Officer	0.5		✓	✓
9	EPSDT Coordinator	1.0	✓	✓	✓
10	Financial Officer/CFO	0.5	✓	✓	✓
11	Health Coordination Director	1.0	✓	✓	✓
12	Health Coordination Managers	Adequate to meet Contract requirements	✓		
13	Health Coordination Team	Adequate to meet Contract requirements	✓		

14	IT Director or Chief Information Officer (CIO)	0.5		✓	✓

Mandated QI Staff		Requirements			
Position		FTE or # of Positions	Hawaii	Resume	Change Notification
15	IT Hawaii Manager (If no Hawaii-based IT Director or CIO)	Adequate to meet Contract requirements	✓	✓	✓
16	IT Staff	Adequate to meet Contract requirements			
17	LTSS Coordinator	1.0	✓		
18	Medical Director	1.0	✓	✓	✓
19	Member Grievance Coordinator	0.5	✓	✓	✓
20	Member Services Director	1.0	✓	✓	✓
21	Member Services Staff (to include Call Center staff)	Adequate to meet Contract requirements	✓		
22	Pharmacy Coordinator/Director/Manager	1.0	✓	✓	✓
23	PA/Utilization Management/Medical Management Director	1.0	✓	✓	✓
24	PA/Utilization Management/Medical Management/Concurrent Review Staff	Adequate to meet Contract requirements	✓		
25	Provider Grievance Coordinator	0.5	✓	✓	✓
26	Provider Services/Contract and Credentialing Manager	1.0	✓	✓	✓

27	Provider Services/Contract and Credentialing Staff	Adequate to meet Contract requirements	✓		
28	Quality Management Coordinator	1.0	✓	✓	✓

B. Full-Time Equivalent Requirement

1. Some positions have a full-time equivalent (FTE) requirement. An FTE is a measure of full-time work. Full-time work is employment for at least thirty-five (35) hours per week. For a position with an FTE requirement, the FTE indicates the minimum amount of full-time work that shall be dedicated to, and performed for, that particular position by one person, in order to meet its staffing requirement for purposes of this RFP.

2. Except as otherwise noted, a specific FTE or number of positions, is not required. There shall be adequate staff to meet Contract requirements. For each position having an FTE requirement, the Health Plan shall submit to DHS, the FTE that each individual serving in said position, is assigned to perform work only toward that position as it relates to the QI program. This information shall be included in the Staffing Plan and in staffing change notifications, discussed below, and submitted to DHS.

3. The Health Plan shall ensure adequate staff are available and assigned to appropriate areas to fulfill the required functions specified in this Contract. The Health Plan shall increase staffing in specific areas if determined by DHS that contractual requirements are not being met.

C. State of Hawaii – Location of Residence and Work

1. Positions with a checkmark in the "Hawaii (HI)" column shall be

filled by individuals residing and working in the State of Hawaii unless an exception applies. The Health Plan shall submit to DHS whether each individual serving in any such position resides and works in the State of Hawaii. This information shall be

included in the Staffing Plan and in staffing change notifications, as discussed below, and submitted to DHS.

2. Exceptions to State of Hawaii work and residence requirement:

   a. The Claims Administrator/Manager should be located in a Hawaii. If this is not feasible, the Health Plan shall provide a Manager residing and working in Hawaii who is able to address issues regarding claims during Hawaii business hours, for example, a Provider Services Manager. If applicable, the Health Plan shall describe the roles and responsibilities of the Claims Administrator/Manager and the Hawaii-based Manager in the Staffing Plan, as discussed below.

   b. The requirement to have an IT Hawaii Manager position is contingent upon the residence and work location of the IT Director/CIO. The Health Plan does not need to have an IT Hawaii Manager if the IT Director/CIO resides in Hawaii. If the IT Director/CIO does not reside in Hawaii, the Health Plan shall have an IT Hawaii Manager who resides and works in Hawaii. If applicable, the Health Plan shall describe the roles and responsibilities of the IT Director/CIO and the IT Hawaii Manager as part of the Staffing Plan.

D. Resumes

1. For positions with a checkmark in the “Resume” column, the

Health Plan shall submit to DHS a current resume of each individual serving in any such position during Readiness Review. Resumes shall be submitted to DHS as part of the Staffing Plan, as discussed below, and with staffing change notifications, as discussed below.

E. Professional References

1. Upon request, the Health Plan shall submit to DHS three (3) professional references for an individual in QI Staffing Table. Each professional reference shall include the first name, last name, job title, company, phone number, and email address. Such references shall be from the current, if any, and most recent previous employers.

F. Staffing Change Notification

1. For positions with a checkmark in the "Change Notification" column, the Health Plan shall notify DHS in writing, within seven (7) days of learning of a change in the status of such positions. The submission to DHS of a completed Staffing Change Notification Form with all required attachments, will serve as written notification to DHS. If a position remains vacant at the time the written notification is submitted to DHS, the Health Plan shall provide the name, position title, and contact information of the interim employee within the written notification. As soon as the vacancy is filled, the Health Plan shall provide written notification to DHS of such staffing change, including the name of the individual filling the vacancy and other related information. Upon DHS request, the Health Plan shall provide a written plan for filling the vacant position, including expected timelines.

2. The Health Plan shall follow the Staffing Change Notification Form, the Staffing Change Notification Form Instructions, and the Staffing Change Notification Form Sample, in the Health Plan Manual.

G. Job Descriptions

1. Upon request, the Health Plan shall submit a job description for positions listed in the QI staffing table, to DHS for review during Readiness. The job description shall include the function, duties, and responsibilities of the position. The job description shall also include the minimum education, experience, and other position qualifications required.

H. Staffing Plan and Training Plan

1. Overview

a. The Health Plan shall ensure all staff have the necessary qualifications such as the education, skills, experience, and licenses to fulfill position requirements and duties. The Health Plan shall conduct initial and ongoing training of its staff to ensure the staff are knowledgeable, capable, and prepared to perform the work. Staff shall be prepared to meet the obligations of this Contract.

b. A complete and up-to-date Staffing Plan and a Training Plan shall be submitted to DHS for Readiness Review as described in §13.3.B.

2. Staffing Plan

a. The Staffing Plan shall include a table that matches the Staffing Table in §11.2.A.

1) For each required QI RFP position, the Health Plan shall note the corresponding Health Plan position that meets the QI RFP staffing requirement.

2) The table shall provide:
   a) Names, titles, qualifications, and work contact information, including phone and email, of all individuals serving in each required position with a checkmark in the "Change Notification" column;
   b) FTE each individual will serve in the position held, if applicable;
   c) Whether each individual resides and works in the state of Hawaii, if applicable;
   d) Names and functions of the Hawaii-based Manager for exceptions to the residing in Hawaii requirements; and
   e) Total FTE for each mandated staff category, for example, "6.0 FTE total" for the mandated "Claims Processing Staff" category.

b. The Staffing Plan shall include an organizational chart visually showing roles, responsibilities, and relationships for QI line of business, including dotted line roles, responsibilities, and relationships. At a minimum, mandatory QI roles should be displayed.

c. The Staffing Plan shall include the number of proposed FTEs dedicated to the Contract by required staffing category and operational area, and how the Health Plan determined the appropriateness of these ratios. Office locations for staff shall be provided. This can be attached to the Staffing Table

as described above.

d. All resumes, if applicable, shall be submitted as part of the Staffing Plan. Resumes shall include any degrees, credentials, clinical licensure as applicable, years and type of experience. Resumes may be provided as attachments to the staffing plan table described above.

e. Health Coordination Team

    1) The Health Coordination Team shall consist of a Director, Coordination Managers, and specific coordinators for behavioral health, LTSS, SHCN, EHCN and CIS+. Additionally, the multidisciplinary teams shall have two types of staff, clinical and non-clinical:

        a) Clinical staff: Including but not limited to licensed nurse and social worker health coordinators, and behavioral health specialists such as psychiatric technicians and CSACs. The team may have pharmacists and paramedics.
        b) Non-clinical staff: Including, but not limited to, community health workers, peer specialists, and assistant coordinators.

f. The Health Plan shall include, as an addendum to its Staffing Plan, a description of its Health Coordination Team that meets the staffing needs as described in §3.7 and the Health Plan Manual. For Readiness Review, the Health Plan shall provide to DHS for review and approval, a description of its current and proposed Health Coordination Team including employee names along with their titles and roles.

g. The Health Coordination Team description shall include the following:

a) Titles and roles of the Health Coordination team membership;

b) FTE of each individual on the team;

c) Job description including education and qualification requirements of each role on the team; and

d) An organizational chart showing roles, reporting and relationship structures, including dotted line roles, reporting, and relationships.

3. Training Plan

a. The Training Plan shall include a description of the Health Plan's proposed training of staff to fulfill all requirements and responsibilities of the Contract for all operational areas.

b. The Training Plan shall describe the Health Plan's approach to monitoring Subcontractors' progress in recruiting and training of staff to meet all requirements of Contract.

c. The Training Plan shall include a system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the Federal and State standards and requirements under the Contract, pursuant to 42 CFR §438.608, and that are designed to detect and prevent fraud, waste, and abuse.

11.3 Position Descriptions

A. The following position descriptions provide basic and minimum

requirements. The Health Plan shall ensure all QI staff are appropriately and adequately qualified, experienced, and able to execute and meet the administrative and service requirements of this RFP. DHS reserves the right to amend required QI staff and position descriptions, in the best interests of the QI program and Members.

1. Administrator/CEO/Executive Director:

    a. The Health Plan shall have at least one dedicated employee (e.g., Administrator, CEO, Executive Director, etc.) who has clear authority over the general administration and day-to-day business activities of this RFP.

2. Behavioral Health Coordinator:

    a. The Behavioral Health Coordinator shall be responsible for all behavioral health services, including all the stepped approach requirements described in §3.5 supporting the CSC system, and all other behavioral health requirements described in Section 3 and 4. This person shall be a physician, psychologist, RN (may have additional training, e.g., APRN), or clinical social worker who is licensed in the state of Hawaii with experience related to the behavioral health needs of the QI population.

3. Compliance Officer:

    a. The Health Plan shall have a Compliance Officer as described in Section 12 of this RFP.

4. Data Analytics Officer:

    a. The Health Plan shall have a Data Analytics Officer to support and oversee all data analytics activities of the

contract including, but not limited to, the implementation of sophisticated predictive analytic tools to identify target populations for various programs, conducting disparities and trend analyses, informing the incorporation and use of SDOH data into clinical and administrative data, operationalizing non-standard performance and quality metrics, and supporting the reporting and evaluation needs of the Contract.

5. EPSDT Coordinator:

    a. 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.

6. Financial Officer/CFO:

    a. The Health Plan shall have a Financial Officer/CFO who is responsible for all accounting and finance operations, including all audits related to FWA and VBP arrangements.

7. Health Coordination Director:

    a. The Health Plan shall have a Health Coordination Director who is responsible for overseeing all health coordination activities (care and service coordination). The person shall serve as the liaison to the state of Hawaii for these activities. The Health Coordination Director shall oversee the training and work of all staff performing health coordination functions and oversee all delegated health coordination activities. The Health Coordination Director should be either

an RN, licensed social worker, or experienced with serving individuals who receive health coordination activities.

8. IT Director/CIO:

    a. The Health Plan shall have an IT Director/CIO who is responsible for all IT activities.

9. IT Hawaii Manager:

    a. As stated above in the QI staffing table, if the IT Director/CIO does not reside in the state of Hawaii, the Health Plan shall have an IT Hawaii Manager who resides and works in the state of Hawaii. The Health Plan shall include in the CIO and the IT HI Manager position, the IT job duties and reporting structures of the two positions for DHS review.

10. Medical Director:

    a. 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 DHS Medical Director and participate in DHS Medical Director meetings, Provider Advisory Board meetings and any committee meetings relating to the programs when requested by DHS.

11. Member Grievance Coordinator:

    a. The Health Plan shall have a Member Grievance Coordinator

who is responsible for, and oversees, all Member Grievance and Appeal System activities.

12. Member Services Director:

    a. The Health Plan shall have a Member Services Director who is responsible for all Member service activities including, but not limited to, call center staffing, Member handbook

updates, and translation activities. In addition, this person shall oversee the training and work of all line personnel performing Member service functions.

13. Pharmacy Coordinator/Director/Manager:

    a. 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 beneficiaries.

14. Prior Authorization/Utilization Management/Medical Management Director:

    a. The Health Plan shall have a PA/Utilization Management (UM)/Medical Management Director. This person shall oversee all activities related to PAs and concurrent and post-payment reviews, to include UM line personnel. In addition, this person shall be responsible for overseeing the training and work of all line personnel performing these functions.

15. Provider Grievance Coordinator:

    a. The Health Plan shall have a Provider Grievance Coordinator who is responsible for and oversees the provider grievance and appeals system.

16. Provider Services/Contract and Credentialing Manager:

    a. The Health Plan shall have a Provider Services/Contract and Credentialing Manager who is responsible for the provider network activities including contracting, credentialing, and provider education. This person shall oversee the training

and work of all line personnel performing provider service functions.

17. Quality Management Coordinator:

    a. The Health Plan shall have a Quality Management Coordinator or Quality Management Director who is responsible for all quality improvement activities. This person shall be a physician or RN licensed in the state of Hawaii.

SECTION 12 – Program Integrity

12.1 Fraud, Waste and Abuse (FWA)

A. Administrative Requirements

1. Pursuant to 42 CFR Part 455 (Program Integrity: Medicaid) and 42 CFR Part 438, Subpart H (Additional Program Integrity Safeguards), the Health Plan and Subcontractors, to the extent that the Subcontractor can be delegated responsibilities, shall implement, and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse, and that meet all requirements of 42 CFR §438.608. This includes, but is not limited to, having a Compliance Program as outlined in 42 CFR §438.608. This program shall include internal controls, policies, procedures, and standards of conduct for the prevention, detection, reporting, and corrective action for known or suspected cases of FWA in the administration and delivery of services under this Contract.

2. The Health Plan shall have a Compliance Officer who is responsible for the Compliance Program, and who shall fulfill required duties and activities in accordance with 42 CFR §438.608. The Compliance Officer must meet requirements under Section 11 of this RFP and ensure sufficient staffing and resources to identify and investigate unusual incidents, and develop and implement corrective action plans to assist the Health Plan in preventing and detecting potential FWA activities. The Compliance Officer shall be responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the Contract and

shall report directly to the Chief Executive Officer and the board of directors. The Compliance Officer shall be responsible for ensuring that policies are followed to establish effective lines of communication between the Compliance Officer and Health Plan staff, and between the Compliance Officer and DHS staff.

3. The Health Plan shall have a Regulatory Compliance Committee either of the governing board, or which reports to the governing board, or senior management level executives. The regulatory Compliance Committee shall be charged with overseeing the organization's Compliance Program and its compliance with the requirements under the Contract.

