Department of Human Services
Med-QUEST Division

QI HEALTH PLAN MANUAL

Part I: Administrative Overview

TABLE OF CONTENTS

Health Plan Manual Revision History

Version*	Release Date	Effective Date	Changes**
21.1	04/15/21	7/1/2021	Initial release
21.2	10/01/21		Summary of updates:

* First digits are year, second digit incrementing by whole numbers for each release.

** Includes all Health Plan Manual documents, parts, and chapter updates.

CHAPTER 1: Overview

A) The state of Hawaii, Department of Human Services (DHS or State), has issued this Health Plan Manual. The DHS manual contains operational guidance, policies, and procedures required of the Health Plan participating in QUEST Integration (QI). The Health Plan Manual 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 QI Health Plan Contract. The Health Plan will comply with requirements included in the Health Plan Manual (RFP-MQD-2021-008, §2.5.F). The Health Plan Manual contains terms that are defined in the RFP §2.6.

B) If there is a conflict between the Health Plan Manual and the QI Health Plan Contract, the Contract rules take precedence. The Health Plan Manual is intended to provide guidance; it is not intended to, nor does it create, any rights that are not contained in the QI Health Plan Contract.

C) The provisions of the Health Plan Manual reflect the general operating policies and essential procedures of the managed care program, are not all inclusive, and may be amended or revoked at any time by DHS. The Health Plan Manual will be reviewed on a periodic basis to determine if changes are needed.

D) It is the responsibility of the individuals and entities affiliated with QI to review and be familiar with the Health Plan Manual and any amendment.

CHAPTER 2: Grievance and Appeal

2.1 Overview

A) The QI Health Plans will provide to Members their Grievance and Appeal rights and process as described in RFP-MQD-2021-008.

B) The QI Health Plans will provide to Members their Grievance and Appeal rights and process as described in RFP-MQD-2021-008, Section 9.5.

The Health Plan will provide information to Members on how to access the State's administrative hearing process and exhaust its internal grievance and appeals process prior to accessing the State's administrative hearing system.

C) Use templates developed by DHS for communication to Members regarding the grievance and appeal.

D) Develop policies and procedures for its grievance and appeals process and submit these to DHS for review and approval. Submit to DHS any proposed changes to policies and procedures within thirty (30) days prior to implementation.

E) Give Members any reasonable assistance in completing forms and taking other procedural steps such as auxiliary aids, interpreter services, and toll-free numbers that have adequate TTY/TTD and interpreter capability.

F) Acknowledge receipt of each filed grievance and appeal in writing within five (5) business days. For example: 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.

G) Have procedures to notify all Members in their primary language of the grievance and appeal resolutions.

H) 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.

1. The individual making decisions on grievances and appeals will be healthcare professionals who have the appropriate clinical expertise, as determined by the State, in treating the Member's condition or disease.
2. These decision makers on grievances and appeals of adverse benefit determinations will 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.

I) A Member 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.

2.2 Authorized Representative of a Member

A) Members will be allowed to authorize another person to represent their interests as their authorized representative.

B) Members will be allowed 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.

2.3 What is a Grievance?

A) A Member may request for a grievance due to the following:

1. The quality of care of a Provider;
2. Rudeness of a Provider or a Provider's employee;
3. Failure to respect the Member's rights regardless of whether remedial action is requested; or
4. Dispute an extension of time proposed by the Health Plan to make an authorization decision.

B) A Member or a Member's authorized representative may file a grievance orally or in writing and accept any grievance filed without verbal or written consent of the Member. However, the outcome will be sent to the Member, unless a signed authorized representative form is on file.

2.4 What is a State Grievance Review?

A) When a Member is not satisfied with the Health Plan's decision of a grievance, the Member may request for a State grievance review with the State.

B) A Member may request for a State grievance review within thirty (30) days of the Member's receipt of the grievance disposition from the Health Plan. A State grievance review may be made by contacting 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

C) The State will make a decision regarding the grievance review within ninety (90) days and the decision is final.

2.5 What is a Grievance extension?

A) When an existing grievance has not been resolved within the standard 90-day window, an extension may be granted for another 14 days if the delay is in the member's best interest.

