STATE OF HAWAII

DEPARTMENT OF HUMAN SERVICES
MED-QUEST DIVISION
KAPOLEI, HAWAII

Legal Ad Date: June 14, 2006

REQUEST FOR PROPOSALS

No. RFP-MQD-2007-002

Competitive Sealed Proposals:

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

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

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

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SECTION 10 ADMINISTRATIVE OVERVIEW

10.100 Purpose of the Request for Proposal

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

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

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

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

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

10.200 Authority for Issuance of RFP

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

10.300 Issuing Officer

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

Ms. Leslie Tawata
Department of Human Services/Med-QUEST Division
601 Kamokila Boulevard, Suite 518
Kapolei, HI 96707
Telephone: (808) 692-8050

10.400 Use of Subcontractors

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

10.500 Organization of the RFP

This RFP is composed of 10 sections plus appendices:

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

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

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

SECTION 20 RFP SCHEDULE AND REQUIREMENTS

20.100 RFP Timeline

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

Issue RFP	June 14, 2006
Orientation	June 21, 2006
Submission of Written Questions on Technical Proposal	June 29, 2006
Notice of Intent to Propose	June 30, 2006
Issue Section 90 Business Proposal of the RFP and Data Book	July 7, 2006
Second Orientation	July 14, 2006
Submission of Written Questions on Business Proposal	July 17, 2006
Written Responses to Technical Proposal Questions	July 26, 2006
Written Responses to Business Proposal Questions	July 26, 2006
Proposal Due Date	August 28, 2006
Contract Award	September 18, 2006
Contract Effective Date	September 25, 2006
Commencement of Services to Members	February 1, 2007

20.200 Orientation

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

A second orientation for offerors in reference to this RFP will be held on July 14, 2006 from 9:00 a.m. to 11:30 a.m. Hawaii Standard Time via teleconference call. Offerors should also have access to a computer connected to the internet to view documents and the presentation by the MQD contracted actuary. Website address is:

https://milliman.webex.com/milliman/j.php?ED=87275752&UID=33247822

Meeting number: 551 792 021
Meeting password: quest

Please click the above link to see more information, or to join the meeting.

NEW USER? Prepare your computer in advance of the meeting by clicking New User on the navigation bar

To access the teleconference on July 14, 2006 offerors should call 1-800-335-5016 or 1-877-246-9080 (Toll Free USA or Canada). Metro Seattle call 1-206-315-8571. Participant Conference entry code 8711 followed by the # key.

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

20.300 Submission of Written Questions

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

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

The written questions shall reference the RFP section, page and paragraph number in the format provided in Appendix G. Offerors must submit written questions on the technical proposal by 4:30 p.m. (H.S.T.) on June 29, 2006 and on the business proposal by 4:30 p.m. (H.S.T) on July 17, 2006. The DHS shall

respond to the written questions no later than July 26, 2006. No verbal responses shall be considered as official.

20.400 Notice of Intent to Propose

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

The Notice of Intent can be mailed or faxed to:

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

20.500 Tax Clearance

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

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

The tax clearance certificate shall be obtained on the State of Hawaii, DOTAX Tax Clearance Application Form A-6 (rev. 2004) which is available at the DOTAX and IRS office in the State of Hawaii or the DOTAX website at www.hawaii.gov/tax/tax.html. The offeror is also required to submit an original current tax clearance certificate for final payment on the contract.

20.600 Certificate of Good Standing

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

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

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

"Certificate of Good Standing" from the DCCA; these costs are the responsibility of the health plan.

20.700 Current and Prior Medicaid Experience

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

20.800 Documentation

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

- QUEST applications/renewals
- QUEST Program Documentation
- Organization charts and functional statements
- QUEST Health Plan Manual
- QUEST Policy Memorandum Manual
- EPSDT Manual
- Forms Manual
- HEDIS
- QUEST Financial Reporting Guide

- Information on the development of the capitated rate ranges
- Other pertinent data

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

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

20.900 Rules of Procurement

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

20.910 No Contingent Fees

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

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

20.920 Discussions with Offerors

A. Prior To Submittal Deadline:
Discussions may be conducted with offerors to promote understanding of the purchasing agency's requirements.

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

21.100 RFP Amendments

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

21.200 Costs of Preparing Proposal

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

21.300 Provider Participation in Planning

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

21.400 Disposition of Proposals

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

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

21.500 Rules for Withdrawal or Revision of Proposals

A proposal may be withdrawn or revised at any time prior to, but not after, the Proposal Due Date of August 28, 2006 provided that a request in writing executed by an offeror or its duly authorized representative for the withdrawal or revision of such proposal is filed with the DHS before the deadline for receipt of proposals. The withdrawal of a proposal shall not prejudice the right of an offeror to submit a new proposal.

21.600 Independent Price Determination

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

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

21.700 Confidentiality of Information

If the offeror seeks to maintain the confidentiality of sections of the proposal, each page of the section(s) should be marked as "Proprietary" or "Confidential." An explanation to the DHS of

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

21.800 Acceptance of Proposals

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

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

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

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

21.900 Submission of Proposals

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

Six (6) bound copies and one (1) unbound copy of the technical proposal and two (2) bound copies and one (1) unbound copy of the business proposal shall be received by the Issuing Officer no later than 4**:**30 p.m. (H.S.T.) on August 28, 2006, or postmarked by the USPS no later than August 28, 2006. All mail-ins postmarked by USPS after August 28, 2006, will be rejected. Hand deliveries will not by accepted after 4:30 p.m., H.S.T., August 28, 2006. Deliveries by private mail services such as FEDEX shall be considered hand deliveries and will not be accepted if received after 4:30 p.m., H.S.T., August 28, 2006. Proposals shall be mailed or delivered to:

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

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

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

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

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

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

22.100 Disqualification of Offerors

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

- Proof of collusion among offerors, in which case all bids involved in the collusive action shall be rejected and any participant to such collusion shall be barred from future bidding until reinstated as a qualified offeror;
- An offeror's lack of responsibility and cooperation as shown by past work or services;
- An offeror's being in arrears on existing contracts with the State or having defaulted on previous contracts;
- An offeror's lack of sufficient experience to perform the work contemplated and/or lack of proper provider network;
- An offeror's lack of a proper license to cover the type of work contemplated if required to perform the required services;
- An offeror shows any noncompliance with applicable laws;
- An offeror's delivery of proposal after the proposal due date;
- An offeror's failure to pay, or satisfactorily settle, all bills overdue for labor and material on former contracts with the State at the time of issuance of this RFP;
- An offeror's lack of financial stability and viability; or
- An offeror's consistently substandard performance related to meeting the MQD requirements from previous contracts.

22.200 Irregular Proposals

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

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

22.300 Rejection of Proposals

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

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

1. Rejection for failure to cooperate or deal in good faith (Section 3-141-201, HAR);
2. Rejection for inadequate accounting system (Section 3-141-202, HAR);
3. Late Proposals (3-143-603, HAR);
4. Inadequate response to RFPs (Section 3-143-609, HAR);
5. Proposal not responsive (Section 3-143-610 (1), HAR); or
6. Offeror not responsible (Section 3-143-610(2), HAR).

22.400 Cancellation of RFP

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

22.500 Opening of Proposals

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

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

22.600 Additional Materials and Documentation

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

22.700 Award Notice

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

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

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

22.800 Disputes on Award of Contract

Offerors may file a Notice of Protest against the awarding of the contract. An original and two (2) copies of the Notice to Protest shall be mailed by United States Postal Service (USPS) or hand delivered to the procurement officer who is conducting the procurement (as indicated below) A Notice of Protest regarding an award shall be served within five (5) business days of the postmark of the notice of findings and decision sent to the protester. Delivery services other than USPS shall be considered

hand deliveries and considered submitted on the date of the actual receipt by the DHS. The Notice of Protest form, SPO-H-801, is available on the SPO website www2.hawaii.gov/spoh. Only the following may be protested:

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

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

SECTION 30 BACKGROUND AND DEPARTMENT OF HUMAN SERVICES RESPONSIBILITIES

30.100 Background and Scope of Service

30.110 Scope of Service

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

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

30.120 Background

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

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

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

30.200 Definitions/Acronyms

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

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

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

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

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

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

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

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

Appeal - A request for review of an action.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Health Maintenance Organization (HMO) – See Managed Care Organizations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Non-Managed Care Med-QUEST Division programs- programs run by the Med-QUEST Division outside of the managed care program such as FFS or SHOTT (section 30.710).

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

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

Participating - When referring to a health plan it means a health plan that has entered into a contract with the DHS to provide covered

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

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

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

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

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

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

Primary Care – All health care services and laboratory services customarily furnished by or through a general practitioner, family practitioner, internal medicine physician, obstetrician/gynecologist, or

pediatrician, to the extent the furnishing of those services is legally authorized in the State.

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

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

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

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

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

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

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

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

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

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

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

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

Risk Corridor – A risk sharing mechanism in which the State and the health plan share in both the profits and losses under the contract

outside of predetermined threshold amount so that after an initial corridor in which the health plan is responsible for all losses or retains all profits, the State contributes a portion toward any additional losses and receives a portion of any additional profits.

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

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

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

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

State - The State of Hawaii.

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

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

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

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

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

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

30.300 Program Descriptions

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

30.310 QUEST

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

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

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

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

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

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

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

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

30.320 QUEST-Net

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

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

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

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

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

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

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

30.330 QUEST- ACE

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

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

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

30.340 Excluded Populations

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

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

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

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

30.400 The Department of Human Services (DHS) Responsibilities

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

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

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

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

30.410 Eligibility Determinations

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

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

30.500 Enrollment Responsibilities

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

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

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

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

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

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

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

30.510 Positive Enrollment Period for Existing Members

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

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

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

30.520 Newborn Enrollment

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

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

30.530 Children in Foster Care

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

30.540 Special Considerations Regarding Enrollment into QUEST-Net

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

30.550 90-Day Grace Period

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

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

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

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

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

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

30.560 Annual Plan Change Period

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

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

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

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

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

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

30.570 Member Enrollment Caps

The DHS will implement enrollment caps as follows:

Islands with 3 or more plans	65% of island enrollment
Islands with 2 or fewer plans	no cap

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

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

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

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

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

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

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

30.580 Hospitalizations During Enrollment Changes

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

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

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

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

30.590 Member Education Regarding Status Changes

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

- Death of the member or family member (spouse or dependent);
- Birth;
- Marriage;
- Divorce;
- Adoption;
- Transfer to long-term care;
- Change in health status (e.g., pregnancy or permanent disability);
- Change of residence and/or mailing address;

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

30.600 Disenrollment Responsibilities

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

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

- Member no longer qualifies based on the medical assistance eligibility criteria or voluntarily leaves the programs;
- Member chooses another plan during the annual plan change period;
- Member does not pay the required premium (for members with premium share requirements);
- Member's PCP is not in the health plan's provider network and is in the provider network of a different health plan;

- Death of a member;
- Incarceration of the member;
- Member enters the State Hospital;
- Determination by the DHS or their contractor that the member meets the nursing facility level of care;
- Member is waitlisted at an acute hospital for a long-term care bed (after 60 days);
- Member is transferred to an ICF-MR facility;
- Member is determined disabled or blind by the DHS;
- Member is age 65 or older;
- Member becomes a PACE or Pre-Pace participant;
- Member is in foster care and has been moved out-of-state by the DHS;
- Member becomes a Medicare Special Savings Program recipient beneficiary;
- Member enters a home and community based waiver program and qualifies for the Medicaid fee-for-service program;
- Member provides false information with the intent of enrolling in the programs under false pretenses; or
- Member requests disenrollment for cause, at any time, due to:
    - An administrative appeal decision;
    - Provisions in administrative rules or statutes;
    - A legal decision;
    - Relocation of the member to a service area where the health plan does not provide service;
    - An administrative decision for foster children which is the result of an agreement between the DHS, the

child welfare service worker and the health plan involved;