4. Coordination with the State

   a. In order to facilitate cooperation with the State, the Health Plan shall establish and maintain a special investigative unit (SIU), either in-house or by contract with another entity,to investigate possible acts of FWA for all services provided under the Contract, including those services provided by Subcontractors.

   b. The Health Plan Compliance Officer, Health Plan SIU, and applicable Subcontractors shall work cooperatively with DHS, the State of Hawaii MFCU, the OIG and CMS, and any other law enforcement agencies, as appropriate, to administer effective FWA practices and participate in any subsequent legal actions. The Health Plan shall take part in coordination activities within the State to maximize resources for FWA issues. Health Plan cooperation shall include access to the Health Plan's place of business during normal business hours and provision of requested

information, including financial records, medical records, claims, and internal reports of action taken, such as investigative, corrective, and legal actions. The Health Plan shall also provide access to their employees and consultants for interviews, at no charge to the State, including but not limited to: those with expertise in the administration of the program and/or medical or pharmaceutical matters, or those who are in any matter related to an investigation.

1) The Health Plan shall include Compliance Officer or designee and one secondary contact person for program integrity and investigation-related records, documents, data, media, or other information requests. Requests will be sent to the designated Health Plan contact person(s) in writing by email, fax, or mail, and will provide the specifics of the information being requested.

2) The Health Plan shall respond to the appropriate DHS staff member within the timeframe designated in the request. If the Health Plan is unable to provide all of the requested information within the designated timeframe, the Health Plan may request an extension in writing (email) to the DHS requestor no less than two (2) business days prior to the due date.

5. The Health Plan's response shall include data for all data fields as requested by DHS. The data shall be provided in the order and format requested. If any data field is left blank, an explanation shall accompany the response. The Health Plan shall not add or delete any additional data fields in its response. The

Health Plan Compliance Officer and designated staff shall attend FWA training sessions as scheduled by the MFCU or DHS.

6. The MFCU or DHS will convene and facilitate monthly meetings regarding program integrity and FWA. The Health Plan shall participate in meetings with state Program Integrity, Investigations, or Fraud Control personnel, the Department's RAC, and with other Health Plan compliance staff. Using a pre-defined template provided by DHS, the Health Plan shall prepare a written update on cases, audits, recoveries, and trends. The Health Plan shall submit the completed template to DHS program integrity staff three (3) business days prior to the monthly meeting. The Health Plan representatives shall participate in discussions and share Health Plan activities and findings with all meeting attendees.

7. Health Plan shall be compliant with the following requirements as directed by DHS:

   a. Within fifteen (15) business days of receipt of information from DHS on a questionable billing pattern, or provider with questionable claims patterns, the Health Plan shall complete and submit an analysis of the provider's billing history related to the claims pattern. The analysis shall include, but is not limited to, the review time period, number of claims reviewed, number of claims with the specific claim pattern identified by DHS or a Health Plan, total dollars for reviewed claims, and dollars identified for the specific claim pattern or allegation. The completed analysis shall be submitted to the program integrity representative designated by DHS.

   b. If DHS terminates a provider's participation in the Medicaid

program, a written notice of the termination will be provided by DHS to all Health Plans. The Health Plan is required to terminate the provider from its respective provider network in compliance with the terms provided in the DHS written notice.

8. In addition to reporting requirements related to prompt and timely information on suspected FWA described in Section 12, the Health Plan shall provide compiled reports on FWA activities to DHS as described in §6.2. Information on FWA activities may be requested in a number of ways, and across multiple reports, including but not limited to: Suspensions, Terminations, and Program Integrity Education Report; Fraud, Waste, and Abuse Report; and Overpayments Report, as described in Section 6.2.

9. The Health Plan's failure to comply with any requirement of Section 12 may subject the Health Plan to all available remedies set forth in §14.21, in addition to any other legal remedy.

B. Compliance Program and Compliance Plan

1. The Health Plan shall have a Compliance Program that shall comply with 42 CFR §438.608 and include, but is not limited to, written program goals and objectives; program scope; assignments, policies, and procedures; and methodology in compliance with 42 CFR §438.608. The Health Plan shall have a written description of the Compliance Program, which shall include, but is not limited to, the above written requirements, and address the Compliance Program mandates enumerated below in Section 12.1.B.2 of this RFP, and in 42 CFR §438.608. The written description of the Compliance Program shall be called the Compliance Plan.

2. Among other requirements of 42 CFR §438.608, the Health Plans Compliance Program shall:

   a. Designate a Compliance Officer who meets requirements of Sections 11 and 12.1.A.2 of this RFP;

   b. Establish a Compliance Committee that meets quarterly and reviews FWA compliance issues;

   c. Establish an organizational structure and personnel roles and responsibilities for preliminary investigation(s) of provider FWA.

   d. Require the reporting of suspected and/or confirmed FWA be done as required in §6.2.F;

   e. Submit timely Health Plan disclosures in accordance with §6.2(F);

   f. Ensure notification to DHS Program Integrity staff requesting permission before initiating any form of adverse action, including but not limited to: notifying a provider of the outcome of an investigation and/or recovering any overpayments identified;

   g. Ensure all of its officers, directors, managers, and employees know and understand the policies, procedures and practices of the Health Plan's Compliance Program;

   h. Have processes in place to monitor all providers and their officers/directors/agents/managing employees as described in §§8.1.A and 8.2;

   i. Ensure and describe effective training and education for the Compliance Officer and the organization's employees, senior

and mid-level management, and Subcontractors;

j. Ensure that providers and the Members are educated about FWA identification and reporting, and include information in the provider and the Member material;

k. Ensure the enforcement of standards through well-publicized disciplinary guidelines;

l. Ensure provision of internal monitoring and auditing of reported FWA violations, including specific methodologies, and provisions for prompt response to potential offenses, and for the development of corrective action initiatives relating to the Health Plan's FWA efforts;

m. 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 MCOs;

n. Ensure no individual who reports Health Plan violations or suspected FWA is retaliated against;

o. Include a monitoring program that is designed to prevent and detect potential or suspected FWA. This monitoring program shall include but not be limited to:

    1) Monitoring the billings of its providers to ensure the Members receive services for which the Health Plan is billed;

    2) Requiring the investigation of all reports of suspected fraud and over billings (upcoding, unbundling, billing for services furnished by others, and other overbilling

practices);

3) Reviewing providers for over-utilization or under-utilization;

4) Verifying with the Members the delivery of services as claimed; and

5) Reviewing and developing mechanisms to track consumer complaints on providers;

p. Ensure all suspected instances of internal and external FWA relating to the provision of, and payment for, Medicaid services including, but not limited to, Health Plan employees/management, providers, Subcontractors, vendors, be reported to DHS. Additionally, any final resolution reached by the Health Plan shall include a written statement that provides notice to the provider that the resolution in no way binds the State of Hawaii or the federal government nor precludes the State of Hawaii or the federal government from taking further action for the circumstances that brought rise to the matter; and

q. Ensure the Health Plan shall cooperate fully in any investigation by federal and state oversight agencies and federal and state law enforcement agencies, as appropriate, and any subsequent legal action that may result from such an investigation.

3. The Health Plan shall submit its Compliance Plan for DHS review in accordance with §13.3.B.

4. The Health Plan shall submit a written Compliance Plan to DHS for approval each year. The plan shall be submitted ninety (90)

days prior to the start of the SFY. If the Health Plan has not made any changes to its plan from the previous year, it may notify DHS that:

a. No changes have been made to the previously-approved Compliance Plan; and

b. The plan will remain in place for the upcoming SFY. The notification shall be signed and certified by an officer or director of the Health Plan that is responsible for carrying out the Compliance Plan.

5. Upon receipt of a written request from DHS, the Health Plan shall submit the complete Compliance Plan to the [requester] DHS within two (2) business days.

6. The Health Plan's failure to fully implement, enforce, and monitor its Compliance Plan and Compliance Program may subject the Health Plan to all remedies available set forth in §14.21, in addition to any other legal remedy available to DHS.

C. Investigating Suspected Fraud, Waste, and Abuse

1. All suspected FWA committed by the Member should be reported to the appropriate entity. The Health Plan shall report eligibility fraud affecting medical assistance to the Investigations Office (INVO) of DHS. The reporting shall be done either through written notification or a telephone call to the INVO hotline.

2. The Health Plan shall report the Member fraud for circumstances such as fraudulently obtaining controlled substances, other medical services, or collusion between provider and the Member to obtain services, to DHS after a preliminary investigation is complete.

3. If the Health Plan receives a complaint of suspected Medicaid FWA from any source or identifies any questionable practices, either by the Members or Providers, it shall conduct a preliminary investigation to determine whether there is sufficient basis to warrant a further investigation by DHS and/or the MFCU. If the findings of a preliminary investigation give the Health Plan reason to believe that an incident of FWA has occurred in the Medicaid program, the Health Plan shall promptly refer any potential FWA that it identifies to DHS. Health Plans are required to report all incidences of suspected FWA to DHS within fourteen (14) days of making such a determination. It is possible the Health Plan may need to report the suspected activity immediately, such as when patient safety is at risk, evidence is being destroyed, or there is ongoing significant monetary loss. Criminal intent to commit fraud is not

   determined by either DHS or the Health Plan. Based on all the evidence gathered, DHS or the Health Plan only determines that an identified activity has the potential to be fraudulent and is likely not the result of an unintentional error.

4. The Health Plan shall use the report form provided by DHS to report or refer suspected cases of Medicaid FWA. At a minimum, this form shall require the following information for each case:

   a. Subject (name and ID number);

   b. Source of complaint;

   c. Type of provider;

   d. Health Plan contact;

   e. Contact information for Health Plan staff with practical

knowledge of the workings of the relevant programs;

f. Date reported to the State;

g. Description of suspected intentional misconduct, with specific details:

    1) Category of service.

    2) Factual explanation of the allegation. (The Health Plan should provide as much detail as possible concerning the names, positions, and contact information of all relevant persons; a complete description of the alleged scheme as it is understood by the Health Plan, including, when possible, one or more examples of specific claims that are believed to be fraudulent; the manner in which the Health Plan

    came to learn of the conduct; and the actions taken by the Health Plan to investigate the allegations.)

    3) Date(s) of conduct. (When exact dates are unknown, the Health Plan should provide its best estimate.)

h. Specific statutes, rules, regulations, or policies violated includes all applicable federal/Medicaid violations as well as Health Plan policy violations;

i. Amount paid to the provider during the past three (3) years or during the period of the alleged misconduct, whichever is greater;

j. Sample/exposed dollar amount when available;

k. Legal and administrative disposition of the case; and

l. Copies of any and all communications between the Health

Plan and the provider concerning the conduct at issue (including, provider enrollment documentation, and any education given to the provider as a result of past problems; as well as advisory bulletins, policy updates, or any other general communication to the provider community regarding questionable behavior. Letters, emails, faxes, memorandums, and phone logs are all sources of communication).

5. In addition to the information required on the form, this report shall include any and all evidence obtained by the Health Plan in its preliminary investigation including but not limited to, copies of claims and medical records reviewed, summary of interviews conducted, and copies of audit results or review board determinations.

6. The required form and additional information shall be submitted to DHS within the timeframes set forth in §12.1.

7. When it is determined that an investigation has the potential to be fraudulent, the Health Plan shall not: contact the provider who is the subject of the investigation about any matters related to the investigation; attempt to negotiate any settlement or agreement; or accept any item of monetary value or otherwise offered by the provider (or its representative) who is the subject of the investigation in connection with the incident.

D. Prompt Reporting of Overpayments to Providers and Recoveries

1. The Health Plan shall recover and report all overpayments, unless otherwise prohibited under this RFP or federal or state law. "Overpayment" as used in this section is defined in 42 CFR

§438.2. All overpayments identified by the Health Plan shall be reported to DHS in accordance with §6.2.F. The overpayment shall be reported in the reporting period in which the overpayment is identified. It is understood the Health Plan may not be able to complete recovery of overpayment until after the reporting period. The Health Plan shall report to DHS the full overpayment identified.

a. The Health Plan shall track claims and providers being audited and submit a written report to DHS Program Integrity detailing the auditing activities on a quarterly basis.

b. During the eighteen (18)-month period after the date of payment, DHS Program Integrity and other entities will not initiate a separate review of claims being audited by the Health Plan.

c. The Health Plan may retain funds recovered due to audit activities it initiates during the initial eighteen (18) months from the date of services. After eighteen (18) months, DHS Program Integrity or other entities have full right to audit and pursue overpayments directly from providers. DHS or their representatives will notify the Health Plan of recoveries, or direct the health plan to make recoveries. In all cases, encounters should be adjusted and submitted to DHS within one hundred twenty (120) days of adjudication or adjustment.

2. The Health Plan may negotiate and retain a lesser repayment amount with the provider; however, the full overpayment amount will be used by the Health Plan when submitting

replacement encounter data and by DHS when setting capitation rates for the Health Plan.

3. The Health Plan shall have in place a process for providers to report to the Health Plan when it has received an overpayment, and a process for the provider to return the overpayment to the Health Plan within thirty (30) days after the date on which the overpayment was identified. The Health Plan shall require the provider to notify the Health Plan in writing of the reason for the overpayment. DHS, or its contractor, may recover any overpayments made to the Health Plan, and the method of recovery shall be determined by DHS.

4. The Health Plan shall also report quarterly to DHS on all recoveries as described in §6.2.F. This report shall specify overpayments identified as FWA. The Health Plan shall check the reporting of overpayments recoveries for accuracy and shall provide such accuracy reports to DHS upon request. The Health Plan shall certify that the report contains all overpayments and those overpayments are reflected in encounter data submitted to DHS, and list these overpayments as itemized recoveries in reports submitted to DHS, as described in §§6.2.F and 6.4.

5. The Health Plan is prohibited from recovering overpayments that are being investigated by the State, are the subject of pending federal or state litigation or investigation, or are being audited by the Hawaii RAC or other State contracted auditor. Once the Health Plan receives notice from DHS or other state or federal agency of such action, the Health Plan shall cease any ongoing recovery efforts and coordinate with the notifying agency.

6. If DHS determines there is a credible allegation of fraud against

a provider, then payments to the provider shall be suspended absent a good cause exception. DHS will be responsible for the determination of a credible allegation of fraud and any good cause exception.

a. The Health Plan shall have in place policies and controls to prevent payments to providers under payment suspension.

b. DHS will notify the Health Plan in writing if payments to a provider are to be suspended and provide the effective date of the payment suspension. The Health Plan shall suspend payments to the provider within one (1) business day of DHS notification or the suspension effective date, whichever is later.

c. DHS will notify the Health Plan in writing if the payment suspension may be discontinued. The Health Plan shall respond to the notice from DHS within three (3) business days and inform DHS of action taken.

d. The Health Plan shall also report all of the following information to DHS after it suspends payment to the provider or discontinues the suspension: dates the Health Plan suspended payments or discontinued the payment suspension, outcome of any appeals, and amount of adjudicated Medicaid payments held.

e. If the Health Plan fails to suspend payments to a provider after being notified in accordance with this section, any payments made to the provider during the effective suspension may be recovered from the Health Plan, and liquidated damages or sanctions may be imposed in accordance with §14.20.