B) Within 2 calendar days give the member oral and 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.

C) Refer to CFR "438.408 Resolution and notification: Grievances and appeals" and the RFP-MQD-2021-008, 9.5 Member Grievances and Appeals, E. Grievance Process, number 9 and 10 for further details.

2.6 What is an Appeal?

A) When a Member receives a Notice of Adverse Benefit Determination, the Member first requests for an appeal with the Health Plan.

B) After a decision is made regarding the appeal, the Health Plan will send a Final Resolution letter to the Member to inform them of the appeal decision.

C) The Member will then be able to request for a State administrative hearing.

2.7 What is an Expedited Appeal Process?

A) A Member may request for an expedited appeal when 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.

B) A decision will be made within seventy-two (72) hours and a written decision provided to the Member. The Member may also be informed orally regarding the expedited appeal decision

C) If the Health Plan denies the request for an expedited resolution of an appeal, it will 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.

2.8 What is a State Administrative Hearing?

A) If the Member is not satisfied with the written notice of the final disposition of the appeal from the Health Plan, the Member may file for a State administrative hearing within one hundred and twenty (120) days.

B) If the Member is not satisfied with the decision by the hearing officer, the Member may file for an appeal with the Court.

2.9 Expedited State Administrative Hearings

A) The Member may file for an expedited State administrative hearing only after the Member has requested an expedited hearing with the Health Plan, provided an expedited appeal and the action of the appeal was determined to be adverse to the Member (Action Denied).

B) The Member may file for an expedited State administrative hearing process by submitting a letter to the Administrative Appeals Office (AAO) within one hundred and twenty (120) days from the receipt of the Member's appeal determination.

C) An expedited State administrative hearing will 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.

D) In the event of an expedited State administrative hearing, the Health Plan will submit information that was used to make the determination (e.g., medical records, written documents to and from the Member, provider notes, etc.). The Health Plan will submit this information to DHS within twenty-four (24) hours of the decision denying the expedited appeal.

2.10 What is Continuation of Benefits

A) 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 will continue the Member's benefits if the following conditions have been met:

1. An appeal was requested within sixty (60) days following the date on the adverse benefit determination notice;
2. The appeal or request for State administrative hearing involves the termination, suspension, or reduction of a previously authorized service;
3. The services were ordered by an authorized provider;
4. The original authorization period has not expired; and

5. The Member timely files for continuation of benefits on or before the later of the following:
   a. Within ten (10) days of the Health Plan mailing the notice of adverse benefit determination; or
   b. The intended effective date of the Health Plan's proposed adverse benefit determination.

B) If the Health Plan continues or reinstates the Member's benefits while the appeal or State administrative hearing is pending, the Health Plan will not discontinue the benefits until one of the following occurs:

1. The Member withdraws the appeal or request for a State administrative hearing;
2. 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;
3. A State administrative hearing decision unfavorable to the Member is made; or
4. If the final resolution of the appeal or State administrative hearing upholds the Health Plan's adverse benefit determination, the Health Plan may 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.