- The health plan's refusal, because of moral or religious objections, to cover the service the member seeks as allowed for in Section 40.280;
- The member's need for related services (for example a cesarean section and a tubal ligation) to be performed at the same time and not all related services are available within the network and the member's PCP or another provider determines that receiving the services separately would subject the member to unnecessary risk;
- Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's health care needs, lack of direct access to certified nurse midwives, pediatric nurse practitioners, family nurse practitioners, if available in the geographic area in which the member resides; or
- Lack of direct access to women's health care specialists for breast cancer screenings, pap smears and pelvic exams.

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

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

30.610 Special Considerations Regarding Disenrollment from QUEST-Net

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

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

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

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

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

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

member on a waitlist and the DHS's agent does not agree with the placement, that member will remain in the health plan and the health plan remains financially responsible for all services.

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

30.710 State of Hawaii Organ and Transplant (SHOTT) Program

The DHS will provide transplants which are not experimental or investigational and not covered by the health plan through the SHOTT Program. The SHOTT Program covers adults and children for liver, heart, heart-lung, lung and allogenic and autologus bone marrow transplants. In addition, children will be covered for transplants of the small bowel with or without liver. Children and adults must meet specific medical criteria as determined by the State and the SHOTT Program contractor. The health plan shall submit a Form 1144 to request an evaluation by the SHOTT Program and also a Form 1180 to determine if the member meets disability criteria. The State and the SHOTT Program contractor will determine eligibility of individuals for transplants except those transplants provided by the health plan. If the DHS and the SHOTT Program contractor determine the individual meets the transplant criteria, the individual will be disenrolled from the health plan and transferred to the SHOTT program.

30.720 PACE and Pre-PACE Programs

Medicaid recipients or health plan members who are determined eligible for or elect to participate in the PACE or Pre-PACE Program shall not be enrolled in, or will be disenrolled from, the

programs. These individuals will receive all covered services under the Medicaid fee-for-service program.

30.730 Dental Services

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

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

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

30.740 School Health Services

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

30.750 Department of Health (DOH) Programs

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

30.751 *Vaccines for Children (VFC) Program*

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

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

30.752 *Zero-To-Three Program*

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

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

under the plan and EPSDT screens/services including evaluations to confirm the medical necessity of the service.

30.753 *Craniofacial Review Panel*

The Craniofacial Review Panel (Panel), coordinated by the DOH/Family Health Services Division/Children with Special Health Needs Branch, performs multidisciplinary evaluation, case management and treatment planning for children with serious craniofacial conditions. For health plan members, the Panel may conduct evaluations and provides treatment recommendations for health plan members. When the Panel is convened, the health plan shall participate in the Panel meetings if one of their members is involved. The health plan shall provide transportation for the child and parent/guardian, if necessary, to attend the Panel meeting(s).

30.760 Behavioral Health Services for Adults with Serious Mental Illness (SMI)Prior to July 1, 2010, adult members, as determined by the DHS to have serious and persistent mental illness (SPMI) may be enrolled in the behavioral health managed care (BHMC) plan. Refer to Section 40.800 for further information on the BHMC plan.

Persons who are SMI are defined as persons who, as a result of a mental disorder, exhibit emotional, cognitive, or behavioral functioning which is so impaired as to interfere substantially with their capacity to remain in the community without supportive treatment or services of a long-term or indefinite duration. Additional criteria for designation of a member as a SMI can be found in Appendix J.

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

Adults with SMI who have been determined disabled by the DHS shall be disenrolled from the QUEST health plan and enrolled in the QExA program for services.

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

The health plans will contract with the State of Hawaii, Child and Adolescent Mental Health Division (CAMHD) for provision of services to children with SEBD at fees that do not exceed the current Medicaid fee schedule and shall assume responsibility for providing those services through CAMHD effective July 1, 2010. The CAMHD will provide outpatient behavioral health services to children and adolescents age three through twenty (3-20) years who the health plan determines is in need of intensive behavioral health services and are eligible for the SEBD program.

For the purposes of the contract, children and adolescents determined eligible for SEBD are persons with special health care needs.

30.780 Aid to Disabled Review Committee (ADRC)

The ADRC determines the disability status of persons who are not in receipt of Retirement, Survivors and Disability Insurance (RSDI) and Social Security Insurance (SSI) disability benefits. If the health plan identifies a member that it believes would meet the disability criteria, it should refer the member to DHS-Clinical Standards Office for an ADRC evaluation utilizing the ADRC packet (DHS Form 1180, 1128, 1127). Individuals who are determined to be disabled will be disenrolled from the QUEST health plan and enrolled into a QExA health plan. The QUEST health plan shall be responsible for providing all medical services to the member until the effective date of enrollment into QExA, which is the first day of the second month following the date a complete ADRC packet is received by DHS. From the effective date of QExA coverage forward, the QExA health plan becomes responsible for all member services except as defined in section 50.110.

If a QExA health plan identifies a member as not disabled, the health plan should submit an ADRC packet to re-assess the disability status. An individual found not disabled will be disenrolled from the QExA health plan and enrolled into the QUEST health plan on the first day of the second month following the date a complete ADRC packet is received.