7. Health Plan Recoveries of Overpayments to Providers

a. The Health Plan shall be in compliance with 42 CFR §438.608(d) as follows:

1) The treatment of recoveries made by the Health Plan of overpayments to providers due to FWA shall specify:

a) The retention policies for the treatment of recoveries of overpayments due to FWA:
b) The process, timeframes, and documentation required for reporting the recovery for all overpayments; and
c) The process, timeframes, and documentation required for payment of recoveries of overpayments to DHS in situations where the Health Plan is not permitted to retain some or all of the recoveries of overpayments.

b. The Health Plan shall have a mechanism for a network provider to report to the Health Plan when it has received an overpayment, to return the overpayment to the Health Plan within sixty (60) days after the date on which the overpayment was identified, and to notify the Health Plan in writing of the reason for the overpayment.

c. The Health Plan shall report to DHS within sixty (60) days when it has identified capitation payments or other payments in excess of amounts specified in the Contract.

E. Employee Education About False Claims Recovery

1. The Health Plan shall establish written policies and procedures

for its employees (including management, Subcontractors, providers, and agents) that provide detailed information about the False Claims Act and any other federal and state laws described in Section 1902(a)(68) of the Act, including whistleblower protections, administrative remedies for false claims, any state laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting FWA in federal healthcare programs. The Health Plan shall include in any employee handbook a description of the laws and the rights of employees to be protected as whistleblowers.

2. The Health Plan's failure to comply with the requirements of Section 12 may subject the Health Plan to all available remedies set forth in §14.21, in addition to any other legal remedy.

F. Child and Adult Abuse Reporting Requirements

1. The Health Plan shall report all cases of suspected child abuse to the CWS Branch of the Social Services Division of DHS, and all suspected dependent adult abuse to the Adult Protective and Community Services Branch of the Social Services Division of DHS as required by state and federal laws, rules, and regulations.

2. The Health Plan shall ensure its network providers report all cases of suspected child abuse to the CWS Branch of the Social Services Division of DHS, and all suspected dependent adult abuse to the Adult Protective and Community Services Branch of DHS as required by state and federal laws, rules, and regulations.

12.2 Verification of Services and Electronic Visit Verification

A. Verification of Services

1. VOS billed by providers and actually received by beneficiaries is required by 42 CFR §455.20. The VOS shall include a summary of the claim(s) or explanation of benefits for the month prior to mailing.

2. The Health Plan shall include in each VOS a cover letter explaining the document and provide a telephone number for the Member to call if they did not receive the services. All written communication shall comply with §9.4.D.

3. Whether the method of verification is by explanation of benefits or a summary of the claim(s), the verification shall include the service furnished, name of the provider furnishing the service, date on which service was furnished and amount of payment made to the provider for the service. The Health Plan shall encourage the Members to respond to the VOS by calling the Health Plan if the billing information is not correct.

4. The Health Plan shall send by mail VOS each month to at least twenty-five (25) percent of their Members who received services. The Health Plan shall randomly select the Members who received inpatient, outpatient, HCBS, prescription drugs, and institutional services, such as nursing facility, at least forty-five (45) days after the claim(s) was submitted.

5. If the Member responds that the service was not received or provided, the Health Plan shall report this finding to their FWA staff. Once received by the FWA staff, steps should be initiated by the Health Plan to investigate accuracy of information

provided by the Member. The Health Plan shall report information on their VOS program as part of their FWA program as specified in §6.2.F.

B. Electronic Visit Verification

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

2. At a minimum, the EVV system shall be able to electronically capture these six (6) data points:

   a. Type of service performed;

   b. Individual receiving the services;

   c. Date of service;

   d. Location of service delivery at beginning and end;

   e. Individual providing the service; and

   f. Time the service begins and ends.

3. DHS deployed an Open Vendor Model in the State of Hawaii. This model has the following characteristics:

   a. DHS contracted statewide with a single EVV vendor for both the EVV data capture services, for PCS and HHCS, and a mandated data aggregator;

   b. Providers and Health Plans may choose to use an alternate EVV vendor. Providers and Health Plans choosing to use an alternate system will incur any and all related costs,

including, but not limited to, costs related to system requirements necessary to securely and efficiently transmit data to/from the statewide EVV data aggregator in a format used or convertible by the statewide EVV; and

c. The statewide EVV data aggregator will contain all EVV data from either the State vendor or an alternate vendor.

4. Health shall comply with the following:

a. Health Plans shall submit PCS and HHCS prior authorization information to the statewide EVV vendor.

b. Health Plans shall be required to validate, with the statewide EVV data aggregator, that the six (6) EVV data points have been captured as a pre-payment edit prior to PCS and HHCS claim payment.

c. Health Plans shall review EVV data and ensure:

1) Services that have been authorized were delivered. If not, the Health Plan shall provide additional services or supports as needed.

d. Services are compliant with authorization protocols set forth in the Contract.

e. Detection of potential or actual FWA in the delivery of services to the Members.

f. Compliance with FWA requirements set forth in the Contract.

12.3 Program Integrity Compliance

A. The Health Plan failure to comply with any requirement in this Section 12 may subject to all available remedies set forth in §14.21, in

addition to any other legal remedy.

SECTION 13 – Readiness Review and Contract Implementation Activities

13.1 Overview

A. DHS is committed to ensuring the Health Plan is prepared and able to serve as an effective administrator of the Medicaid managed care program. DHS and the Health Plan will engage in detailed Readiness Review and contract implementation activities beginning immediately after contract award through Date of Commencement of Services to Members, or a different period as determined by DHS. The Readiness Review may be conducted in phases at the discretion of DHS. The readiness review shall include all areas identified in 42 CFR §438.66 and others to be identified by DHS.

13.2 DHS Responsibilities

A. Prior to the Date of Commencement of Services to Members as described in §1.5, DHS or its agent shall conduct a Readiness Review of the Health Plan in accordance with 42 CFR §438.66 in order to provide assurances that the Health Plan is able and prepared to perform all administrative functions required by this Contract and to provide high-quality service to Members.

B. Based on the results of the review activities, DHS shall provide the Health Plan with a summary of findings including the identification of areas requiring corrective action before DHS shall enroll Members in the Health Plan.

C. If the Health Plan is unable to demonstrate its ability to meet the requirements of the contract, as determined by DHS, within the

timeframes specified by DHS, DHS may postpone availability for enrollment or terminate the contract.

D. A Health Plan's failure to pass the readiness review thirty (30) days prior to the beginning of service delivery may result in the assessment of financial penalties against the Health Plan, delayed operations and/or immediate Contract termination.

13.3 Health Plan Responsibilities

A. Overview and Scope of Readiness Review

1. The Health Plan shall comply with all readiness review activities at the Health Plan's or Subcontractor's facilities as required by DHS. As requested by DHS, the Health Plan shall require participation of Subcontractors in readiness review activities. The scope of the desk and onsite readiness review activities conducted by DHS will include, but will not be limited to, review and/or verification of the Health Plan's progress on the following:

   a. Submission of all required review documents;

   b. A walkthrough of the Health Plan's operations and administration;

   c. A walkthrough of the Subcontractors' operations;

   d. Operational readiness of Subcontractors, including system readiness and demonstrations;

   e. Health Plan information systems readiness and demonstrations;

   f. Interviews with Health Plan and Subcontractor staff;

g. Statewide provider network composition and access;

h. Staffing Plan and Training Plan;

i. Transition of care plan;

j. Continuum of service providers;

k. Readiness of call centers;

l. Member education and outreach;

m. Provider education and outreach;

n. Policies and procedures required under the terms of the Contract, including grievance and appeals;

o. QAPI program standards;

p. PA and medical records standards;

q. UM program; and

r. Submission of updates on implementation activities.

B. Readiness Review

1. The Health Plan shall submit all required review documents identified in Table 8: 13.3.B.1, below, by the required due date. DHS reserves the right to request additional documents for review and approval during readiness review. DHS will provide due dates for additional documents at the time of the request.

Table 8: 13.3.B.1. Readiness Review Timeframes

Document	RFP Reference Section	Due Date (no later than)
NCQA Certificate of Accreditation	5.1.E	30 days after contract award date

Document	RFP Reference Section	Due Date (no later than)
QAPI Plan (including SDOH Plan)	5.1.B	30 days after contract executed date
Request for Delegation of QAPI Program Functions or Activities (if applicable)	5.1.B.7	30 days after contract executed date
UMP Description, Work Plan, Policies, and Procedures	5.2.A	30 days after contract executed date
PA Policies and Procedures	5.2.B	30 days after contract executed date
PA/Pre-Certification Policies and Procedures	5.2.B.1	30 days after contract executed date
Selection and Retention of Providers Policies and Procedures	8.1.A.13	30 days after contract executed date
Provider Network Listing (use Appendix H)	8.1.A.14	30 days after contract executed date
Availability of Providers Policies and Procedures	8.1.C.4	30 days after contract executed date
PCP Policies and Procedures	8.1.E.11	30 days after contract executed date
Credentialing, Re-Credentialing, and Other Certification Policies and Procedures	8.2.A.10	30 days after contract executed date
Model for Each Type of Provider Contract	8.3.A.4	30 days after contract executed date
Provider Education Materials	8.4.A.5	30 days after contract executed date
Provider Grievance and Appeals System Policies and Procedures	8.4.B.4	30 days after contract executed date
Provider Manual	8.4.C.4	30 days after contract executed date

Document	RFP Reference Section	Due Date (no later than)
Provider Call Center Policies and Procedures	8.4.D.6	30 days after contract executed date
Website (Member and Provider Portals) Update Policies and Procedures	8.4.E.3	30 days after contract executed date
Provider Website Screenshots	8.4.E.4	30 days after contract executed date
Access to Provider website	8.4.E.4	30 days after contract executed date
Transition of Care Policies and Procedures	9.3.C.1	30 days after contract executed date
Member Services Policies and Procedures	9.4.A.7	30 days after contract executed date
Member Education Materials	9.4.B.4	30 days after contract executed Date and prior to use of materials
Translation Certification Contractor Agreement	9.4.C.5	30 days after contract executed date
Oral Interpretation and Translation of Materials Policies and Procedures	9.4.D.7	30 days after contract executed date
Member Handbook	9.4.E.5	30 days after contract executed date
Sample Member ID Card	9.4.H.3	30 days after contract executed date
Member Call Center Policies and Procedures	9.4.I.10	30 days after contract executed date
Access to Member Website	9.4.J.10	30 days after contract executed date
Member Grievance and Appeals System Policies and Procedures	9.5.A.3	30 days after contract executed date
Marketing Materials	9.6.C and 9.6.D	30 days after contract executed date

Document	RFP Reference Section	Due Date (no later than)
Health Plan IT Functionality, including Timeline for Compliance with All Expected Functionality if Not Fully Met	10.2.H.1 and 10.2.H.2	30 days after contract executed date
Documentation Describing Health Plan Disaster Planning and Recovery Operations	10.2.H.3	30 days after contract executed date
Staffing Plan and Training Plan	11.2.H	30 days after contract executed date
Fraud, Waste, and Abuse Compliance Plan	12.1.B	30 days after contract executed date
Subcontractor Agreements Templates	14.4	30 days after contract executed date
UMP Description, Corresponding Work Plan, and UMP Policies and Procedure	5.2.A	30 days after the Date of Commencement of Services to Members
Medical Records Standards	5.3.A.5	30 days after the Date of Commencement of Services to Members
Contract Termination Procedures	14.16	120 days after the Date of Commencement of Services to Members

13.4 RFP Implementation Timeframes

1. The Health Plan and DHS have timelines for implementation of processes prior to and after Commencement of Services to Members. Table 9: 13.4.1, below is a central location that compiles these processes for ease of implementation.

Table 9: 13.4.1. Implementation Timeframes

Document/Requirement	Due Date	Responsible Party
Prior to Commencement of Services to Members		
HAP template plan format	30 days	DHS

Grievance and Appeal System templates	30 days	DHS
QI memoranda	30 days	DHS
Appeal procedures for sanctions	30 days	DHS
Submission of marketing materials	30 days	Health Plan
Enrollment cap for auto-assignment	30 days	DHS
DHS remotely monitor Member call center	30 days	DHS/Health Plan
After Commencement of Services to Members – Initial Year		
Quality-based component of auto-assignment	30 days after start of new benefit period	DHS
After Commencement of Services to Members – Annual		
Update certificate of insurance	Within 30 days of contract execution	Health Plan
Enrollment cap for auto-assignment	90 days prior to APC	DHS
Submission of marketing materials	45 days prior to APC	Health Plan
Update performance bond	60 days after start of new benefit period	Health Plan
Quality-based component of auto-assignment	January 1st of each year	DHS

SECTION 14 – Special Terms and Conditions

14.1 Overview

A. DHS and the Health Plan agree to the following amendments to the General Conditions and additional special conditions

1. Contract for Health and Human Services: Competitive Purchase of Service (AG Form 103F1 (10/08)) (see Appendix E), including General Conditions for Health & Human Services Contracts (AG Form 103F (10/08) (see Appendix E), any Special Conditions, attachments, and addenda;

2. This RFP, appendices, attachments, and addenda, which shall be incorporated by reference; and

3. The Health Plan's technical proposal submitted in response to this RFP form, which shall be incorporated by reference.

B. References to "General Conditions" in this Section 14 are to the General Conditions for Health & Human Services Contracts attached as Appendix E.

14.2 Conflict between Contract Documents, Statutes, and Rules

A. Replace General Condition 7.5, Conflict between General Conditions and Procurement Rules, with the following:

1. Contract Documents: In the event of a conflict among the Contract documents, the controlling 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.

2. Contract and Statutes: In the event of a conflict between the language of the Contract, and applicable statutes, the statute shall prevail.

3. Contract and Procurement Rules/Directives: In the event of a conflict between the Contract and the Procurement Rules or a Procurement Directive, Procurement Circular, the Procurement Rules or any Procurement Directive in effect on the date this Contract is executed and are hereby incorporated by reference.

4. The sections of the rules and regulations cited in this RFP may change as the rules and regulations are amended for DHS. No changes shall be made to this RFP due to changes in the section numbers.

14.3 Licensing and Accreditation

A. General Condition 1.2.2, Licensing and Accreditation, is amended to read as follows:

1. 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 HRS §§ 431, 432, or 432D, 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, as described in Section 15. 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.

14.4 Subcontractor Agreements

A. Replace General Condition 3.2, Subcontracts and Assignments, with the following:

1. 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.

2. The Health Plan shall submit to DHS for review and prior approval, all Subcontractor agreements related to the provision of covered benefits and services and Member services activities to the Members (i.e., call center) and provider services activities and payments to providers. The Health Plan shall submit these Subcontractor agreements in accordance with §13.3. In addition, DHS reserves the right to inspect all Subcontractor agreements at any time during the Contract period.

3. The Health Plan shall notify DHS in writing at least ninety (90) days prior to adding or deleting Subcontractor agreements or making any change to any Subcontractor agreements which

may materially affect the Health Plan's ability to fulfill the terms of the Contract.

4. The Health Plan shall provide DHS with immediate notice in writing by registered or certified mail of any action or suit filed against it by any Subcontractor, and provide 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 to, or otherwise impact in any way, the Contract the Health Plan has with the State of Hawaii.

5. 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 HRS §40-58.

