Department of Human Services
Med-QUEST Division

QI HEALTH PLAN MANUAL

Part I: Administrative Overview

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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: Appendix A – Remove expiration date on ID card. Appendix C – Provider Contract Requirements – Revised to include NEMT contract language and request adverse event data for additional population. Appendix J – Revise PA1 and PA2 to PAI and PAII Appendix T – New - Medical Standard Record Appendix U – New - Financial Responsibility Guideline Part I – Administration Overview; • New subsection G – Health Plan Appeal- added to Section 3.2, and • New Chapter 4 – Financial Responsibilities. Part II – Operational Guide; • Section 1.5 – New paragraph A. • Section 7.1 – "Going Home Plus" added to the subject line. • Section 7.1.B – 90 days change to 60 days. • Section 9.6.4.Q – Revised. • Section 10.1.A – New subsection 8 and 9. • Section 11.1 – New subsection D • Section 11.3 – New subsection C • Section 11.5 – New subsection B and revised subsection C • Section 13.2.A.4 – Revised • Section 13.2.1.B - Revised

			• New section 17.3 - Medical Record Standard. Part III – Refer to "QI Health Plan Manual Part III Amendment #1" file for all changes made in Part III. Revised report tools and all related files have "v2" in the file name. Part IV - The HPMMIS Technical Guide – Encounter is updated in MQD website.
22.1	01/03/2022		Summary of Updates: Appendix – V SBIRT Process to Treatment Part I – Administration Overview; • New subsection 4.2 TPL Part II – Operational Guide; • Section 3.3 - Revised • Section 3.4 - Revised • Section 4.2 - Revised • Section 4.3 – Revised. • Section 6.9 – New Section - LTSS Service Authorization Reviews • Section 6.10 - Revised • Section 8.3.A.1.a – Homelessness Z Code changed • Section 9.8 – New Section - SBIRT • Section 17.4 -New Section – NEMT Provider Eligibility • Chapter 21 – New Chapter – NEMT Policy Part III – Refer to "QI Health Plan Manual Part III Amendment #2" file for all changes made in Part III.
22.2	04/01/2022		Summary of Updates: Appendix – C Provider Contract Requirements –

			Removed B.4, B.5 Appendix W – New – Health and Functional Assessment (HFA), Health Action Plan (HAP), and Personal Assistance and/or Nursing Tool (PANS) Part I – Administration Overview; • Section 4.3 – New Section - NEMT – Emergency Transportation to Alternative Destinations Payment Part II – Operational Guide; • Section 3.4.D – Revised • Section 3.4.D.2 – Revised • Section 4.2.A.1 – Revised • Section 4.3 – Revised Part III – Refer to "QI Health Plan Manual Part III Amendment #3" file for all changes made in Part III. Revised report tools will have a "v#" in the file name.
22.3	07/01/2022		Summary of Updates: Appendix G – Level of Care and At-Risk Evaluation – Revised 01/2021 Appendix L – Medicaid Eligibility for Long-Term Care Services – Revised 02/2022 Appendix X – New - Transition of Care Part I – Administrative Overview • Section 4.4 – New Section – Transition of Care Part II – Operational Guide; • Section 6.15 – New Section – Bed-Hold Requirements for Long Term Care Part III – Refer to "QI Health Plan Manual Part III Amendment #4" file for all changes made in Part III. Revised report tools will have a "v#" in the file name.
22.4	10/01/2022		Summary of Updates: Appendix Y – Waiver Request SOP - New Appendix Y1 – Waiver Request Form – New Appendix Z – Material Submission SOP – New

			Appendix Z1 – Material Submission Review Tool - New Part I – Administrative Overview • New Chapter 5 – Waiver Request • New Chapter 6 – Material Submission Part III – There were no changes during this quarter Part III - There were no revised report tools this quarter