Newborns of QUEST moms are enrolled into the same QUEST plan as the mom effective the date of birth. If the newborn of a QUEST mom is thought to be disabled, the newborn goes through the ADRC process, and if found disabled, will be enrolled

into a QExA health plan the first day of the second month following the date the complete ADRC was received. Non-disabled newborns of QExA moms are covered by FFS prior to QUEST health plan enrollment. If the QUEST health plan believes the newborn of the QExA mom is disabled, the QUEST health plan should attach the signed DHS Form 1180 to the DHS Form 1179, checking the box stating "ADRC Requested/Disabled," and submit an ADRC packet. If found disabled, the QExA coverage will be effective from the date of birth.

The ADRC packet is also required to be submitted with the DHS Form 1144 to request for State of Hawaii Organ and Tissue Transplant (SHOTT) program services. Once approved for SHOTT, the member will be disenrolled from the health plan, converted to FFS, and transitioned to SHOTT. Prior to exiting from SHOTT, the member will be re-evaluated for disability determination then placed in the appropriate QUEST or QExA program.

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

Members with a medical or psychological condition which may resolve within one year will be required to be re-evaluated after one year from the effective date of QExA enrollment and before fourteen (14) months. DHS will inform the eligibility workers

and the QExA health plans of the members that are coming up on one year of temporary disability status. The member must be re-evaluated within sixty (60) days for continued disability determination. If the member is found to no longer be disabled, the member will be re-enrolled into QUEST in accordance with Section 30.500.

The DHS will be regularly reviewing the appropriateness of ADRC referrals submitted for disability determinations. Effective January 1, 2010, if ADRC referrals from the QUEST health plan are determined to be not disabled for more than 10% of health plan's annual referrals, the health plan will be required to reimburse DHS for the cost of disability determinations over the allowable threshold. The DHS will provide updates of percent of referrals not found disabled on a quarterly basis.

30.800 Monitoring and Evaluation

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

As part of these monitoring responsibilities the DHS will:

- Assess the quality and appropriateness of care and services furnished to all members, with particular emphasis on care/services provided to members with special health care needs;

- Regularly monitor and evaluate the health plan's compliance with the standards established by the State in accordance with federal law and regulations; and
- Arrange for annual, external independent reviews of the quality outcomes and timeliness of, and access to, the services covered under each health plan contract Reference Section 30.820.

30.810 Quality Assessment and Performance Improvement (QAPI) Program Monitoring

In accordance with 42 CFR 438.240(e), Program Review by the State, the DHS will review, at least annually, the impact and effectiveness of each health plan's QAPI Program. The scope of the DHS review also includes monitoring of the systematic processes developed and implemented by the health plan to conduct its own internal evaluation of the impact and effectiveness of its QAPI program as well as to effect necessary improvements.

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

- Document reviews;
- Reviewing and evaluating the QAPI Program reports regularly required by the DHS (e.g. member grievances and appeals reports, provider complaints, grievances and appeals reports, reports of suspected cases of fraud and abuse, the HEDIS report, performance improvement project (PIPs) reports, QAPI Program

Description/Workplan, the QAPI Program Annual Evaluation Report, etc.);

- Reviewing, evaluating or validating implementation of specific policies and procedures or special reports relating to areas such as:
    - Enrollee rights and protections;
    - Care/services provided to enrollees with special health care needs;
    - Utilization management (e.g. under and over utilization of services);
    - Access to care standards, including the:
        - Availability of services;
        - Adequate capacity and services;
        - Continuity and coordination of care;
        - Coverage and authorization of services;
    - Structure and Operation Standards, including:
        - Provider selection;
        - Enrollee information;
        - Confidentiality;
        - Enrollment and disenrollment;
        - Grievance systems;
        - Subcontractual relationships and delegation;
    - Measurement and Improvement Standards;
    - Practice guidelines;
    - QAPI Program;
    - Health information systems;
    - Conducting on-site reviews to interview health plan staff for clarification, review records, or validate implementation of processes/procedures; and

- Reviewing medical records.

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

30.820 External Quality Review/Monitoring

The DHS through its agent will perform, on an annual basis, an external, independent review of the quality outcomes, timeliness of, and access to, services provided by the health plans. The DHS will contract with an External Quality Review Organization (EQRO) to monitor the health plan's compliance with all applicable provisions of 42 CFR Part 438, Subpart D.

Specifically, the EQRO will provide the following mandatory activities:

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

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

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

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

- Administration and reporting the results of the CAHPS® 3.OH Consumer Survey. The survey will be conducted annually, administered to an NCQA-certified sample of members enrolled in each health plan and analyzed using NCQA guidelines. The EQRO will provide an overall report of survey results to the DHS, and the DHS and the health plan will receive a copy of their health plan-specific raw data by island;
- Administration and reporting of the results of the Provider Satisfaction Survey. This survey will be conducted every other year within the broad parameters of CMS' protocols for conducting Medicaid EQR surveys (the DHS, CMS 2002, Final Protocol, Version 1.0 -- *Administering of Validating*

Surveys: Two Protocols for Use in Conducting Medicaid External Quality Review Activities). The EQRO will assist the DHS in developing a survey tool to gauge PCPs' and specialists' satisfaction in areas such as how providers feel about managed care, how satisfied providers are with reimbursement, and how providers perceive the impact of health plan utilization management on their ability to provide quality care. The EQRO will provide the DHS with a report of findings, including the raw data broken down by island. Each health plan will receive a diskette with its plan-specific raw data per island from the EQRO; and

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

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

30.830 Conduct Case Study Interviews

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

30.900 QUEST Policy Memorandums

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

31.100 Readiness Review

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

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

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

Based on the results of the review activites, the DHS will provide the health plan with a summary of findings including the

identification of areas requiring corrective action before the DHS will enroll members in the health plan.