6. All Subcontractor agreements shall include all provisions that comply with 42 CFR §438.230, and:

    a. Describe the activities, including reporting responsibilities, to be performed by the Subcontractor and require that the Subcontractor meet all established criteria prescribed and provide services in a manner consistent with the minimum standards specified in the Health Plan's Contract with the State;

    b. Require that the Subcontractor fulfill the requirements of 42 CFR §438.6 that are appropriate to the service delegated under the subcontract;

    c. Provide information regarding the Member rights and processes regarding the Member Grievance and Appeal System found in §9.5, if applicable;

d. Include a provision that allows the Health Plan to:

    1) Evaluate the Subcontractor's ability to perform the activities to be delegated;

e. 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 DHS and consistent with industry standards or State laws and regulations;

f. Identify the Subcontractor's deficiencies or areas for improvement; and

g. Take corrective action or impose other sanctions including, but not limited to, revoking delegation, if the Subcontractor's performance is inadequate.

h. Require that the Subcontractor submits to the Health Plan proof from the IRS that all federal taxes have been paid and a tax clearance certificate from the Director of the Department of Taxation, State of Hawaii, showing that all delinquent taxes, if any, levied or accrued under State law against the Subcontractor have been paid;

i. Include a provision that the Health Plan shall designate itself as the sole point of recovery for any Subcontractor;

j. 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;

k. Require that Subcontractors have in place and follow written policies and procedures for processing requests for initial and continuing authorization of services.

l. Require that the Subcontractor track and report complaints against itself to the Health Plan;

m. 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 and, if applicable, execute a BAA pursuant to HIPAA;

n. Require that the Subcontractor follow all audit requirements as outlined in §14.18, Audit Requirements. The actual requirements shall be detailed in the agreement;

o. Require that the medical records be retained in compliance with §14.5, Retention of Records and Documents. The actual requirements shall be detailed in the agreement;

p. Require that the Subcontractor comply with all requirements related to confidentiality of information as outlined in §14.17, Confidentiality of Information. The actual requirements found in this section shall be detailed in the agreement;

q. Require that the Subcontractor notify the Health Plan and DHS 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) days of the discovery of the breach;

r. Require the requirements of 42 CFR §434.6 that are appropriate to the service delegated under the subcontract;

s. Provide that the Members will not be billed for Covered Services in any amount greater than would be owed if the entity provided the services directly (i.e., no balance billing by Subcontractors);

t. Require that the Health Plan or the Subcontractor provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the State or the Health Plan determines that the Subcontractor has not performed satisfactorily;

u. Require that the Subcontractor allow the state and federal government full access to audit, evaluate, and inspect any books, records, contracts, documents, computer or other electronic system that pertain to any aspect of services and activities performed, or determination of amounts payable under the Health Plan's contract with DHS;

v. Require that the Subcontractor make available its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems relating to its Medicaid Members for the purposes of an audit, evaluation, or inspection by the state or federal government;

w. Require the Subcontractor agree that the right to audit by the State, CMS, the DHHS Inspector General, the Comptroller General or their designees, will exist through ten (10) years from the final date of the contract period or from the date of the completion of any audit, whichever is later;

x. Require that the Subcontractor comply with all applicable Medicaid laws, regulations, including applicable sub-

regulatory guidance and contract provisions;

y. Submit data in standard claims submission formats on all services provided, and be subject to accuracy, completeness, timeliness, and other requirements described in §6.5;

z. Require that if the State, CMS, or the DHHS Inspector General determine that there is a reasonable possibility of fraud or similar risk, then the State, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Subcontractor at any time; and

aa. Require that physical access, reasonable accommodations, and accessible equipment for the Members with physical or mental disabilities are provided.

7. The Health Plan contract with the pharmacy benefit manager shall exclude spread pricing, which is defined as the amount charged by a pharmacy benefit manager to a managed care organization that is in excess of the amount paid to the pharmacy for a prescription, including the ingredient cost and dispensing fee. Contracts must include a pass-through pricing model in which the pharmacy benefit manager is compensated based on the ingredient cost and dispensing fee paid to the pharmacy plus a reasonable administrative fee.

14.5 Retention of Records and Documents

A. The following is added to the end of General Condition 2.3, Records Retention:

1. The Health Plan and its providers shall retain all records and

documents, in accordance with 42 CFR §438.3(h), for a minimum of ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later. For minors, the Health Plan shall retain all records and documents during the period of minority plus a minimum of ten (10) years after the age of majority.

2. The Health Plan shall include in its subcontracts and provider agreements record and document retention requirements that are at least equivalent to those stated in this section.

3. During the period that records and documents are retained under this section, the Health Plan and any Subcontractor or provider shall allow the state and federal government full access to inspect and audit any records or documents, and inspect the premises physical facilities, and equipment where Medicaid-related activities or work is conducted, to the extent allowed by law.

B. The Health Plan and the Health Plan's Subcontractors retain, as applicable, the Member grievance and appeal records in 42 CFR §438.416, base data in 42 CFR §438.5(c), MLR reports in 42 CFR §438.8(k), and the data, information, and documentation specified in 42 CFR §§438.604, 438.606, 438.608, and 438.610 for a period of no less than ten (10) years.

14.6 Responsibility for Taxes

A. 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 (HRS chapter 431, Article 7, Part II). Each Health Plan is responsible for determining whether it is subject to, or exempt from, any such federal, state, or local taxes. 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.

14.7 Full Disclosure

A. Business Relationships

1. By submitting a proposal, 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 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.

2. The Health Plan shall not knowingly have a director, officer, partner, or person with more than five (5) percent 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 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.

3. The Health Plan cannot be controlled by a sanctioned individual under Section 1128(b)(8) of the Social Security Act.

4. The Health Plan shall submit:
   a. The name, date of birth, Social Security Number and address of any individual with an ownership or controlling interest in the Health Plan and its Subcontractors. Where applicable, the name and address of any corporation with an ownership or control interest in the Health Plan and its Subcontractors. Corporate entities shall include as applicable primary business address, every business location, and P.O. Box address.

   b. Other tax identification number of any corporation with an ownership or control interest in the Health Plan and any Subcontractor in which the Health Plan has a five (5) percent or more interest.

   c. Information on whether an individual or corporation with an ownership or control interest in the Health Plan is related to another person with ownership or control interest in the Health Plan as a spouse, parent, child, or sibling.

   d. Information on whether a person or corporation with an ownership or control interest in any Subcontractor in which the Health Plan has a five (5) percent or more interest is related to another person with ownership or control interest in the Health Plan as a spouse, parent, child, or sibling.

e. The name of any other disclosing entity in which an owner of the Health Plan has an ownership or control interest.

f. The name, address, date of birth, and Social Security Number of any managing employee of the Health Plan.

5. The Health Plan shall report to DHS and, upon request, to the Secretary of the DOH, and DHHS, the Inspector General of DHHS, and the Comptroller General a description of transactions between the Health Plan and a party in interest (as defined in Section 1318(b) of such Social Security Act), including the following transactions:

a. Any sale or exchange, or leasing of any property between the Health Plan and such a party;

b. Any furnishing for consideration of goods, services (including management services), or facilities between the Health Plan and such a party, but not including salaries paid to employees for services provided in the normal course of their employment; and

c. Any lending of money or other extension of credit between the Health Plan and such a party.

6. The Health Plan shall include the provisions of §14.7.A in any subcontract or provider agreement. DHS will review the ownership and control disclosures submitted by the Health Plan and any of the Health Plan's Subcontractors.

B. Litigation

1. The Health Plan shall disclose any pending litigation both in and out of Hawaii to which they are a party, including the disclosure

of any outstanding judgment.

C. Effect of Prohibited Relationships

1. If DHS learns that the Health Plan has a prohibited relationship with an individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or if the Health Plan has relationship with an individual who is an affiliate of such an individual, DHS may continue an existing agreement with the Health Plan unless the Secretary of DHHS directs otherwise.

2. If DHS learns that a Health Plan has a prohibited relationship with an individual or entity that is excluded from participation in any Federal healthcare program under Section 1128 or 1128A of the Act, DHS may continue an existing agreement with the Health Plan unless the Secretary of DHHS directs otherwise.

3. If DHS learns that a Health Plan has a prohibited relationship with an individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or if the Health Plan has relationship with an individual who is an affiliate of such an individual, DHS may not renew or extend the existing agreement with the Health Plan unless the Secretary of DHHS provides to DHS and to Congress a written statement describing compelling reasons that exist for renewing

or extending the agreement despite the prohibited affiliation.

4. If DHS learns that the Health Plan has a prohibited relationship with an individual or entity that is excluded from participation in any Federal healthcare program under Section 1128 or 1128A of the Act, DHS may not renew or extend the existing agreement with the Health Plan unless the Secretary provides to DHS and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliation.

14.8 Conflict of Interest

A. The following is added to the end of General Condition 1.7, Conflicts of Interest:

1. 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 HRS §84, Standards of Conduct.

2. The Health Plan shall not contract with the State of Hawaii unless the conflict of interest safeguards described in 42 CFR §438.58 and in Section 27 of the Office of Federal Procurement Policy Act (41 USC §423) are in place and complies with the requirement described in Section 1902 (a)(4)(c) of the Social Security Act, applicable to contracting officers, employees, or independent contractors.

14.9 Employment of State Personnel

A. 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.

14.10 Fiscal Integrity

B. Warranty of Fiscal Integrity

1. As described in Section 1, a Health Plan shall have financial stability and viability when submitting its proposal. After contract execution, the Health Plan shall continue to warrant that it is of sufficient financial solvency to ensure 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. The Health Plan shall provide financial data and information to prove its financial solvency upon request by DHS within ten (10) days.

C. Performance Bond

1. 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 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.

2. The amount of the performance bond shall be adjusted at the time the Members begin enrolling in the plan. At that time, the amount of the performance bond shall approximate eighty (80) percent 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.

3. The Health Plan may, in place of the performance bond, provide the following in the same amount as the performance bond:

    a. Certificate of deposit, share certificate, or cashier's, treasurer's, teller's or official check, or a certified check made payable to State of Hawaii, DHS, 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 shall be issued by different financial institutions.

    b. Letter of credit with a bank insured by the FDIC with State of Hawaii, DHS designated as the sole payee.

4. 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 DHS shall have the authority to, retain funds for additional costs including, but not limited to:

   a. Any costs for a special plan change period necessitated by the termination of the Contract;

   b. Any costs for services provided prior to the date of termination that are paid by DHS;

   c. Any additional costs incurred by the State due to the termination; and

   d. Any sanctions or penalties owed to DHS.

14.11 Term of the Contract

A. This is a multi-term contract solicitation that has been deemed to be in the best interest of the State by the Director of DHS in accordance with HAR §3-149-302(c). The Contract is for the initial term from the date of commencement of services to the Members as specified in §1.5 to December 31, 2026. The Contract may be extended without the necessity of re-bidding, for not more than three (3) additional twelve (12) month periods or parts thereof, and only upon mutual agreement of the parties in writing. The Health Plan shall not contract with the State of Hawaii unless safeguards at least equal to Federal safeguards (41 USC 423) are in place.

B. 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.

C. The Contract will be terminated 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. If this Contract is terminated because funds are not appropriated, then the Health Plan shall be reimbursed for the unamortized, reasonably incurred, and non-recurring costs.

D. 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, as allowed by law.

14.12 Liability Insurance Requirements

A. Liability Insurance Requirements Generally

1. The Health Plan shall maintain insurance acceptable to DHS in full force and effect throughout the term of this Contract, until DHS certifies that the Health Plan's work has been completed satisfactorily.

2. Prior to or upon execution of the Contract and any supplemental contracts, the Health Plan shall provide to DHS certificate(s) of insurance, including any referenced endorsements, dated within thirty (30) days of the effective date of the Contract necessary to satisfy DHS that the insurance provisions of this Contract have been complied with. Upon request by DHS, Health Plan shall furnish a copy of the policy(ies) and/or updated Certificate of Liability Insurance including referenced endorsement(s) necessary for DHS to verify the coverages required by this section.

3. 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 HRS §431:8-301, et seq., if utilizing an insurance company not licensed by the State of Hawaii.

4. The policy(ies) shall provide at least the limit(s) and coverage detailed in Table 10: 14.12.A below:

Table 10: 14.12.A. Insurance Coverage

Coverage	Limits
Commercial General Liability	Per occurrence, not claims made • $1 million per occurrence • $2 million in the aggregate
Automobile	May be combined single limit: • Bodily Injury: $1 million per person, $1 million per accident • Property Damage: $1 million per accident
Workers Compensation/ Employers Liability (EL)	• Workers Comp: Statutory Limits • EL each accident: $1,000,000 • EL disease: $1,000,000 per employee, $1,000,000 policy limit • EL $1 million aggregate
Professional Liability, if applicable	May be claims made: • $1 million per claim • $2 million annual aggregate

5. Each insurance policy required by this Contract shall contain the following clauses, which shall also be reflected on the certificate of Insurance, applicable to the commercial general liability and automobile insurance coverage:

   a. "The State of Hawaii is an additional insured with respect to operations performed for the State of Hawaii." "Any insurance maintained by the State of Hawaii shall apply in excess of, and not contribute with, insurance provided by this policy."

6. Automobile liability insurance shall include excess coverage for the Health Plan's employees who use their own vehicles in the course of their employment.

7. The Health Plan shall immediately provide written notice to DHS should any of the insurance policies required under the Contract be cancelled, limited in scope, or not be renewed upon expiration.

8. 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 DHS to exercise any or all of the remedies provided in this Contract for a default of the Health Plan.

9. The procuring of such required policy or policies of insurance shall not be construed to limit the Health Plan's liability hereunder nor to fulfill the indemnification provisions and requirements of this Contract. Notwithstanding said policy or policies of insurance, the Health Plan shall be liable for the full and total amount of any damage, injury, or loss caused by the

Health Plan in connection with this Contract.

10. If the Health Plan is authorized by 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.

B. Waiver of Subrogation

1. Health Plan shall agree by entering into a contract with DHS to provide a Waiver of Subrogation for the Commercial General Liability, Automobile Liability, and Workers Compensation policies. When required by the insurer, or should a policy condition not permit the Health Plan to enter into a pre-loss agreement to waive subrogation without an endorsement, the Health Plan shall agree to notify the insurer and request the policy be endorsed with a Waiver of Subrogation in favor of DHS. This Waiver of Subrogation requirement shall not apply to any policy, which includes a condition specifically prohibiting such an endorsement, or voids coverage should Health Plan enter into such an agreement on a pre-loss basis.

14.13 Modification of Contract

A. The following is added as General Condition 4.1.4:

1. All modifications of the Contract may be negotiated and accompanying capitated rates established. Such modifications shall result in a supplemental change, included in the amended contract agreement, produced by DHS and delivered to the Health Plan.

2. If the Health Plan agrees with the supplemental change, then the amended contract agreement shall be signed by an authorized representative of the Health Plan and returned to DHS for signature by the Director of DHS.