* 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

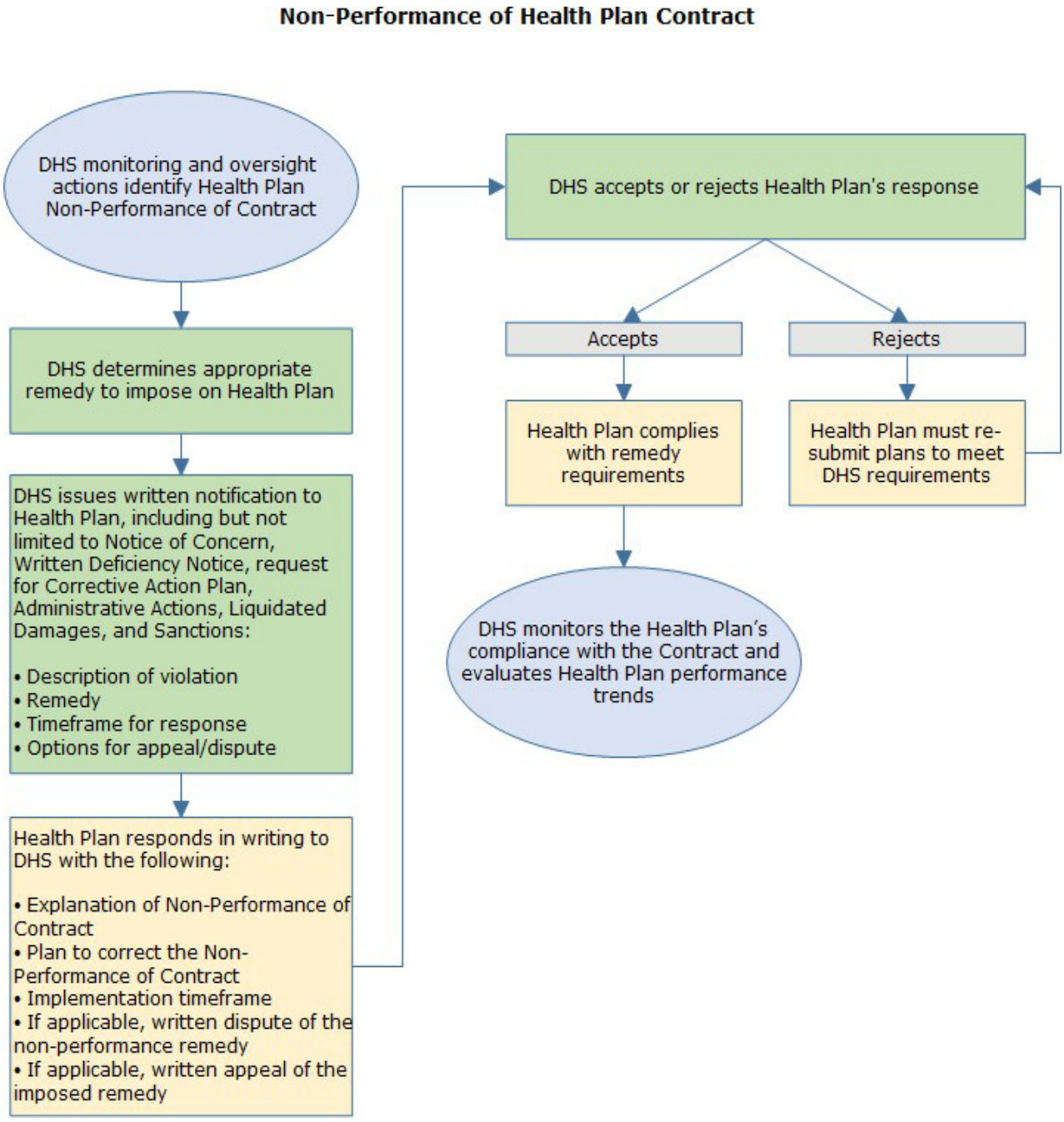
A) Section 14.21 of RFP-MQD-2021-008 details DHS' rights to seek remedies for any non-performance of the Contract or non-compliance with State or Federal law or regulation by the Health Plan or its subcontractors.

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.

G) Heath Plan Appeal

1. The Health Plan may file an appeal to contest liquidated damage, sanction and termination of contract imposed by the MQD. This appeal must be filed within ten (10) calendar days of receipt of the written notice.
2. The written statement of appeal contesting the remedies must be mailed by certified mail, return receipt requested, to the Director of Department of Human Services at the address listed below:

   P.O. Box 339

   Honolulu, HI 96809-0339

3. DHS shall afford the Health Plan an opportunity to be heard and to offer evidence in support of its challenge to the remedies.
4. The Director shall request information from MQD regarding the remedies.
5. The Director shall review the information provided from both the Health Plan and the MQD.
6. The Director shall submit his/her decision in writing via mail within ninety (90) calendar days after receiving the written statement of appeal from the Health plan.
7. The MQD shall suspend imposition of the appealed remedies pending the Director's decision.
8. Pending the Director's decision and any subsequent legal proceedings regarding the remedies, the Health Plan shall proceed diligently with the performance of the contract.
9. The Director's decision shall be final and binding upon the Health Plan and may only be set aside by a State court of competent jurisdiction in the City and County of Honolulu, where the decision was fraudulent, capricious, arbitrary, or grossly erroneous as to imply bad faith.