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

31.200 Information Systems

31.210 Hawaii Prepaid Medicaid Management Information Systems (HPMMIS)

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

- Receiving daily eligibility files from Hawaii Automated Welfare Information Systems (HAWI) and processing enrollment/disenrollment of members' into/from the health plans based on established enrollment/disenrollment rules;
- Processing member health plan choices submitted to the MQD enrollment call center;
- Producing daily enrollment/disenrollment rosters; monthly enrollment rosters; and TPL rosters;
- Processing monthly encounter submissions from health plans and generating encounter error reports for health plan correction. Accepting and processing monthly health

plan provider network submissions to assign QUEST provider IDs for health plan use. Errors associated with these submissions are generated and returned to the health plans on a monthly basis for correction;

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

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

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

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

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

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

SECTION 40 PROVISION OF SERVICES – HEALTH PLAN RESPONSIBILITIES

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

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

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

40.200 Provider Network

40.210 Required Providers

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

At a minimum, the health plan shall have the following providers for adult members with serious and persistent mental illness

(SPMI) in its network. These ratios shall be maintained across all islands where the health plan is providing services.

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

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

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

Acute hospital with ability to treat acute psychiatric illness	2 for Oahu, 1 for Maui, 1 for Kauai, 2 for Hawaii*
Crisis response providers	1 per island
Psychosocial Rehabilitation provider	4 for Oahu, 1 for Maui, 1 for Kauai, 2 for Hawaii*
Specialized Residential Treatment provider	2 for Oahu, 1 for Maui, 1 for Kauai, 2 for Hawaii*

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

Health plans shall require one provider for partial hospitalization or intensive outpatient hospitalization statewide.

The physician specialties must be available at the hospital to which the health plan's PCPs admit if the specialty is available in the community. If the specialty is not available in the community, the requirement is not applicable.

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

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

The health plan shall maintain written policies and procedures for the credentialing and re-credentialing of network providers, using standards established by the NCQA. DHS will follow the most current NCQA credentialing and re-credentialing standards including delegation and provider monitoring/oversight, but reserves the right to require approval of standards and thresholds set by the organization (e.g. with regards to performance standards, office

site criteria, medical record keeping, complaints triggering on-site visits). The health plan must also meet requirements of the RFP related to appointment availability (40.220) and medical record keeping (50.530).

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

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

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

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

40.220 Availability of Providers

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

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

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

The health plan shall ensure that all network providers accept members for treatment, unless providers have a full panel and are not accepting new program members. The health plan shall also ensure that network providers do not intentionally segregate members in any way from other persons receiving services. The health plan shall ensure that members are provided services without regard to race, color, creed, sex, religion, health status, income status, or physical or mental disability. The health plan shall ensure that its network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service, if the provider sees only Medicaid recipients.

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

prohibited from charging the member more than it would have if the services were furnished within the network.

40.230 Primary Care Providers (PCPs)

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

Each PCP shall be licensed in Hawaii as:

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

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

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

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

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

The health plan shall establish policies and procedures on choosing and changing PCPs. These PCP policies and procedures shall not establish unreasonable limits on the frequency that a member may choose a new PCP and the criteria for changing PCPs. To the extent possible and appropriate, the health plan shall allow each member to have freedom of choice in choosing

his or her PCP. The health plan's PCP policies and procedures shall apply equally to members residing on islands with multiple plans as well as to members residing on islands with only one plan.

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

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

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

40.240 Direct Access

The health plan shall provide female members with direct in-network access to a women's health specialist for covered care

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

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

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

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

The health plan shall ensure that members have appropriate access to certified nurse midwives, pediatric nurse practitioners, family nurse practioners, and behavioral health nurse practitioners through either provider contracts or referrals. This includes certified nurse midwives, pediatric nurse practioners, family nurse practioners, 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 practioners, and behavioral health practitioners, if requested and available in the geographic area in which the member resides, must be provided. If there are no providers of the specific services in the area, the

health plan will not be required to fly the member to another island to access these services.

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

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

40.270 Rural Exceptions

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

- Choose from at least two (2) PCPs or case managers;
- Obtain services from any other provider under any of the following circumstances:

- The service or type of provider (in terms of training, experience, and specialization) is not available within the health plan;
- The provider is not part of the network but is the main source of a service to the member, is given the opportunity to become a participating provider under the same requirements for participation in the health plan, and chooses to join the network. If this provider chooses not to join the network, or does not meet the necessary qualifications to join, the health plan shall transition the member to an in-network provider within sixty (60) calendar days. If the provider is not appropriately licensed or is sanctioned, the health plan shall transition the member to another provider immediately;
- Select an out-of-network provider because the only provider in-network and available to the member does not, because of moral or religious objections provide the services the member seeks or all related services are not available;
- The member's PCP determines that the member needs related services that would subject the member to unnecessary risk if received separately and not all of the related services are available within the network; and
- The State determines that other circumstances warrant out-of-network treatment.

40.280 Provider “Gag Rule” Prohibition

The health plan may not restrict physicians or other health care professionals from advising their patients about their medical conditions or diseases and the care or treatment required, regardless of whether the care or treatment is covered under the contract, if the professional is acting within the lawful scope of practice. Under the current law, all members are entitled to receive from their provider, the full range of medical advice and counseling appropriate for their condition. The health plan is prohibited from imposing any type of prohibition, disincentive, penalty, or other negative treatment upon a provider for discussing or providing any information regarding treatment options and medically necessary or appropriate care, including no treatment, even if the information relates to services or benefits not provided by the health plan.

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

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

- Members and potential members before and during enrollment.

40.290 Provider Services

The health plan shall be responsible for educating the providers on managed care and all program requirements. Providers shall be informed of the health plan's referral process, prior authorization process, the role of the PCP, availability of care coordination/case management services and how to access these services, the role of care coordinators, members' rights and responsibilities, reporting requirements, circumstances and situations under which the provider may bill a member for services or assess charges or fees, and the grievance/appeals process for providers. The grievance and appeals process shall provide for the timely and effective resolution of any disputes between the health plan and provider(s).