3. If the Health Plan is unable to reach an agreement within thirty (30) days of the Health Plan's receipt of the amended contract agreement, the provisions of such supplemental change will be deemed to have been accepted on the thirty-first (31st) day after the Health Plan received the amended contract agreement, even if the amended contract agreement has not been signed by the Health Plan, unless within the thirty (30) days after the Health Plan received the amended contract agreement, the Health Plan notifies DHS in writing that it refuses to sign the amended contract agreement. If the Health Plan provides such notification, DHS will initiate termination proceedings.

14.14 Conformance with Federal Regulations

A. Any provision of the Contract that conflicts with Federal Medicaid statutes, regulations, or CMS policy guidance, is superseded to conform to the provisions of those laws, regulations, and federal policy. Changes shall be effective on the effective date of the statutes or regulations necessitating it, and shall be binding on the parties even though an amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

14.15 Conformance with State Regulations

A. Should any part of the scope of work under this Contract relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn

federal authority, or which is the subject of a legislative repeal), the Health Plan shall do no work on that part after the effective date of the loss of program authority. DHS shall adjust capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law. If the Health Plan works on a program or activity no longer authorized by law after the date the legal authority for the work ends, then the Health Plan will not be paid for that work. If DHS paid the Health Plan in advance to work on a no-longer-authorized program or activity and under the terms of this Contract the work was to be performed after the date the legal authority ended, then the payment for that work should be returned to DHS. However, if the Health Plan worked on a program or activity prior to the date legal authority ended for that program or activity, and DHS included the cost of performing that work in its payments to the Health Plan, then the Health Plan may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

14.16. Termination of Contract

A. DHS may terminate the Contract for the reasons in the General Conditions in Appendix E, and for any of the following reasons:

   1. Termination for Default;

   2. Termination for Expiration or Modification of the Programs by CMS; or

   3. Termination for Bankruptcy or Insolvency.

B. Termination for Default

   1. The failure of the Health Plan to comply with any term, condition,

or provision of the Contract or applicable requirements in Sections 1932, 1903(m) and 1905(t) of the Social Security Act shall constitute default by the Health Plan. In the event of default, DHS shall send a potential termination notification to the Health Plan by certified or registered mail, with return receipt requested, as well as regular mail, 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. Regular mail is deemed received two (2) days after mailing. 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, 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. Nothing in this provision preclude DHS from terminating the Health Plan under General Condition 4.3 in Appendix E.

2. 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. Termination for Default does not preclude DHS from seeking any remedies under §14.21.

C. Termination for Expiration or Modification of the Programs by CMS

1. DHS may terminate performance of work under the Contract in whole or in part whenever, for any reason, including if CMS terminates or modifies the programs. In the event that CMS

elects to terminate its agreement with DHS, DHS shall notify the Health Plan by certified or registered mail, return receipt requested, as well as regular mail. Regular mail is deemed received two (2) days after mailing. The termination shall be effective as of the date specified in the notice. The Health Plan shall cooperate with DHS to effect in an orderly transition of services to the Members.

D. Termination for Bankruptcy or Insolvency

1. In the event that the Health Plan ceases to conduct business in the normal course, becomes insolvent, makes a general assignment for the benefit of creditors, suffers or permits the appointment of a receiver for its business or its assets or avails itself of, or becomes 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, DHS may, terminate the Contract. If the Health Plan becomes subject to any proceeding under the Federal Bankruptcy Act, then it shall provide DHS with copies of the bankruptcy filing within two (2) business days of the filing or of the receipt of the filed bankruptcy documents.

2. In the event 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, as well as regular mail. Regular mail is deemed received two (2) days after mailing. The termination shall be effective as of the date specified in the notice.

3. In the event of insolvency of the Health Plan, the Health Plan shall cover continuation of services to the Members for the

duration of period for which payment has been made, as well as for inpatient admissions up until discharge. The Members shall not be liable for the debts of the Health Plan. In addition, in the event of insolvency of the Health Plan, the Members may not be held liable for the Covered Services provided to the Member for which the State does not pay the Health Plan.

4. If DHS terminates under this provision then the Health Plan shall cooperate with DHS to effect in an orderly transition of services to the Members.

E. Procedure for Termination

1. In the event the State decides to terminate the Contract, 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.

2. In the event of any termination, the Health Plan shall:

   a. Stop work under the Contract on the termination date and to the extent specified in the notice of termination;

   b. Complete the performance of such part of the work as shall not have been terminated by the termination date;

   c. 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 DHS that are necessary to transition the Health Plan’s Members to another Health

Plan;

d. Promptly supply all information necessary for the reimbursement of any outstanding claims;

e. 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;

f. Terminate all orders and subcontracts to the extent that they relate to the performance of work terminated by the notice of termination;

g. At DHS request, assign to DHS in the manner and to the extent directed by the MQD Administrator the right, title, and interest of the Health Plan under the orders or subcontracts so terminated, in which case 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;

h. 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;

i. 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 DHS has or may acquire an interest;

j. Within thirty (30) business days from the effective date of the termination, deliver to 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 DHS. The Health Plan agrees that DHS or its designee shall have a non-exclusive, royalty-free right to the use of any such documentation; and

k. Submit one hundred (100) percent of encounter data no later than fifteen (15) months following the end of the Contract term.

3. 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 DHS for review and approval in accordance with §13.3.B.

F. Termination Claims

1. 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.

2. 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.

3. The Health Plan shall be paid only the following upon termination:

   a. At the Contract price(s) for the number of the Members enrolled in the Health Plan at the time of termination; and

   b. At a price mutually agreed to by the Health Plan and DHS.

4. In the event the Health Plan and 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 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.

5. The Health Plan shall have the right to appeal any such determination made by the MQD Administrator as stated in §14.19.

14.17 Confidentiality of Information

A. In addition to the requirements of General Condition 8, the Health Plan understands that the use and disclosure of information concerning applicants, beneficiaries or the Members is restricted to purposes directly connected with its performance under the Contract and the administration of the Hawaii Medicaid program, and agrees to guard the confidentiality of an applicant's, Member's or the 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:

1. 42 CFR Part 431, Subpart F;
2. The Administrative Simplification provisions of HIPAA and the regulations promulgated thereunder, including but not limited to the Security and Privacy requirements set forth in 45 CFR Parts 160 and 164; HRS §346-10; and
3. All other applicable federal and State statutes and administrative rules, including but not limited to:
    a. HRS §325-101, relating to persons with HIV/AIDS;
    b. HRS §334-5, relating to persons receiving mental health services;
    c. HRS §577A, relating to emergency and family planning services for minor females;
    d. 42 CFR Part 2 relating to persons receiving substance abuse services;
    e. HRS §487J, relating to social security numbers; and

f. HRS §487N, relating to personal information.

g. Session Laws of Hawaii, Act 139(16), relating to insurance.

4. Access to the 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 DHHS), the Secretary, DHS, and other individuals or entities as may be required by DHS. (See 42 CFR §431.300, et seq. and 45 CFR Parts 160 and 164.)

5. 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 PHI is performed in compliance with the HIPAA Privacy Rule.

6. 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 HAR Chapter 17-1702 shall apply to the Health Plan to the same extent as they apply to DHS.

7. 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 the Members.

8. Health Plans are business associates of DHS as defined in 45 CFR §160.103, and agree to the terms of the BAA found in Appendix F.

14.18 Audit Requirements

A. The State and Federal standards for audits of DHS designees, contractors and programs conducted under contract are applicable to this subsection and are incorporated by reference into the Contract. DHS, the HHS, the Secretary, CMS, the Office of the Inspector General, the Comptroller General, and their designees may, at any time, inspect and audit any records, inspect the premises, physical facilities, and equipment of the Health Plan and its Subcontractors, Subcontractor's contractors, or providers where Medicaid-related activities or work is conducted. There shall be no restrictions on the right of the State or Federal government to conduct whatever inspections and audits are necessary to ensure quality, appropriateness or timeliness of services and reasonableness of their costs. The right to audit shall exist for ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later.

B. Accounting Records Requirements

1. 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.

2. 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. The Health Plan shall submit audited financial reports specific to this Contract to DHS annually. The audit shall be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards.

C. Inclusion of Audit Requirements in Subcontracts

1. The provisions of §14.18, and its associated subsections shall be incorporated in every subcontract/Provider agreement.

14.19 Ongoing Inspection of Work Performed

A. DHS, the State Auditor of Hawaii, the U.S. DHHS Secretary, CMS, the General Accounting Office (GAO), the Comptroller General of the United States, OIG, MFCU of the Department of the Attorney General, State of Hawaii, or its authorized representatives shall have the right to enter into the premises of the Health Plan, all Subcontractors and providers, or such other places where duties under the Contract are being performed, to inspect, monitor, or otherwise evaluate the work being performed and have access to all records. All inspections and evaluations shall be performed in such a manner to not unduly delay work. This includes timely and reasonable access to the personnel for the purpose of interview and discussion related to the records. All records and files pertaining to the Health Plan shall be located in the

State of Hawaii at the Health Plan's principal place of business or at a storage facility on Oahu that is accessible to the foregoing identified parties.

14.20 Disputes

A. The parties shall first attempt to resolve all disputes arising under this Contract by informal resolution. Where informal resolution cannot be reached, the Health Plan shall submit a written request for dispute resolution (by certified mail, return receipt requested) to the Director of DHS or the Director's duly authorized representative. The Health Plan shall be afforded the opportunity to be heard and to present evidence in support of its position in the dispute. The Director of DHS or the Director's authorized representative shall issue a written decision within ninety (90) days of the Health Plan's written request. The decision of the Director of DHS or the Director's authorized representative shall be final and binding and may only be set aside by a State court of competent jurisdiction where the decision was fraudulent, capricious, arbitrary, or grossly erroneous as to imply bad faith.

B. The Health Plan shall proceed without undue delay in the performance of the Contract in accordance with the Director's final decision while any subsequent legal proceeding is pending.

C. Any legal proceedings against the State of Hawaii regarding this RFP or any resultant contract shall be brought in a state court of competent jurisdiction in the City and County of Honolulu, State of Hawaii.

D. This dispute resolution section does not apply to the appeals of sanctions imposed under §14.21.F.

14.21 Remedies for Non-Performance of Contract

A. Understanding and Expectations

1. The Health Plan shall comply with all terms, conditions, requirements, performance standards and applicable State and Federal laws as set forth in this Contract or any amendments thereto including any rules, policies, or procedures incorporated pursuant to this Contract.

2. DHS reserves the right to seek any legal or equitable remedy for any violation of the Contract or non-compliance with State or Federal law or regulation by the Health Plan or its Subcontractors.

a. Risk Categories

1) DHS may conduct performance reviews at its discretion at any time that relate to any Health Plan responsibility for timely and responsive performance of Contract requirements. Based on such performance reviews or as determined through other means, upon the discovery of a Health Plan's or Subcontractor's violation or non-performance of the terms, conditions, or requirements of this Contract, DHS shall assign the violation or non-performance into one of the following categories of risk:

a) Category 1: Action(s) or inaction(s) that jeopardize the health, safety, and welfare of the Members(s); reduces the Members' access to care; and/or jeopardize the integrity or viability of Hawaii's Medicaid managed care program;

b) Category 2: Action(s) or inaction(s) that jeopardize the integrity or viability of Hawaii's Medicaid managed care program, but do(es) not necessarily jeopardize the Member(s') health, safety, and welfare or reduce access to care; or

c) Category 3: Action(s) or inaction(s) that diminish the efficient operation and effective oversight and administration of Hawaii's Medicaid managed care program.

b. Remedial Considerations

1) If any of the Health Plan's performance under the contract does not conform to the Contract requirements, then DHS may pursue remedies for correcting violations or non-performance. At any time and at its sole discretion, DHS may impose or pursue one or more remedies for each violation or item of non-performance. DHS may impose additional remedies if the Health Plan fails to comply with the originally imposed remedy. DHS will consider some or all of the following factors in determining the need to impose remedies against the Health Plan as set forth in §14.21.B through §14.21.I below:

a) Risk category;

b) The nature, severity, and duration of the violation, breach, or non-performance;

c) The type of harm suffered (e.g., impact on the quality of care, access to care, Program Integrity);

d) Whether the violation or non-performance (or one

that is substantially similar) has previously occurred;

e) The timeliness in which the Health Plan self-reports a violation, breach or non-performance;

f) The Health Plan's history of compliance;

g) The good faith exercised by the Health Plan in attempting to stay in compliance (including self-reporting by the Health Plan); and

h) Any other factor DHS deems relevant based on the nature of the violation or non-performance.

B. Notice of Concern and Opportunity to Cure

1. Should DHS determine that the Health Plan or a Subcontractor is in violation or non-performance of any requirement of the Contract, DHS may issue a "Notice of Concern" prior to the imposition of remedies against the Health Plan as set forth in §14.21.C through §14.21.I.

2. DHS will provide the Health Plan with the written Notice of Concern detailing the nature of the violation or non-performance, the assigned Risk Category, any action DHS seeks to impose against the Health Plan, and, if applicable, the method and timeframes by which the Health Plan may dispute the claim of violation or non-performance and the imposed actions.

3. The Health Plan shall within ten (10) business days (or another date approved by DHS) of receipt of the written Notice of Concern, provide DHS a written response that:

a. Explains the reasons for the deficiency, the Health Plan's plan to remediate the violation or non-performance, and the

date and time by which the violation or non-performance will be cured; or

b. If the Health Plan disagrees with DHS' findings, its reasons for disagreeing with those findings.

4. If the Health Plan fails to timely contact DHS regarding the Notice of Concern, DHS shall proceed to additional remedies contained in this Contract.

5. The Health Plan shall confirm in writing the date that the violation or non-performance was resolved and the actions the Health Plan took to remediate the deficiency(ies).

6. The Health Plan's proposed cure is subject to the approval of DHS.

C. Corrective Action Plan

1. Should DHS determine that the Health Plan or a Subcontractor is in violation or non-performance of any requirement of the Contract, DHS may issue a Written Deficiency Notice to the Health Plan specifying the violation or non-performance, assigning a Risk Category, and requesting a Corrective Action Plan be filed by the Health Plan within ten (10) business days following the date of the Written Deficiency Notice. DHS reserves the right to require a more accelerated timeframe if the deficiency warrants a more immediate response.

2. The Corrective Action Plan shall provide the following information at a minimum:

a. The names of the individuals who are responsible for implementing the Corrective Action Plan.

b. A description of the deficiency(ies) and the cause of the deficiency(ies) that resulted in need for Corrective Action.

c. A detailed approach for addressing the existing deficiency(ies) and prevention of the repeated and/or similar deficiency(ies) in the future.

d. The timeline for implementation, establishment of major milestones and correspondence dates to the Department, and notification of completion of Corrective Actions.

3. The Corrective Action Plan shall be submitted by the deadline set forth in DHS request for a Corrective Action Plan.

4. The Corrective Action Plan shall be subject to approval by DHS, which may accept the Corrective Action Plan as submitted, may accept the Corrective Action Plan with specified modifications, or may reject the Corrective Action Plan in full within ten (10) business days of receipt.

5. DHS may extend or decrease the timeframe for Corrective Action depending on the nature of the specific deficiency.

6. The Health Plan shall update the Corrective Action Plan on an ongoing basis and report progress to DHS on a frequency to be determined by DHS.