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.

CHAPTER 4: Financial Responsibilities

4.1 Overview

A) The Health Plan shall follow the guidelines listed in the "Financial Responsibilities Guideline for QI and CCS health plans" Appendix U in the "Health Plan Manual – Appendices" document.

4.2 Third Party Liability (TPL) Requirements

A) In accordance with the Bipartisan Budget Act (BBA) of 2018 (Pub. L. 115-123) and the Medicaid Services Investment and Accountability Act (MSIAA) of 2019 (Pub. L. 116-16 affecting the BBA of 2013, Health Plans shall meet the following requirements:

1. The requirement for states to apply cost avoidance procedures to claims for prenatal services, including labor, delivery, and postpartum care services;
2. The requirement for states to make payments without regard to potential TPL for pediatric preventive services, unless the state has made a determination related to cost-effectiveness and access to care that warrants cost avoidance for 90-days; and
3. State flexibility to make payments without regard to potential TPL for up to 100 days for claims related to child support enforcement beneficiaries.

B) The Med-QUEST Division submitted the following language in State Plan Amendment (SPA), SPA 21-0017 Attachment 4.22-B, to incorporate the TPL requirements listed in section A above (that is pending approval):

1. The State shall use standard coordination of benefits cost avoidance when processing claims for prenatal services, including labor and delivery and postpartum care claims.

2. The State shall make payments without regard to third party liability for pediatric preventive services unless a determination related to cost-effectiveness and access to care that warrants cost avoidance for up to 90-days has been made.
3. The State shall pay and chase third parties when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried out by the State Title IV-D Agency. For such claims, the State shall only authorize payment under the following conditions:
    a. Up to 100-days have elapsed from the date of service.
    b. The provider billed the third-party.
    c. Documentation is attached verifying that a. and b. have been met.
4. The State shall monitor the pay and chase system for such claims for improper billings made by providers and take appropriate corrective action.
5. Providers who have billed a third party prior to billing Medicaid must certify on the Medicaid claim that a third party has been billed, that claim has been fully adjudicated by the third party, and that payment has not been received by Medicaid.

C) Guidance for pediatric preventive services:

1. For child support enforcement beneficiaries and other Medicaid children, the health Plan shall make payments for well child visits, immunizations/vaccines, screenings or other preventive services used to evaluate the child's current health regardless of TPL. The Health Plan shall make payment after receiving clean claims and not hold onto the claim for 90-days.

2. If MQD makes a determination related to cost-effectiveness and access to care that warrants cost avoidance for 90-days, MQD will notify the Health Plans either by email, memo and/or Health Plan Manual update.

D) Guidance for non-pediatric preventive services with no known TPL:

1. For child support enforcement beneficiaries and other Medicaid children, the Health Plan shall make payments after receiving the clean claim if the provider attests with documentation that there is no known TPL.

E) Guidance for non-pediatric preventive services with a TPL:

1. Medicaid children, not including child support enforcement beneficiaries:
    a. If there is a known TPL identified in the 834 file or through other sources, the Health Plan shall reject, but not deny, claims and return it back to the provider noting the known TPL.
    b. If the provider billed the TPL as described in one of the scenarios below and documentation is provided, the Health Plan shall pay clean claims to meet the requirements in the QI RFP section 7.2.C.4 (Clean Claim Requirements) and not hold onto the claim for 90-days.
        1) If the provider billed the TPL and the TPL paid partial amount, the Health Plan shall pay the remainder of the clean claim once it's received.
        2) If the provider billed the TPL and the TPL denied the claim, the Health Plan shall make payments after receiving the clean claim.
        3) If the provider billed the TPL and attests that the TPL did not pay or respond, the Health Plan shall make payments under the condition that 90-days has elapsed from the Date of Service after receiving the clean claim.
2. Child support enforcement beneficiaries:

a. If there is a known TPL identified in the 834 file or through other sources, the Health Plan shall reject, but not deny, claims and return it back to the provider noting the known TPL.
b. If the provider billed the TPL as described in one of the scenarios below and documentation is provided, the Health Plan shall pay clean claims to meet the requirements in the QI RFP section 7.2.C.4 (Clean Claim Requirements) and not hold onto the claim for 100-days.
    1) If the provider billed the TPL and the TPL paid partial amount, the Health Plan shall pay the remainder of the claim once it's received.
    2) If the provider billed the TPL and the TPL denied the claim, the Health Plan shall make payments after receiving the clean claim.
    3) If the provider billed the TPL and attests that the TPL did not pay or respond, the Health Plan shall make payments under the condition that 100-days has elapsed from the Date of Service after receiving the clean claim.