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

- The member's right to file grievances and appeals and their requirements, and timeframes for filing;
- The member's right to a State administrative hearing, how to obtain a hearing and rules on representation at a hearing;
- The availability of assistance in filing a grievance or an appeal;

- The member's right to have a provider or authorized representative file a grievance and/or an appeal on his or her behalf, provided he or she has provided written consent to do so;
- The toll-free numbers to file a grievance or an appeal; and
- When an appeal or hearing has been requested by the member, the right of a member to receive benefits while the appeal or hearing is pending and that the member may be held liable for the costs of those benefits if the health plan's adverse action is upheld.

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

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

procedures outlined in Section 50.800 Member Grievance System.

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

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

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

A – the provider complaint is expected to be resolved by the reporting date to the state, or

B – the provider complaint will unlikely be resolved by the reporting date to the state.

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

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

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

40.295 Provider Contracts

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

The health plan's written provider contracts shall:

- Prohibit the provider from seeking payment from the member for any covered services provided to the member within the terms of the contract and require the provider to look solely to the health plan for compensation for services rendered, with the exception of nominal cost sharing pursuant to the Hawaii Medicaid State plan;
- Require the provider to cooperate with the health plan's quality improvement and utilization review and management activities;
- Include provisions for the immediate transfer to another PCP or health plan if the member's health or safety is in jeopardy;
- Not prohibit a provider from discussing treatment or non-treatment options with members that may not reflect the

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

- Not prohibit, or otherwise restrict, a provider from acting within the lawful scope of practice, from advising or advocating on behalf of a member for the member's health status, medical care, or treatment or non-treatment options, including any alternative treatments that might be self-administered;
- Not prohibit, or otherwise restrict, a provider from advocating on behalf of the member to obtain necessary health care services in any grievance system or utilization review process, or individual authorization process;
- Require providers to meet appointment waiting time standards pursuant to the terms of this contract;
- Provide for continuity of treatment in the event a provider's participation terminates during the course of a member's treatment by that provider;
- Require that providers comply with HIPAA provisions and maintain the confidentiality of member's information and records;
- Prohibit discrimination with respect to participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of such license or certification. This provision should not be construed as any willing provider law, as it does not prohibit the health plan from limiting provider participation to the extent necessary to meet the needs of the members. Additionally, this provision shall not preclude

the health plan from using different reimbursement amounts for different specialties or for different practitioners in the same specialty. This provision also does not interfere with measures established by the heatlh plan that are designed to maintain quality and control costs;

- Prohibit discrimination against providers serving high-risk populations or those that specialize in conditions requiring costly treatments;
- Specify that CMS and the DHS or their respective designee will have the right to inspect, evaluate, and audit any pertinent books, financial records, medical records, documents, papers, and records of any provider involving financial transactions related to this contract and for the monitoring of quality of care being rendered with/without the specific consent of the member;
- Specify covered services and populations;
- Require provider submission of complete and accurate encounter data on a monthly basis and any and all medical records to support encounter data upon request from the health plan with/without the specific consent of the member, DHS or its designee for the purpose of validating encounters;
- Require provider to certify claim/encounter submissions to the plan as accurate and complete;
- Require the provider to provide medical records or access to medical records by the health plan and the DHS or its designee, within sixty (60) days of a request. Refusal to provide medical records, access to medical records or

inability to produce the medical records to support the claim/encounter shall result in recovery of payment;

- Include the definition and standards for medical necessity, pursuant to the definition in this contract;
- Specify rates of payment and require that providers accept such payment as payment in full for covered services provided to members, as deemed medically necessary and appropriate under the health plan's quality improvement and utilization management program, less any applicable member cost sharing pursuant to this contract;
- Specify acceptable billing and coding requirements;
- Require that providers comply with the health plan's cultural competency plan;
- Require that any marketing materials developed and distributed by providers relating to the programs be submitted to the health plan to submit to the DHS for approval prior to distribution;
- Specify that in the case of newborns the health plan shall be responsible for any payment owed to providers related to the newborn;
- Comply with 42 CFR 434 and 42 CFR 438.6;
- Require that providers not employ or subcontract with individuals or entities whose owner or managing employees are on the state or federal exclusions list;
- Prohibit providers from making referrals for designated health services to health care entities with which the provider or a member of the provider's family has a financial relationship;

- Require providers of transitioning members to cooperate in all respects with providers of other health plans to assure maximum health outcomes for members;
- Require that providers who impose a no-show fee for QUEST-Net or QUEST-ACE members inform the members in advance of imposing the no-show fee, or their intent to apply such a fee and what members must do to avoid such an assessment (e.g., how many hours in advance an individual member needs to cancel an appointment); and
- Require that providers submit a Form DHS 1147 to the DHS or its designee when they identify an individual they believe is eligible for long-term care level of services and the Form 1180 to the ADRC to determine disability status.

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

The health plan shall submit to the DHS:

- All finalized and executed contracts thirty (30) days after the date of contract award;
- All finalized and executed contracts that have not been previously submitted sixty (60) days after the date of contract award;
- All finalized and executed contracts that have not been previously submitted ninety (90) days after the date of contract award; and
- All finalized and executed contracts that have not been previously submitted one hundred twenty (120) days after the date of contract award.

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

40.300 Covered Benefits and Services

The health plan shall be responsible for providing all medically necessary services to members as defined in this section. These medically necessary services shall be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to recipients under Medicaid fee-for-service. The health plan may not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of the diagnosis, type of illness or condition. The health plan may incorporate utilization controls as described in Section 50.600 as long as the services furnished to the member can be reasonably expected to achieve their purpose.

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

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

general surgeons), as defined in Appendix M. Section 40.320 provides further description of the health plan's responsibilities.