7. Notwithstanding the submission and acceptance of a Corrective Action Plan, the Health Plan remains responsible for achieving all written performance criteria.

8. DHS' acceptance of a Corrective Action Plan under this section will not:

a. Excuse the Health Plan's prior substandard performance;

b. Relieve the Health Plan of its responsibility to comply with

c. performance standards; or

d. Prohibit DHS from assessing additional remedies or pursuing other appropriate remedies for continued substandard performance.

D. Administrative Actions

1. At its discretion and based on the Risk Category, DHS may impose one or more of the following remedies for each item of violation or non-performance and will determine the scope and severity of the remedy on a case-by case basis:

   a. Conduct accelerated monitoring of the Health Plan. Accelerated monitoring includes more frequent or more extensive monitoring by DHS or its agent;

   b. Require additional, more detailed, financial and/or programmatic reports to be submitted by the Health Plan; or

   c. Require additional and/or more detailed financial and/or programmatic audits or other reviews of the Health Plan.

E. Liquidated Damages

1. Should DHS determine that the Health Plan or a Subcontractor is in violation or non-performance of any requirement of the Contract, and said failure results in damages that can be measured in actual cost, DHS will assess the actual damages warranted by said failure.

2. The Health Plan acknowledges that its failure to complete the tasks, activities and responsibilities set forth in Appendix G,

Liquidated Damages will cause DHS substantial damages of types and in amounts which are difficult or impossible to ascertain exactly. DHS and the Health Plan further acknowledge and agree that the specified liquidated damages in Appendix G, are the result of a good faith effort by the parties to estimate the actual harm caused by the Health Plan's failure to meet requirements under the Contract.

3. DHS and the Health Plan further acknowledge and agree that the liquidated damages referenced in Appendix G, are not intended to be in the nature of a penalty, but are intended to be reasonable estimates of DHS projected financial loss, approximate costs of obtaining alternative medical benefits for its Members and damage resulting from: the Health Plan's non-performance, including financial loss as a result of project delays, of the activities and responsibilities described in Appendix G; or the Health Plan's failure to timely submit the deliverables described therein. As applicable, 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.

4. The Health Plan acknowledges, affirms, ratifies, and agrees that the damage provisions set forth herein meet the criteria for enforceable damages that are reasonable, appropriate, and necessary. Liquidated damages shall be in addition to any other remedies that DHS may have. Accordingly, DHS reserves the right to seek all other reasonable and appropriate remedies available at law and in equity.

5. If the Health Plan commits any of the violations or fails to meet

the requirements set forth in Appendix G, the Health Plan shall submit a written Corrective Action Plan to DHS as set forth in §14.21.C. In addition, the Health Plan may be subject to Administrative Actions as described in §14.21.D.

6. The Health Plan shall agree to or provide evidence acceptable to DHS to challenge the reimbursement to the State for actual damages or the amounts set forth as liquidated damages within thirty (30) days.

7. DHS will notify the Health Plan in writing of the proposed damage assessment. At the Department's sole discretion, DHS may require the Health Plan to remit the actual or liquidated damages within thirty (30) days following the notice of assessment or resolution of any dispute or DHS may be deduct from any fees, capitation payments or other payments to the Health Plan until such damages are paid in full.

8. 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 violation or breach of the Contract.

F. Sanctions

1. DHS may impose sanctions for non-performance or violations of Contract requirements if DHS determines that a Health Plan acts or fails to act as follows:

   a. Fails substantially to provide services based on Medical Necessity that the Health Plan is required to provide, under law or under its contract with the State, to a Member covered under the Contract.

   b. Imposes on Members premiums or charges that are in

excess of the premiums or charges permitted under the Medicaid program.

c. Acts to discriminate among Members on the basis of their health status or need for healthcare services. This includes termination of enrollment or refusal to reenroll a Member, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage Enrollment by Members whose medical condition or history indicates probable need for substantial future medical services.

d. Misrepresents or falsifies information that it furnishes to CMS or to the State.

e. Misrepresents or falsifies information that it furnishes to a Member, potential Member, or Healthcare Provider.

f. Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in §§422.208 and 422.210 of this chapter.

g. Has distributed directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the State or that contain false or materially misleading information.

h. Has violated any of the other requirements of sections 1903(m) or 1932 of the Act, or any implementing regulations.

2. Sanctions shall be determined by the State and may include:

a. Imposing civil monetary penalties in accordance with 42 CFR

§438.704 and as described in §14.21.F.6;

b. Suspending enrollment of new Members with the Health Plan;

c. Suspending payment to the Health Plan after the effective date of the sanctions and until CMS or DHS is satisfied that the reason for imposition of the sanctions no longer exists and is not likely to re-occur;

d. Notifying and allowing the Members to change Health Plans without cause;

e. Appointment of temporary management of the Health Plan (as described in §14.21.H);

f. Terminating the Contract (as described in §14.16);

g. Additional remedies allowed under State statutes or State regulations that address areas of non-compliance specified in 42 CFR §438.700;

h. Referral to appropriate State licensing agency for investigation; and

i. Referral to the Department of the Attorney General or other appropriate legal authority for investigation.

3. DHS may impose a sanction and penalty under this Contract and may simultaneously request a Corrective Action Plan from the Health Plan as set forth in §14.21.C. In addition, the Health Plan may be subject to Administrative Actions as described in §14.21.D.
4. 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.

5. The civil or administrative monetary penalties imposed by DHS on the Health Plan shall not exceed the maximum amount established by federal statutes and regulations.

6. The civil monetary penalties that may be imposed on the Health Plan by the State are set forth in Table 11: 14.21.F, as follows:

Table 11: 14.21.F Civil Monetary Penalties

Number	Activity	Penalty
1	Misrepresentation of actions or falsification of information furnished to the CMS or the State	A maximum of one hundred thousand dollars ($100,000) for each determination
2	Acts to discriminate among Members on the basis of their health status or need for healthcare services	A maximum of one hundred thousand dollars ($100,000) for each determination
3	Failure to implement requirements stated in the Health Plan's proposal, the RFP or the Contract, or other material failures in the Health Plan's duties, including but not limited to failing to meet readiness review or performance standards	A maximum of fifty thousand dollars ($50,000) for each determination
4	Substantial failure to provide medically-necessary services that are required under law or under Contract, to an enrolled Member	A maximum of twenty-five thousand dollars ($25,000) for each determination
5	Imposition upon Members' premiums and charges that are in excess of the premiums or charges permitted under the Medicaid 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

Number	Activity	Penalty

		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 requirements of Sections 1903(m), 1905(t)(3) or 1932 of the Social Security Act and any implementing regulations	A maximum of twenty-five thousand dollars ($25,000) for each determination
8	Failure to comply with the requirements for physician incentive plans, as set forth in 42 CFR §§422.208 and 422.210	A maximum of twenty-five thousand dollars ($25,000) for each determination
9	Distribution, directly or indirectly through any agent or independent contractor, of marketing materials that have not been approved by the State in form in which distributed or that contain false or materially misleading information	A maximum of twenty-five thousand dollars ($25,000) for each determination
10	Failure to use DHS approved materials for marketing during APC	Loss of all auto-assignment for contract year for that Initial Enrollment or APC
11	Not enrolling a Member because of a discriminatory practice	A maximum of fifteen thousand dollars ($15,000) for each Member the State determines was not enrolled because of a discriminatory practice
12	Failure to resolve Member appeals and grievances within the time frames specified in Section 9.5.	A maximum of ten thousand dollars ($10,000) for each determination of failure
13	Failure to comply with the claims processing standard required in Section 7.2(A).	A maximum of five thousand dollars ($5,000) for each determination of failure
14	Failure to meet minimum compliance of provision of periodic screens to EPSDT eligible Members as described in Section 4.3	A maximum of five thousand dollars ($5,000) for each determination of failure

Number	Activity	Penalty

15	Failure to conduct an assessment or develop a service plan within the timeframe required in Section 3.	A maximum of five thousand dollars ($5,000) for each determination of failure
16	Failure to comply with staffing requirements as outlined in Section 11.	A maximum of five thousand dollars ($5,000) for each determination of failure
17	Failure to provide accurate information, data, reports and medical records, including behavioral health and substance abuse records to DHS under the Contract.	Two hundred dollars ($200) per day until all required information, data, reports and medical records are received
18	Failure to report confidentiality breaches relating to Medicaid applicants and recipients to DHS by the specific deadlines provided in Section 14.16.	One hundred dollars ($100) per day per applicant/recipient. A maximum of twenty-five thousand dollars ($25,000) until the reports are received

7. 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 §438.730.

8. If DHS elects not to exercise any of the sanction and penalty clauses as set forth in this Contract, this decision shall not be construed as a waiver of DHS' right to pursue the future assessment of that contractual or performance standard requirement and associated penalties.

G. Termination

1. Should DHS determine that the Health Plan or a Subcontractor is in violation or non-performance of any requirement of the Contract, DHS may terminate the Contract pursuant to §14.16.

H. Special Rules for Temporary Management

1. The sanction of temporary management may be imposed by the

State, as allowed or required by 42 CFR §438.706, if it finds that:

a. There is continued egregious behavior by the Health Plan, including, but not limited to, behavior that is described in 42 CFR §438.700, or that is contrary to any requirements of Sections 1903(m) and 1932 of the Social Security Act;

b. There is substantial risk to the Member's health; or

c. The sanction is necessary to ensure the health of the Health Plan's Members while improvements are made to remedy violations under 42 CFR §438.700 or until there is an orderly termination or reorganization of the Health Plan.

2. 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 may not delay imposition of temporary management to provide a hearing before imposing this sanction.

3. The State may not terminate temporary management until it determines that the Health Plan can ensure that the sanctioned behavior will not recur.

4. In the event the State imposes the sanction of temporary management, the Members shall be allowed to disenroll from the Health Plan without cause.

I. Administrative Reporting

1. DHS will give CMS written notice whenever it imposes or lifts a sanction based on requirements set forth in 42 CFR Subpart I – Sanctions. The notice will be given no later than thirty (30) days

after DHS imposes or lifts the sanction, and will specify the type of sanction, and the reason for the decision to impose or lift the sanction.

2. The Department may provide written notice to the Hawaii DCCA Insurance Division, when DHS assesses liquidated damages or imposes or lifts any sanctions against the Health Plan.

3. DHS, at its sole discretion, may post on its public website information regarding contractual remedies taken against Health Plans. Remedies include monetary and other forms of Corrective Action, including but not limited to, payment of liquidated damages, imposed sanctions, requiring Corrective Action Plans, suspending all or part of new Member enrollments, or suspending or terminating all or part of the Contract.

4. Such remedies may be posted by DHS at any time and contain the following information:

   a. Name and address of the Health Plan;

   b. A description of the contractual obligation the Health Plan failed to meet;

   c. The date of determination of non-compliance;

   d. The date the remedy was imposed;

   e. The maximum remedy that may be imposed under the Contract for the violation; and

   f. The actual remedy imposed against the Health Plan.

14.22 Compliance with Laws

A. In addition to the requirements of General Condition 1.3, Compliance

with Laws, the Health Plan shall comply with the following:

1. Wages, Hours and Working Conditions of Employees Providing Services

    a. Pursuant to Section HRS §103-55, 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 DHS. Final payment under the Contract shall not be made unless DHS has determined that the noncompliance has been corrected. The Health Plan shall complete and submit the Wage Certification provided in Appendix C.

2. Compliance with other Federal and State Laws

    a. The Health Plan shall agree to conform to the following federal and state laws as affect the delivery of services under the Contract including, but not limited to:

        1) Titles VI, VII, XIX, and XXI of the Social Security Act;

        2) Title VI of the Civil Rights Act of 1964;

        3) Title IX of the Education Amendments of 1972

(regarding education programs and activities);

4) The Age Discrimination Act of 1975;

5) The Rehabilitation Act of 1973;

6) The Americans with Disability Act of 1990 as amended;

7) The Patient Protection and Affordable Care Act of 2010, including Section 1557;

8) HRS §489 (Discrimination in Public Accommodations);

9) Education Amendments of 1972 (regarding education programs and activities);

10) Copeland Anti-Kickback Act;

11) Davis-Bacon Act;

12) Debarment and Suspension;

13) All applicable standards, orders or regulations issued under Section 306 of the Clean Air Act, as amended (42 USC 1857 (h)), Section508 of the Clean Water Act (33 USC 1368), Executive Order 11738, and Environmental Protection Agency regulations (40 CFR part 15) and the Federal Water Pollution Control Act, as amended (33 USC Section 1251, et seq.);

14) The Byrd Anti-Lobbying Amendment (31 USC Section 1352); and

15) 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 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor".

b. The Health Plan shall comply with any and all applicable Federal and state laws that pertain to the Member rights and ensure that its employees and contracted providers observe and protect those rights.

c. 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).

d. 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.

14.23 Miscellaneous Special Conditions

A. Use of Funds

1. 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.

B. Prohibition of Gratuities

1. 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.

C. Publicity

1. General Condition 6.1 is amended to read as follows: Acknowledgment of State Support. The Health Plan shall not use the State's, DHS', MQD's name, logo or other identifying marks on any materials produced or issued without the prior written consent of 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 DHS.

D. Force Majeure

1. 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.

2. Neither party to the Contract shall be responsible for delays or failures in performance resulting from acts beyond the control of such party.

3. Nothing in this section shall be construed to prevent 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.

E. Attorney's Fees

1. In addition to costs of litigation provided for under General Condition 5.2, in the event that DHS shall prevail in any legal action arising out of the performance or non-performance of the Contract, or in any legal action challenging a final decision under §14.20, the Health Plan shall pay, in addition to any damages, all of DHS' expenses of such action including reasonable attorney's fees and costs. The term "legal action" shall be deemed to include administrative proceedings of all kinds, as well as all actions at law or in equity.

F. Time is of the Essence

1. Time is of the essence in the Contract. As such, any reference to "days" shall be deemed calendar days unless otherwise specifically stated.

G. Health Plan request for waiver of contract requirements

1. Health Plans may request a waiver of operational contract requirements from DHS that are described in the RFP. Health Plans may submit this request in a format provided by DHS. DHS shall only approve a Health Plan's request for waiver of a contract requirement that does not adversely affect the outcome

of services that its Members receive, is consistent with State law and policy, and is allowable under federal and State authority. DHS reserves the right to revoke these waivers at any time upon written notice to the affected Health Plans. Whenever possible, DHS shall provide reasonable advance notice of any such revocation to allow the affected Health Plan(s) to make any necessary operational changes.

14.24 Transition Plan for Mergers

A. The Health Plan shall not assign or transfer any right or interest in this Contract to any successor entity or other entity that results from a merger of the Health Plan and another entity, without the prior written consent of DHS. The Health Plan shall include in such request for approval a detailed transition plan for DHS to review. The purpose of the transition plan review is to:

1. Ensure services to the Members are not interrupted or diminished;
2. Evaluate the new entity's staffing plan;
3. Evaluate the new entity's plan to support the Health Plan's provider network;
4. Ensure the new entity can pass a readiness review; and
5. Ensure DHS is not adversely affected by the assignment or transfer of this Contract.