F) Identifying a TPL in the 834 file:

1. The TPL information is in the 834 file. It is found under the Coordination of Benefits (COB) loop, on NM103 of the 2330 loop. The example below identifies the TPL in the 834 file, marked in red.

    Example:
    NM1{IN{2{03Y**VS VISION SERVICE PLAN**

    It is a combination of the following: TPL-SEQ-NO x(2) + TPL-ABS-PARENT x(1) + **TPL-CAR-INFO x(50)**

G) Identifying child support enforcement beneficiaries in the 834 file:

1. Child support beneficiaries are in the 834 file. They will have a 'Y' value as the 'Absent Parent' indicator if MQD received notification that the child may be receiving medical services under the absent parent's medical coverage plan. However, please note that the 'Absent Parent' indicator does not confirm that the absent parent has medical coverage for the child support beneficiary. It depends on if the absent parent is employed and has medical coverage. The example below identifies the absent parent indicator value in the 834 file, marked in red.

   Example:
   Absent Parents: Y/N
   NM1{IN{2{03**Y**VS VISION SERVICE PLAN

   It is a combination of the following: TPL-SEQ-NO x(2) + TPL-**ABS-PARENT x(1)** + TPL-CAR-INFO x(50)

H) The Health Plans shall educate and encourage the providers to submit claims to TPL as primary. Medicaid is generally the 'payer of last resort'.

I) The Health Plan shall develop and maintain policies and procedures that comply with the requirements in the above sections.

4.3 NEMT - Emergency Transportation to Alternative Destinations Payments

A) Emergency Triage, Treat, and Transport (ET3) Model

1. The Centers for Medicare and Medicaid Services (CMS) is testing new payment models for ambulance services as a part of the Emergency Triage, Treat, and Transport (ET3) Model. The ET3 Model provides greater flexibility to ambulance care teams to address emergency health care needs of Medicaid beneficiaries following a 911 call, with the goal of improving quality of care and lowering costs. The Med-QUEST Division is participating in ET3 and is implementing the TAD

payment model.

B) Transportation to Alternative Destinations

1. Currently, health plans pay for emergency ground ambulance services when individuals are transported to emergency departments. This payment model creates an incentive to bring Medicaid beneficiaries to high-acuity, high-cost settings, even when lower-acuity, lower-cost settings may more appropriately meet member needs. TAD aims to address this misaligned incentive by providing person-centered options and more flexibility on the allowed destinations.
2. Effective March 1, 2022, health plans shall pay ambulance providers that transport patients to alternative destinations. Health plans are also encouraged to consider retroactive claims adjustments if appropriate as these services started on November 1, 2021. Alternative destinations are defined in the Hawai'i Administrative Rules section 323D-2, and include but are not limited to, urgent care centers, subacute stabilization units, sobering centers, primary care providers, and physician offices.

C) Billing Codes for Transportation to Alternative Destinations

1. The service codes for non-TAD ground emergency transportation services that are initiated through the 911 dispatch system are listed below:
    a. Basic Life Support (BLS-E) ground ambulance (HCPCS code A0429) transport; or
    b. Advanced Life Support, Level 1 (ALS1-E) ground ambulance (HCPCS code A0427) transport; or
    c. Appropriate adjustments including mileage (HCPCS code A0425) and applicable rural/urban geographic factors or add ons or multiple-patient rule.
2. These same service codes shall be used to bill for TAD services. New

TAD-specific alpha character modifiers shall be used in the "destination" position of the origin/destination modifier combination on ambulance claims to identify TAD claims. These modifiers are billed in combination with the above billing codes, and are specific to TAD claims. Ambulance providers should select the most closely related destination code, as appropriate (e.g., the modifier for Community Mental Health Center, "C" may be appropriate for transport to a residential substance use treatment facility).

a. The destination modifiers are:
    1) C: Community Mental Health Center
    2) F: Federally Qualified Health Center
    3) O: Physician Office
    4) U: Urgent Care

3. The alternative destination providers that receive the members (e.g. urgent care centers, physician offices, etc.) should bill as usual for services rendered.