CHAPTER 3: Health Plan Non-Performance of Contract

3.1 Overview

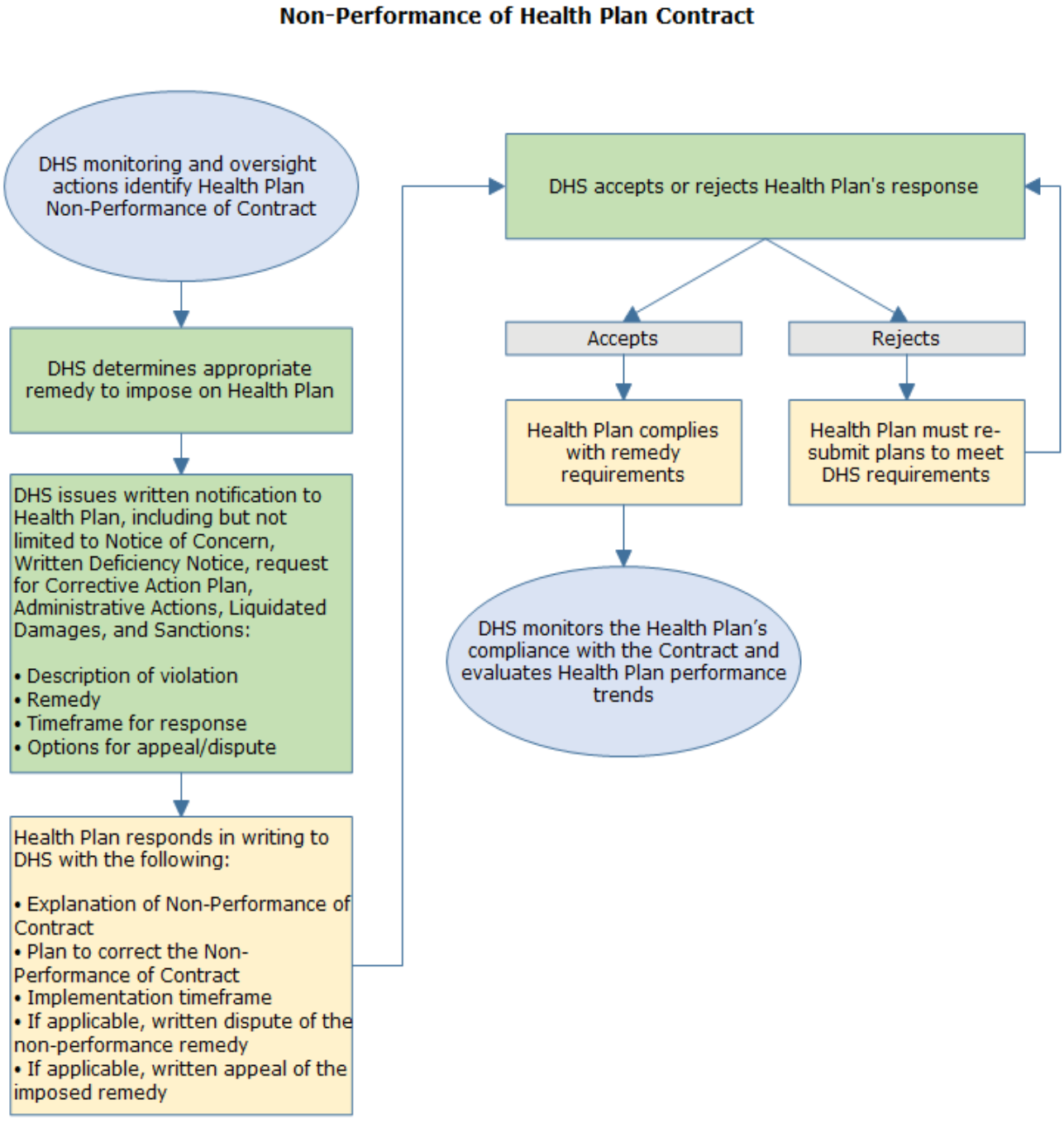
A) Section 14.21 of RFP-MQD-2021-008 details DHS' rights to seek remedies for any non-performance of the Contract or non-compliance with State or Federal law or regulation by the Health Plan or its subcontractors.

B) In the event DHS determines that the Health Plan or its subcontractor has committed non-performance of the Contract requirements, DHS will assess the violation and assign a risk category as stated in §14.21.A.2.a.

C) At its sole discretion, DHS has the flexibility to impose or pursue one or more remedies to address non-performance of Contract by the Health Plan or its subcontractors. Section 14.21.A.2.b describes the various factors that DHS may consider in determining the need to impose remedies against the Health Plan.

D) DHS will monitor Health Plan performance and compliance with the Contract. Designated DHS staff will oversee any remedies imposed by DHS to ensure Health Plan compliance with DHS requirements. Further, DHS will identify and monitor non-performance of Contract trends and opportunities for Health Plan performance improvement. Figure 1 below outlines the general workflow in the event DHS identifies non-performance of Contract by the Health Plan or its subcontractors and then imposes remedies as stated in §14.21 of RFP-MQD-2021-008. It should be noted that DHS reserves the right to alter the general workflow based on the severity of the non-performance of Contract without prior notice.