SECTION 15 – Mandatory and Technical Proposal

15.1. Overview

A. The Health Plan shall comply with all content and format requirements for the technical proposal. The proposal shall be in a letter size format (8 ½" by 11"), one and a half (1.5) line spacing, and with text no smaller than 11-point Verdana font. For graphics and diagrams, text shall be no smaller than 10-point Verdana font. The pages shall have at least one-inch margins. All proposal pages shall be numbered and identified with the Health Plan's name and the respective evaluation category section.

B. The Health Plan shall answer all questions as part of the narrative in the order that they appear in each sub-section. The question shall be restated above the response. The maximum page numbers includes restating the question. The question may be stated single spaced with text no smaller than eleven (11) point Verdana font. All the referenced attachments shall be placed after the narrative responses for that sub-section of the Mandatory Requirements responses and each evaluation category of the Technical Proposal responses. Graphics, flowcharts, diagrams, and other attachments do not count toward the maximum page limits.

C. Any responses in excess of the maximum page limits shall not be reviewed. Any documentation not specifically requested shall not be reviewed. Providing actual policies and procedures in lieu of a narrative shall result in the Health Plan receiving the lowest rating score for that response.

D. The following sections describe the required content and format for the mandatory and technical proposals. These sections are designed

to ensure submission of information essential to understanding and evaluating the proposal.

E. The Health Plan shall submit a proposal that addresses all the provisions in this RFP for Oahu and all the neighbor islands.

15.2 Mandatory Requirements

A. Transmittal Letter

1. The transmittal letter shall be on official business letterhead and shall be signed by an individual authorized to legally bind the Health Plan. It shall include:

   a. A statement indicating that the Health Plan 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 type and percentage of work to be performed by the prime Health Plan and each Subcontractor, as measured as a percentage of the Health Plan's anticipated budget for the contract. If Subcontractors will not be used for this Contract, a statement to this effect shall be included;

   b. A statement that the Health Plan has an established provider network to serve Medicaid Members in the State of Hawaii or will have a provider network to serve Medicaid Members in the state of Hawaii before the Commencement of Services;

   c. A copy of the Health Plan's registration to do business as a Health Plan in the State of Hawaii;

   d. A copy of the Health Plan's State of Hawaii General Excise

Tax License;

e. A statement that the Health Plan's Hawaii Compliance Express information is current and provide a copy of the Certificate of Vendor Compliance conducted no later than seven (7) days prior to proposal submission;

f. A statement to certify that this proposal includes 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;

g. A statement attesting to the accuracy and truthfulness of all information contained in the Health Plan's responses to the RFP;

h. A statement of affirmative action that the Health Plan 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;

i. A statement that no attempt has been made or will be made by the Health Plan to induce any other party to submit or refrain from submitting a proposal;

j. A statement that the Health Plan read, understood, and is able and willing to comply with all provisions and requirements of this RFP;

k. A statement that, if awarded the contract, the Health Plan's organization shall deliver the goods and services meeting or exceeding the specifications in the RFP and amendments;

l. A certification by the person signing the Health Plan's proposal certifies that he/she is the person in the Health Plan's organization responsible for, or authorized to make, the offer firm and binding, and that he/she has not participated and shall not participate in any action contrary to the above conditions;

m. A statement that the Health Plan will follow all applicable laws and rules regarding the procurement process, including, but not limited to, HRS §103F and HAR Title 3, Subtitle 11, §§143 and 148;

n. A statement that the Health Plan understood that the terms of this RFP are self-contained and the Health Plan should not rely on information outside of this RFP in forming its proposal; and

o. A statement confirming the specific island(s) the Health Plan shall provide services to or whether the Health Plan shall provide services statewide (i.e., all islands).

2. The proposals are government records subject to public inspection, unless protected by law, and may include information that the Health Plan feels is confidential or proprietary. If any page is marked "Confidential" or "Proprietary" in the Health Plan's proposal, an explanation to DHS of how substantial competitive harm would occur if the information is released. If DHS determines that it is confidential or proprietary, then the information will be excluded from

disclosure to the public. By submitting a proposal, the Health Plan affirms its understanding that proposals are part of the procurement file and subject to public inspection under the

current law governing information practices after execution of a contract by all parties pursuant to HAR §3-143-616.

B. Company Background and Experience

1. The Health Plan shall provide the following information:

   a. The legal name of the Health Plan, including any names that the Health Plan has used or is using to do business under. Indicate the Health Plan's form of business, for example, corporation, non-profit corporation, partnership, etc.

   b. Federal and State Tax Identification Numbers.

   c. Address, telephone number, and email address of the Health Plan's headquarter office.

   d. Date the company was established and then began operations.

   e. Relationship to parent, affiliated and/or business entities and copies of management agreements with parent organizations.

   f. Organization chart of parent company and all Subcontractors.

   g. Detailed description of the Health Plan's organizational structure for this Contract, including an organizational chart that clearly displays the management structure, lines of responsibility, including dotted line responsibility, and authority for all operational areas of this Contract.

      1) Per §11.2.H.2.e, a description of the proposed Health Coordination Team.

h. Names, addresses, and contact information for all officers, directors, and partners.

i. Provide copies of the Health Plan's articles of incorporation, bylaws, partnership agreements, or similar business entity documents, including any legal entity have an ownership interest of five (5) percent or more.

j. The size and resources, including the gross revenues both in Hawaii and nationally, if applicable.

k. Total current number of employees both in Hawaii and nationally, if applicable.

l. Provide the following information for the Health Plan and any Subcontractors that are providing Covered Services. Information should be in order of most to least current. The Health Plan may exclude workers' compensation cases:

    1) Using Table 12: 15.2.B, below, list pending or recent litigation within the past three (3) calendar years (2018 through 2020) against the Health Plan where the amount in controversy or the damages sought or awarded is $1 million or more and/or is due to the Health Plan's or Subcontractor's failure to provide timely, adequate, or quality Covered Services. The Litigation Events table is provided in Appendix I. The Health Plan shall complete all items in the table for each pending or recent litigation. Completed tables shall not be counted toward the Health Plan's total page limits.

Table 12: 15.2.B. Litigation Events

Disclosure of Pending or Recent Litigation	Vendor Details

Date litigation brought against Entity including case title and case ID	
Name of Entity (Health Plan or Subcontractor)	
Type of Contract and Contracting Entity (e.g., full risk managed care contract with State of Hawaii DHS, etc.)	
Describe nature of litigation, including action leading to the litigation.	
Indicate amount of damages sought or awarded.	
Does the pending or recent litigation have the potential to or will impair your organization's performance in a Hawaii Medicaid managed care Contract? Please explain if "yes."	
Indicate the status of the litigation.	
Indicate outcome of litigation, if resolved.	

2) Any Securities Exchange Commission filings discussing any pending or recent litigation.

m. For the Health Plan, list and describe any confirmed PHI breaches within the past three (3) calendar years (2018 through 2020), both in and out of Hawaii that have occurred and the Health Plan's response to the breach (e.g., Member notification, payment of fines, free credit reporting, etc.). Do not include items excluded per 45 CFR §164.402. The Health Plan shall complete all items for each breach incident as detailed in Table 13: 15.2.B below. Completed tables shall not be counted toward the Health Plan's total page limits.

n. Using the below table, list PHI breaches within the past three (3) calendar years (2018 through 2020). The PHI Breach Events table is listed in Appendix J. The Health Plan shall complete all items in the table for each PHI breach Information and in the order of most to least current.

Table 13: 15.2.B. PHI Breach Events

Date of Breach	Location of breach (State or States)	Did the breach result in the exposure of PHI?	Where did the exposure occur? (i.e. internal, Subcontractor, etc.)	How many Members' data were included in the breach?	How many total records of data were breached?	To what extent was the breached data seen or used?	What steps were taken to mitigate the breach?

o. The Health Plan shall provide evidence of its current NCQA accreditation status for Medicaid, including a copy of its current certificate of accreditation with a copy of the complete accreditation survey report, including scoring of each category, standard, and element levels, and recommendations, as presented via the NCQA Interactive Review Tool.

p. Provide an attestation to whether the Health Plan has ever had its accreditation status (e.g., NCQA, URAC, or Accreditation Association for Ambulatory Health Care, etc.) in any state for any product line adjusted down, suspended, or revoked. If so, identify the state and product line and provide an explanation.

q. Provide a listing of Medicaid managed care contracts both in and out of Hawaii held in the past three (3) years for which the Health Plan has:

    1) Voluntarily terminated all or part of the contract under which it provided healthcare services as the licensed entity.

    2) Had such a contract partially or fully terminated before the contract end date, with or without cause.

r. Describe the Health Plan's experience in operating a D-SNP including a description of the Health Plan's experience aligning administrative processes across Medicare and Medicaid to create a seamless system for dual eligible Members. Describe the Health Plan's experience using Medicare and Medicaid data to coordinate, track, and report on care provided across programs.

C. Understanding of Healthcare in Hawaii

1. The Health Plan shall provide a statement of understanding of the healthcare environment and challenges in Hawaii, the DHS Medicaid program, and the needs of Medicaid Members. This understanding shall address healthcare, geographic and cultural disparities in Hawaii.

D. Other Documentation

1. The Health Plan shall attach, in the following order, completed forms provided in Appendix C:

a. The Proposal Application Identification form (Form SPO-H-200);

b. The State of Hawaii DHS Proposal Letter*;*

c. The Certification for Contracts, Grants, Loans, and Cooperative Agreements form;

d. The Disclosure Statement (CMS required) form;

e. Disclosure Statement;

f. The Disclosure Statement (Ownership) form;

g. The Organization Structure and Financial Planning form;

h. The Financial Planning form;

i. The Controlling Interest form;

j. The Background Check Information form;

k. The Operational Certification Submission form;

l. The Grievance and Appeal System form;

m. Health Plan's Proof of Insurance;

n. The Wage Certification form;

o. The Standards of Conduct Declaration form;

p. The State and Federal Tax Clearance certificates from the prime Health Plan 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 §1.11;

q. Proof of its current license to serve as a Health Plan in the State of Hawaii. A letter from the Insurance Division notifying the Health Plan of its license shall be acceptable "proof" for DHS; and

r. Certificate of Compliance from the State of Hawaii, DCCA Insurance Division.

E. Risk-Based Capital Report

1. The Health Plan shall provide the most recently completed risk-based capital report following the National Association of Insurance Commissioner's risk-based capital report

instructions.

15.3 Technical Proposal

A. The Health Plan should submit all materials as specified in this section in the order in which the information is requested. DHS assumes no responsibility for knowledge of any material that is not presented in accordance with DHS instructions. Unless requested in the technical proposal question, self-promotional materials will not be reviewed or evaluated.

B. DHS shall evaluate the proposals by assigning scores as indicated in Section 16. All the following categories shall include the Health Plan's experience in Hawaii. If the Health Plan does not have experience in Hawaii, the Health Plan shall provide its experience in comparable state Medicaid managed care programs.

C. The Health Plan's responses to the following evaluation categories shall be limited to the total page limit indicated in each evaluation category. The total page limit excludes graphics, exhibits, flowcharts, diagrams, or other attachments.

1. Evaluation Category 1 – Care Delivery and Health Coordination. Total Page Limit for §15.3.C.1: Twenty (20) pages.

    a. Describe the Health Plan's unique approach to utilizing a multi-disciplinary team to provide primary care and behavioral health services across the continuum of HCS, including how the Health Plan will engage the Members in their HAP, and how the Health Plan will implement and monitor the HAP. (Limit to five [5] pages)

    b. Describe the Health Plan experience and innovations to meet

and monitor the behavioral health needs of the Members receiving HCS. (Limit to four [4] pages)

c. Describe the Health Plan's experience and innovations for Health Coordination of LTSS, including using person-centered outreach, engagement, and planning; and empowering individual initiative, autonomy, and independence in making life choices. The Health Plan's response shall address how it will support individual choice in designing and receiving LTSS and promote the Member's full access to their greater community, including opportunities to seek employment and work, engage in community life, and manage their own resources. (Limit to seven [7] pages)

d. Describe the Health Plan's experience and innovations in providing Health Coordination for people experiencing homelessness or at risk of homelessness. Include the Health Plan's experience and innovations coordination with community based homeless services organizations, and in providing CIS, CTS or similar services. (Limit to four [4] pages)

2. Evaluation Category 2 – Covered Benefits and Services. Total Page Limit for §15.3.C.2: Eighteen (18) pages.

a. Describe the Health Plan's experience, innovative approaches providing covered benefits and services, as described in Section 4. The response shall specifically include:

1) Addressing the needs of the unique populations of Hawaii, including Native Hawaiians and Hawaii

residents from Micronesian Nations under the Compact.

2) Approaches to providing EPSDT services.

(Limit to eight [8] pages)

b. Describe the Health Plan's experience, innovative strategies, and comprehensive approach to providing prevention and health promotion services such as lifestyle classes, self-management and education classes, and smoking cessation services, with emphasis on populations for whom standard outreach and engagement strategies are less effective.

(Limit to five [5] pages)

c. Value-Added Services

1) The Health Plan may propose to offer value-added services. For each service proposed, provide the following:

a) Describe the service, including information on who is eligible to receive the service, and the proposed timeframe for implementation.

b) Describe the expected impact in terms of cost savings, and perceived qualitative value of the service.

c) Describe the Health Plan's proposed method(s) of outreach to increase awareness and utilization of the value-added service.

(Limit to five [5] pages)

3. Evaluation Category 3 – Quality, Utilization Management, and

Administrative Requirements. Total Page Limit for §15.3.C.3: Ten (10) pages.

a. The Health Plan shall describe its experience and proposed innovative approaches to the following:

    1) Supporting and evaluating Providers in conducting quality improvement activities;

    2) Increasing the rate of high-value care and reducing variation from evidence-based standards; and

    3) Leveraging PIPs to support wide-scale adoption of successful practices.

    (Limit to seven [7] pages)

b. Utilization Management. The Health Plan shall:

    1) Provide an attestation agreeing to collaborate with other Health Plans contracted with DHS in the development and implementation of an innovative and streamlined UM protocol for Providers.

    2) Provide a workflow for Utilization Management that depicts the process from the initial receipt of a request to final disposition. (Workflow diagram not included in page limit.)

    3) Describe successful strategies the Health Plan has used to minimize Provider burden in seeking prior authorizations for services, and the extent to which each strategy has resulted in reduced Provider burden.

    (Limit to three [3] pages)

4. Evaluation Category 4 – Health Plan Reporting and Encounter Data. Total Page Limit for §15.3.C.4: Five (5) pages.

   a. The Health Plan shall describe one or more reports it has generated, either for internal purposes or for submission to DHS that the Health Plan found to be instrumental in identifying and addressing an issue that impacted access to and/or quality of services provided to its Members or Providers. For each report included, briefly describe the issue identified, how it was resolved, and what data was reviewed to identify and ensure resolution of the issue.