4.4 Transition of Care

A) Purpose:

1. To clarify financial responsibility roles of QUEST Integration (QI) Health Plans, State of Hawaii Organ and Tissue Transplant (SHOTT) program, Community Care Services (CCS), and Med-QUEST Division (MQD) Fee-For-Service (FFS) relating to hospital (H), professional (P), and enabling services (E).

B) Definitions:

1. Hospital Services: Hospital services include 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.

2. Professional Services: Professional services include services provided by physicians and any other outpatient hospital services. Examples may include medical supplies, equipment and drugs; diagnostic services; and therapeutic services including chemotherapy and radiation therapy.

3. Enabling Services: Enabling services include transportation (air or ground), lodging, meals, attendant/escort care, and any other services that may be needed.

4. Transfer: A transfer to another facility (whether in state or out of state) is equivalent to a discharge from the original facility.

5. Level of Care Change: The first change in acuity level (from acute to sub-acute, waitlisted sub-acute, SNF, waitlisted SNF, ICF, waitlisted ICF).

C) The following rules apply in determining which entity (QI health plan, SHOTT, CCS or FFS) is responsible:

1. **Benefits provided under QI** include acute care hospitalization, acute waitlist, skilled nursing, intermediate care, and home and community based services. Health plans do not change in QI due to change in benefits.
2. **Eligibility for long-term care services and enrollment into managed care health plans** can be retroactively applied a maximum of 3 months from the date of application.

3. **For acute inpatient hospitalizations**, the admitting health plan is responsible for hospital services from admission to discharge or to change in level of care, whichever comes first.
4. **Retroactive eligibility,** the MQD will retroactively enroll a member into their former health plan when there is a break in coverage of up to 180-days.
5. **For professional services,** the health plan into which a member is enrolled on the date(s) the service was rendered is responsible, even if the member is in an acute inpatient hospital and enrollment is retroactively applied.
6. **For enabling services,** the health plan into which a member is enrolled on the date(s) the service was rendered is responsible, including transportation, meals, lodging, and attendant care.
7. **For members sent out-of-state/inter-island by the original health plan,** the original health plan is responsible for hospitalization from admission to change in level of care. The original health plan is also responsible for the transportation to get the member and attendant, if applicable, to the out-of-state/off-island services. If round trip tickets were purchased, the original health plan may bill the new responsible party for the return trip of the member and the member's attendant, if applicable. Otherwise, the health plan into which the member is enrolled becomes responsible for enabling services, including transportation, meals, and lodging. As round trip air fare is less costly than one-way fare, the health plans involved may share the cost of a round trip fare, rather than purchase one-way fares.
8. **State of Hawaii Organ and Tissue Transplant (SHOTT) Program** covers members approved as candidates by MQD for solid organ or stem cell/bone marrow transplant. The member will be dis-enrolled

from QI on the date of MQD approval and covered under the SHOTT program until at least one year post transplant. All kidney transplants for individuals with Medicaid secondary will remain in their QI health plan and not be admitted into the SHOTT program.

9. **Community Care Services (CCS) Program** covers members approved by the MQD to meet eligibility criteria for intensive behavioral health services. Upon enrollment, the CCS program covers all behavioral health services, except in cases regarding transition of care, unless otherwise determined by MQD.

D) Appendix X clarifies the financial responsibilities of the Department of Human Services, Med-QUEST Division (MQD) programs [QUEST Integration (QI) health plans, State of Hawaii Organ and Tissue Transplant Program (SHOTT), Community Care Services (CCS), and Fee-for-Service (FFS)] concerning transition of care relating to hospital, professional, and enabling services.

CHAPTER 5: Waiver Request

5.1 Overview

B) The Health Plan shall follow the guidelines listed in the "QI Waiver Procedures for HP" in Appendix Y with "QI Waiver Request Form" Appendix Y1 in the "Health Plan Manual – Appendices"document when submitting a Waiver request.

CHAPTER 6: Material Submission

6.1 Overview

A) The Health Plan shall follow the guidelines listed in the "QUEST Integration Material Submission Procedures"" in Appendix Z with "QUEST Integration Materials Review Tool" Appendix Z1 in the "Health Plan Manual – Appendices" document when submitting materials for review.