Figure 1: Non-Performance of Health Plan Contract Workflow



3.2 Non-Performance of Contract Remedies

Sections 14.21.B to I describes the various remedies that DHS may impose in the event of Health Plan non-performance of Contract. As stated above, DHS may consider the risk categories and other factors when evaluating the appropriate remedies to correct the non-performance of Contract. At its sole discretion, DHS will determine the specific remedy and whether additional remedies are required to resolve the non-performance of Contract.

A) Notice of Concern

1. If DHS determines that the Health Plan or its subcontractor is in non-performance of Contract, it may issue a Notice of Concern to allow the Health Plan to correct the Contract violation before other remedies are imposed. It is important to note that DHS is under no obligation to issue a Notice of Concern before imposing other remedies.
2. The Health Plan's written response to DHS must be submitted within the prescribed timeframe and describe the Health Plan's approach for addressing the non-performance of Contract. If the Health Plan fails to timely respond to the Notice of Concern, DHS may impose additional remedies. DHS will provide written notification of additional remedies pursuant to the Contract.
3. In its written response to DHS' Notice of Concern, the Health Plan has the opportunity to provide its rationale for disputing DHS' findings.

B) Corrective Action Plan

1. If DHS determines that the Health Plan or a subcontractor is in non-performance of Contract, DHS may issue a Written Deficiency Notice to the Health Plan and request a Corrective Action Plan within ten (10) business days unless a more immediate response is necessary.
2. The Health Plan's written Corrective Action Plan shall provide the detailed approach for addressing the existing deficiency and timeline for implementation. It should be noted that DHS reserves the right to modify the timeframe for corrective action based on the nature of the specific deficiency.
3. The Health Plan shall update the Corrective Action Plan approved by DHS on an ongoing basis and report progress to DHS on a frequency to be determined by DHS.

C) Administrative Actions

1. In addition to any other remedies identified in §14.21, DHS may request administrative actions for each non-performance of Contract. Such administrative actions will be determined by DHS based on the scope of the non-performance of Contract. These actions will allow more extensive and timely monitoring by DHS of the Health Plan's performance. The Health Plan's failure to comply with the required administrative actions may result in DHS seeking additional remedies against the Health Plan.

D) Liquidated Damages

1. In the event the Health Plan fails to comply with the requirements for activities and responsibilities described in Appendix G of RFP-MQD-2021-008, DHS has the right to impose liquidated damages.
2. It should be noted that liquidated damages shall be in addition to any other remedies that DHS may seek for the Health Plan's non-performance of Contract. For example, if the Health Plan fails to meet the requirements set forth in Appendix G, the Health Plan shall submit a written Corrective Action Plan to DHS and the Health Plan may be subject to administrative actions.
3. If the Health Plan decides to challenge the liquidated damages imposed by DHS, it must provide evidence acceptable to DHS within thirty (30) days of notice of assessment from DHS.
4. DHS will notify the Health Plan in writing of the proposed damage assessment and the mode of payment (i.e., remittance of amount of liquidated damages or deduction of payment from capitation and other fees).

E) Sanctions

1. DHS may impose sanctions for non-performance of Contract requirements if DHS determines that a Health Plan acts or fails to act as described in §14.21.F.1. DHS will provide the Health Plan timely written notice that explains the basis and nature of the sanction and describes the DHS appeal procedures to contest the sanction.

2. Sanctions shall be determined by DHS and may include imposing civil monetary penalties, as well as other actions described in §14.21.F.2.
3. In addition to sanctions, DHS also has the right to require a Corrective Action Plan from the Health Plan and the Health Plan may be subject to Administrative Actions.

F) Termination of Contract

1. Should DHS determine that the Health Plan or its subcontractor is in violation or non-performance of any requirement of the Contract, DHS may terminate the Contract pursuant to §14.16.

3.3 Administrative Reporting

A) Section 14.21.I describes DHS' administrative reporting requirements and options in the event of Health Plan or subcontractor non-performance of Contract or violation of State or Federal law or regulation.

B) In addition, at its sole discretion, DHS may post on its public website information regarding contractual remedies taken against Health Plans.