5. Evaluation Category 5 – DHS and Health Plan Financial Responsibilities. Total Page Limit for §15.3.C.5: Thirteen (13) pages.

   a. Incentive Strategies for Health Plan Providers

      1) The Health Plan shall describe incentive strategies including the Health Plan's approach for aligning its provider incentive strategies with DHS incentive strategies. The description shall include the Health Plan's experience and innovative approaches to support providers in diverse geographies in achieving these goals with respect to two (2) provider types from the following list:

         a) Primary care providers;

         b) Community health centers;
         c) Hospitals (including CAHs);

         d) Behavioral health providers (mental health and

SUD);

e) LTSS providers, or

f) Other specialists.

(Limit to five [5] pages)

b. Value-Based Payment (VBP)

1) The Health Plan shall describe its approach to ensure payments to providers are increasingly focused on population health, appropriateness of care and other measures related to value. The Health Plan's response should address the following:

a) The Health Plan's strategy for developing APMs that mature along the LAN continuum over the course of the Contract.

b) The Health Plan's utilization of VBP strategies for two of the following provider types. The Health Plan shall choose two different provider types than for their response to the above §15.3.C.5.a:

i) Primary care providers;
ii) Community health centers
iii) Hospitals (including CAHs);
iv) Behavioral health providers (mental health and SUD)
v) LTSS providers, or
vi) Other specialists.

(Limit to five [5] pages)

c. The Health Plan's specific approach to increase investment in, incentivization of, and medical spend on primary care providers in support of advancing primary care.

(Limit to three [3] pages)

6. Evaluation Category 6 – Responsibilities and Requirements of DHS and Health Plans: Provider Networks; Provider Credentialing; Provider Contracts; and Other Functions for Providers. Total Page Limit for §15.3.C.6: Fourteen (14) pages.

a. The Health Plan shall describe its proposed network development strategy, including addressing workforce shortages, to meet all contract requirements and allow for timely availability and access to a continuum of physical health, behavioral health, and LTSS providers. In addition to overall strategy, the Health Plan's response shall specifically address the following:

1) Methods to develop a Provider network that sufficiently addresses the needs of individuals with mental health and/or SUDs, and individuals with co-morbid physical and behavioral health conditions.

(Limit to four [4] pages)

2) How the Health Plan will develop a Provider network that sufficiently addresses LTSS including HCBS.

(Limit to four [4] pages)

3) Innovative contracting methods or strategies the Health Plan will implement to recruit and retain

providers, including specialists, in rural and underserved areas on island(s) the Health Plans will serve. The Health Plan shall include a statement to confirm collaboration with other Health Plans on the expanded use of Telehealth to address access to services and workforce shortages.

(Limit to six [6] pages)

7. Evaluation Category 7 – Responsibilities and Requirements of DHS and Health Plans: Eligibility, Enrollment, Dis-enrollment, Continuity of Care, and Grievance and Appeals. Total Page Limit for §15.3.C.7: Five (5) pages.

    a. Describe innovative methods for communicating, including education and outreach, with the Members as follows:

        1) Approach to identifying, developing, and distributing materials that will be of most use to the Member populations, and efforts the Health Plan proposes to target distribution to specific populations as appropriate. The Health Plan shall describe its methods of using culturally appropriate communications to meet the diverse needs and communication preferences of the Members, including but not limited to individuals with diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity.

        2) Describe innovative technologies the Health Plan will use to ensure high levels of QI Member engagement,

as methods to educate the Members and advance their own involvement in their healthcare, and to communicate information specific to individual health conditions. The response should address the Health Plan's experience in deploying technologies and identifying the populations to which the technologies would best apply.

8. Evaluation Category 8 – Information Systems and Information Technology. Total Page Limit for §15.3.C.8: Five (5) pages.

    a. The Health Plan shall describe its current state of compliance with the requirements set for in §10.2.C. Further, the Health Plan shall describe it approach and timeline for implementing any unmet systems and supports requirements, as applicable.

9. Evaluation Category 9 – Health Plan Personnel. Total Page Limit for §15.3.C.9: Five (5) pages.

    a. Describe the Health Plan's proposed approach to staffing the Contract, including the following information at a minimum:

        1) Description of how the organizational structure provides solutions for meeting programmatic goals specific to Hawaii's Medicaid program, the Members, providers, and other stakeholders.

        2) Summary of mandated QI personnel for which resumes are requested in §11.2, including recruitment timelines and activities for which individuals have not been identified at the time of the proposal. Describe contingency plans should those

positions continue to remain open after Contract Award.

10. Evaluation Category 10 – Program Integrity. Total page limit for §15.3.C.10: Five (5) pages.

    a. The Health Plan shall describe its proposed Compliance Plan, including but not limited to the following:

        1) The Health Plan's FWA detection/prevention program activities for employees, caregivers and providers, including reporting and follow-up, continuous monitoring of compliance, identification and reporting of issues to all required parties, and ongoing training.

        2) A description of the Compliance Committee including Compliance Officer and Special Investigation Unit, and how the Heath Plan works with DHS and Hawaii's MFCU.

        3) Proposed innovations for analyzing and reporting data in the program integrity area. Provide at least one example of successful innovation implemented.

SECTION 16 – Evaluation and Selection

16.1 Overview

A. DHS shall conduct a comprehensive, fair, and impartial evaluation of proposals received in response to this RFP. DHS shall be the sole judge in the selection of the Health Plans. The evaluation of the proposals shall be conducted as follows:

1. Review of the proposals to ensure all mandatory requirements detailed in Section 15 are met;

2. Review and evaluate the technical proposals that meet all mandatory requirements to determine how well the Health Plan met the technical criteria and requirements detailed in Section 15; and

3. Award of the Contract to the selected Health Plans.

B. DHS reserves the right to waive minor irregularities in proposals provided such action is in the best interest of the State. DHS will determine what is considered a minor irregularity. Where DHS may waive minor irregularities, such waiver shall in no way modify the RFP requirements or excuse the Health Plan from full compliance with the RFP specifications and other Contract requirements if the Health Plan is awarded the contract.

16.2 Evaluation Process

A. DHS shall establish an Evaluation Committee (Committee) that shall review and evaluate each Health Plan's proposal and make recommendations for selection. DHS shall issue the contract award. The Committee shall consist of members who are familiar with the programs and the minimum standards or criteria for the particular

area. Additionally, DHS may, at its discretion, designate additional representatives to assist in the evaluation process. DHS reserves the right to alter the composition of the Committee or designate other staff or vendors to assist in the evaluation process. The Committee shall review and evaluate all qualified responses to the RFP. The Committee will be responsible for the entire evaluation process and scoring will be determined by consensus. Each committee member must agree to each score for each question, and no individual member's opinion is weighted more than another.

16.3 Mandatory Proposal Evaluation

A. 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:

   1. The Health Plan successfully met all of the requirements set for in §1.17;

   2. All information required in §15.2, has been submitted; and

   3. The proposal contains the required information in the proper order.

B. A proposal must meet all mandatory requirements prior to the technical evaluation. Any proposal that does not meet all mandatory requirements shall be rejected.

16.4 Technical Proposal Evaluation

A. DHS shall conduct a comprehensive, fair, and impartial evaluation of all Health Plan proposals. DHS may reject any proposal that is incomplete or in which there are significant inconsistencies or inaccuracies. Each Health Plan is responsible for submitting all

relevant, factual, and correct information with their proposal to enable the Committee to afford each Health Plan the maximum score based on the proposal submitted by the Health Plan.

16.5 Technical Proposal Evaluation Categories and Criteria

A. The Technical Proposal Evaluation Categories and points are described in Table 14: 16.5 below:

Table 14: 16.5. Technical Evaluation and Points

Technical Proposal Evaluation Categories	RFP Evaluation Section	Maximum Points Possible
Evaluation Category 1 Care Delivery and Health Coordination (Section 3)	**Section 15.3.C.1**	**190**
Describe the Health Plan's unique approach to utilizing a multi-disciplinary team to provide primary care and behavioral health services across the continuum of HCS.	Question 15.3.C.1.a	50
Describe the Health Plan's experience and innovations to meet and monitor the behavioral health needs of members receiving HCS.	Question 15.3.C.1.b	40
Describe the Health Plan's experience with innovations for health coordination of LTSS.	Question 15.3.C.1.c	60
Describe the Health Plan's experience with innovations in providing health coordination for people experiencing homelessness or at risk of homelessness.	Question 15.3.C.1.d	40
Evaluation Category 2. Covered Benefits and Services (Section 4)	**Section 15.3.C.2**	**175**
Describe the Health Plan's experience and innovative approaches providing covered benefits and services, 1) addressing the needs of unique Hawaii populations; and 2) approaches to EPSDT.	Question 15.3.C.2.a	75
Describe the Health Plan's experience, innovative strategies, and comprehensive approach to provide prevention and health promotion services.	Question 15.3.C.2.b	50
Describe any value-added services the Health Plan can offer.	Question 15.3.C.2.c	50

Evaluation Category 3. Quality, Utilization Management, and Administrative Requirements (Section 5)	**Section 15.3.C.3**	**70**

Technical Proposal Evaluation Categories	RFP Evaluation Section	Maximum Points Possible
Describe the Health Plan's experience and innovative approach to 1) supporting and evaluating Providers in conducting quality improvement activities; 2) increasing rates of high value care and reducing variation; and 3) leveraging PIPs to support wide-scale adoption of successful practices.	Question 15.3.C.3.a	50
Utilization Management	Question 15.3.C.3.b	20
Evaluation Category 4. Health Plan Reporting and Encounter Data (Section 6)	**Section 15.3.C.4**	**50**
Describe the Health Plan's utilization of report and data to resolve issues.	Question 15.3.C.4.a	50
Evaluation Category 5. DHS and Health Plan Financial Responsibilities (Section 7)	**Section 15.3.C.5**	**125**
Incentive Strategies for Health Plan providers	Question 15.3.C.5.a	50
VBP	Question 15.3.C.5.b	50
Investing and incentivizing in primary care	Question 15.3.C.5.c	25
Evaluation Category 6. Responsibilities and Requirements of DHS and Health Plans: Provider Networks, Provider Credentialing, Provider Contracts, and Other Functions for Providers (Section 8)	**Section 15.3.C.6**	**130**
Network Development Description for Individuals with Behavior Health and SUDs	Question 15.3.C.6.a.1	40
Network Development Description for LTSS	Question 15.3.C.6.a.2	40
Network Development Description on innovative methods to recruit and retain providers	Question 15.3.C.6.a.3	50
Evaluation Category 7. Responsibilities and Requirements of DHS and Health Plans: Eligibility, Enrollment, Disenrollment, Continuity of Care, and Grievance and Appeals (Section 9)	**Section 15.3.C.7**	**60**

Describe the Health Plan's innovative methods for communicating, including education and outreach, 1) identifying, developing, and distributing materials that will be of most use to Member populations; 2) innovative technologies the Health Plan will use to ensure high levels of QI Member engagement.	Question 15.3.C.7.a	60

Technical Proposal Evaluation Categories	RFP Evaluation Section	Maximum Points Possible
Evaluation Category 8. Information Systems and Information Technology (Section 10)	**Section 15.3.C.8**	**50**
Describe the Health Plan's compliance with expected functionality; timeline for implementing any unmet systems and supports requirements.	Question 15.3.C.8.a	50
Evaluation Category 9. Health Plan Personnel (Section 11)	**Section 15.3.C.9**	**50**
Describe the Health Plan's approach to staffing.	Question 15.3.C.9.a	50
Evaluation Category 10. Program Integrity (Section 12)	**Section 15.3.C.10**	**50**
Describe the Health Plan's Compliance Program.	Question 15.3.C.10.a	50
Health Plan Proposes Statewide		**50**
Total Possible Points		**1,000**

16.6 Scoring

A. The Committee will score Health Plan proposals using the rating methodology outline in Table 15: 16.6.A below:

Table 15: 16.6.A. Rating Methodology

Rating Score	Description
5	**Excellent.** The proposal response addresses the criterion in a clear and highly comprehensive manner. The proposal response meets the requirements and clearly adds significant value to the requirements listed in the RFP. Demonstrates expert level knowledge and understanding of the subject matter.

4	**Very Good.** The proposal response addresses the criterion in a highly comprehensive manner. The proposal response meets the requirements and may add some value to the requirements listed in the RFP. Demonstrates a strong knowledge and understanding of the subject matter, but not at the expert level.
3	**Good.** The proposal response addresses the criterion well. The proposal response clearly minimally meets the requirements. Demonstrates minimally adequate knowledge and understanding of the subject matter.

Rating Score	Description
2	**Fair.** The proposal response addresses the criterion in a general manner. The proposal response may minimally meet the requirements and/or there no more than two concerning weaknesses. Ambiguously demonstrates minimally adequate knowledge and understanding of the subject matter.
1	**Poor.** The proposal response addresses the criterion in a general manner but there are concerning weaknesses. The proposal response may minimally meet the requirements and there is more than two concerning weakness. Ambiguously demonstrates some knowledge and understanding of the subject matter.
0	**Very Poor.** The proposal response fails to address the criterion or the criterion cannot be assessed due to missing or incomplete information, or because the response was overly ambiguous, conflicting, or confusing.

B. The Health Plan must receive, at minimum, a rating score of three (3) for each Evaluation Category or the Committee shall not make an award recommendation. Health Plans must receive a minimum score of seven hundred fifty (750) points, seventy-five (75) percent of the total available points to be considered responsive to the RFP. Proposals not meeting the total required points shall not be recommended to be awarded a contract.

C. The rating score (0-5) shall represent the corresponding conversion factor used to calculate the points awarded for each Evaluation Category listed in §16.5, as detailed below in Table 16: 16.6.C:

Table 16: 16.6.C. Conversion Factor

Rating Score	Conversion Factor

5	100%
4	88%
3	75%
2	50%
1	25%
0	0%

D. The total maximum number of points available for each Evaluation Category will be multiplied by the applicable conversion factor, based on the rating score given, to determine the number of points awarded for the Evaluation Category. The points awarded for each Evaluation Category shall by totaled to yield a final score.

E. Scoring will be based on the entire content of the proposal and the information as communicated to the Committee. The information contained in any part of the proposal may be evaluated by DHS with respect to any other scored section of the proposal. Lack of clarity and inconsistency in the proposal will impede effective communication of the content and may result in a lower score.

16.7 Selection of Health Plans

A. Upon completion of the Technical Proposal evaluations, DHS shall sum the scores from the evaluation to determine the Health Plans that shall be awarded contracts from the State. Up to five (5) Health Plans with the highest scoring technical proposals shall be selected to provide Covered Services to Medicaid and CHIP Members.

16.8 Contract Award

A. DHS shall notify the Health Plan in writing of an award pursuant to HAR §3-143-303. The letter shall serve as notification that the Health Plan should prepare to begin developing its programs, materials, policies, and procedures.

B. The contracts shall be awarded no later than the Contract Award date identified in §1.5. If an awarded Health Plan requests to withdraw its proposal, it must be requested in writing to DHS before the close of business (4:30 p.m. HST) on the Contract Award date identified in §1.5. After that date, DHS expects to enter into a contract with the Health Plan.

C. This RFP, the Health Plan's technical proposal, and any other materials submitted by the Health Plan shall become part of the contract, excluding any aspect of the technical proposal inconsistent with the RFP as determined by DHS.