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

For new adult enrollments into the program, the health plan may apply a one-month waiting period for any *additional services* that are not included in the Medicaid State Health Plan. The health plan shall use the guidelines provided in Appendix N. The health plan is prohibited from applying a one-month waiting period on individuals under the age of twenty-one (21), pregnant members or adult members who have had a break in coverage of sixty (60) days or less.

40.305 Medical Services to be Provided to QUEST Members

The health plan shall provide the following services:

- Acute inpatient hospital services for medical, surgical, psychiatric, and maternity/newborn care including:
    - Room and board
    - Nursing care
    - Medical supplies, equipment and drugs
    - Diagnostic services

    - Physical, occupational, speech and language therapy services
    - Other medically necessary services
- Outpatient hospital services including:
    - Twenty-four (24) hours, seven (7) days per week emergency room services
    - Ambulatory surgery center services
    - Urgent care services
    - Medical supplies, equipment and drugs
    - Diagnostic services
    - Therapeutic services including chemotherapy and radiation therapy
    - Other medically necessary services
- Preventive services including (See Appendix L for more details on preventive services):
    - Initial and interval histories, comprehensive physical examinations and developmental assessments
    - Immunizations
    - Family planning
    - Diagnostic and screening laboratory and x-ray services, including screening for tuberculosis
- Prescribed drugs including blood and blood products medically necessary to optimize the member's medical condition and behavioral health prescription drugs to children receiving services from CAMHD.:
    - Medication management and patient counseling
- Radiology/laboratory/other diagnostic services including:
    - Radiology and imaging (including screening mammograms)

    - Screening laboratory tests such as PKUs
    - Diagnostic laboratory tests
    - Therapeutic radiology
    - Other medically necessary diagnostic services
- Physician services
- Maternity services
    - Prenatal care
    - Prenatal laboratory screening tests and diagnostic tests
    - Treatment of missed, threatened, and incomplete abortions
    - Delivery of infant
    - Postpartum care
    - Prenatal vitamins
- Other practitioner services including:
    - Optometry
    - Certified nurse midwife service
    - Licensed Advanced Practice Registered Nurse service that include family, pediatric and psychiatric health specialties
    - Other medically necessary practitioner services provided by licensed or certified health care providers
- Therapeutic services including:
    - Physical and Occupational therapy
    - Speech and language pathology
    - Audiology services

- Other medically necessary therapeutic services including services which would prevent institutionalization

- Durable medical equipment and medical supplies including:
  - Oxygen tanks and concentrators
  - Ventilators
  - Wheelchairs
  - Crutches, canes
  - Eyeglasses (no more than one pair of eyeglasses every twenty-four months with no more than one replacement for lost or stolen eyeglasses every twenty-four month period)
  - Orthotic devices
  - Prosthetic devices
  - Hearing aids
  - Pacemakers
  - Medical supplies, such as surgical dressings and ostomy supplies
  - Other medically necessary durable medical equipment covered by the Hawaii Medicaid program
- Home health agency services including:
  - Skilled nursing
  - Home health aides
  - Therapeutic services such as physical, speech, occupational and audiology therapy
  - Medical supplies and durable medical equipment
  - Other therapies, services and supplies and equipment to prevent institutionalization
- Hospice services

- Long-term care services (SNF/ICF and subacute or waitlisted for SNF/ICF and subacute bed in an acute hospital for a maximum of sixty (60) days)
- Cornea transplants and bone graft services
- Transportation services, both emergency and non-emergency, ground and air
- Language translation/interpretation services, sign language interpretation
- Emergency services (see Section 40.335)
- Sterilizations and hysterectomies when federal requirements are met (see Section 40.360)
- Substance Abuse Services (room and board in Special Treatment Facilities for adolescents is not covered but therapy/treatment provided in the facility is the responsibility of the health plan)
- Treatment of non-pulmonary and latent tuberculosis that is not covered by DOH

40.310 Excluded Services

The health plan shall not provide the following services:

- Experimental, investigational services, or services of generally unproven benefit, supplies, equipment, devices and drugs of unproven benefit;
- Treatment of pulmonary tuberculosis when treatment is available at no charges to the general public. Health plans shall cover treatment of non-pulmonary and latent tuberculosis that is not covered by DOH;

- Treatment of Hansen's Disease after a definite diagnosis has been made except for surgical or rehabilitative procedures to restore useful function; and
- Drugs not approved by the U.S. Food and Drug Administration or deemed "less than effective" (DESI 5 and 6) by CMS.

Other specific exclusions are listed in Appendix O.

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

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

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

- Emergency medical situations as defined in Section 40.335;
- Ten (10) inpatient hospital days. There is no maternity benefit for members. However, the health plan shall refer QUEST-Net and QUEST-ACE members who become pregnant to their eligibility worker to determine their qualifications for QUEST, nursery, rehabilitation, or skilled nursing facility level of care;

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

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

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

40.320 Medical Services Related to Dental Needs

The health plan shall provide any dental services or medical services resulting from a dental condition that are provided in a medical facility (e.g., inpatient hospital and ambulatory surgery center). This includes medical services provided to QUEST adults and children that are required as part of a dental treatment and certain dental procedures performed by both dentists (oral surgeons) and physicians (primarily plastic surgeons,

otolaryngologists and general surgeons), as defined in Appendix M.

Specifically, the health plan shall be responsible for:

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

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

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

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

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

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

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

- Adults whose use of prescription medication includes atypical antipsychotics and the chronic use of opioids, the chronic use of polypharmacy, and other chronic usage of specific drugs that exceed the use by other adults in the health plan as identified by the health plan; and
- Adults whose utilization of emergency room services is beyond that generally used by other adults in the health plan for the treatment of chronic medical conditions such as asthma and diabetes; and
- Adults who use or need speech therapy, occupational therapy, and/or physical therapy for chronic medical conditions that exceed the utilization by other adults in the health plan.

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

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

- Children who need or receive treatment or counseling for an emotional, developmental, or behavioral problem that has lasted or is expected to last at least twelve (12) months.

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

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

- Generate a treatment plan that is developed by the member's PCP with the member's participation, and in consultation with any specialist caring for the member;
- Approve the treatment plan in a timely manner;
- Ensure that the treatment plan is in accordance with all applicable State quality assurance and utilization review standards ;
- Coordinate care with other State agencies and community organizations in order to prevent duplication of benefits; and
- Provide access to providers who are experienced in delivering the appropriate care, are available, and are physically accessible. If an appropriate in-network provider is not available the health plan shall allow SHCN members to see an out-of-network provider. In addition,

the health plan shall permit either a standing referral, an adequate number of direct access visits to specialists as determined by the member's PCP, or allow the member to select a specialist as a PCP.

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

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

40.330 Disease Management

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

The health plan's disease management programs shall:

- Have a systematic method of identifying and enrolling members in each program;
- Utilize evidence-based clinical practice guidelines;
- Emphasize the prevention of exacerbation and complications of the diseases;
- Incorporate educational components for both members and providers,

- Utilize an integrated, comprehensive approach to patient care that extends beyond a focus on the prescription drug line item;
- Takes a member-centered approach to providing care by addressing psychological aspects, caregiver issues and treatment of diseases using nationally recognized standards of care;
- Incorporate culturally appropriate interventions, including but not limited to taking into account the multi-lingual, multi-cultural nature of the member population;
- Focus interventions on the member through activities such as disease and dietary education, instruction in health self-management, and medical monitoring;
- Have established measurable benchmarks and goals which are specific to each disease and are used to evaluate the efficacy of the disease management programs; and
- Be analyzed to determine if costs have been lowered by reducing the use of unnecessary or redundant services or by avoiding costs associated with poor outcomes.

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

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

40.335 Emergency Services

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

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

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

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

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

The health plan shall provide payment for emergency services when furnished by a qualified provider, regardless of whether that provider is in the health plan's network. These services shall not be subject to prior authorization requirements. The health plan shall pay for all emergency services that are medically necessary until the member is stabilized. The health plan shall also pay for any screening examination services to determine whether an emergency medical condition exists.

The health plan shall base coverage decisions for emergency services on the severity of the symptoms at the time of presentation and shall cover emergency services when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson. The emergency room physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the health plan, who shall be responsible for coverage and payment. The health plan, however, may establish arrangements with a hospital

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

The health plan shall not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency medical condition under the prudent layperson standard, turned out to be non-emergency in nature. If an emergency screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition does not exist, then the determining factor for payment liability shall be whether the member had acute symptoms of sufficient severity at the time of presentation. In this case, the health plan shall pay for all screening and medically nesessary services provided.

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

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

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

40.340 Post-Stabilization Services

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

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

- The health plan does not respond to the provider's request for pre-certification or prior authorization within one hour;
- The health plan cannot be contacted;
- The health plan's representative and the attending physician cannot reach an agreement concerning the member's care and a health plan physician is not available for consultation. In this situation the health plan shall give

the treating physician the opportunity to consult with an in-network physician and the treating physician may continue with care of the member until a health plan physician is reached or one of the criteria outlined below are met.

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

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

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

40.345 Urgent Care Services

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

40.350 Services for Pregnant Women and Expectant Parents

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

The health plan is also prohibited from:

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

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

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

40.355 Family Planning Services

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

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

- Infertility assessment.

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

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

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

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

expected date of delivery (the expected date of delivery must be provided on the consent form);

- An interpreter is provided when language barriers exist. Arrangements are to be made to effectively communicate the required information to a member who is visually impaired, hearing impaired or otherwise disabled; and
- The member is not institutionalized in a correctional facility, mental hospital or other rehabilitative facility.

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

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

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

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

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

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

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

40.365 Prescription Drugs

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

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

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

40.370 Behavioral Health

Adults

The health plan shall assume financial responsibility for providing all medically necessary behavioral health services to all adult members with SPMI effective July 1, 2010. The provision of these services by the health plan's provider network shall be transitioned in the following phased approach with all transitions completed by September 1, 2010:

Members	Effective Date
Adult Mental Health Division (AMHD) members with active treatment plan of care with last names beginning with A through K	July 1, 2010

AMHD members with an active treatment plan of care with last names beginning with L through Z	September 1, 2010
Members in Behavioral Health Managed Care (BHMC) Health Plan	As agreed to between the QUEST health plan and the BMHC health plan

Behavioral Health services include:

- Inpatient Hospitalizations, including day and partial hospitalizations - room/board, nursing care, medical supplies, equipment, drugs, diagnostic services, psychiatric and other practitioner services, ancillary services, other medically necessary services;
- Ambulatory Mental Health Services, including twenty-four (24) hour access line, mobile crisis response, crisis stabilization, and crisis residential services. For these crisis services, the health plans should contract with the entity contracted by DOH and/or with DOH itself at a rate agreed upon by DOH and DHS that will be factored into capitation rates;
- Diagnostic and Treatment Services - psychological screening, testing, treatment, including individual and group counseling, and monitoring;
- Medications and Medication Management - evaluation, prescription, maintenance of psychotropic medications, medication management/counseling/education, promotion of algorithms and guidelines;

- Medically necessary alcohol and chemical dependency services; and
- Methadone management services.

Additional Services for adults with diagnosis of serious and persistent mental illness (SPMI) who meet the eligibility criteria listed below should include:

- Intensive Care Coordination/Case Management- case assessment, planning, outreach, ongoing monitoring and service coordination, including disease and self-management to promote illness management and recovery;
- Integrated services for individuals with co-occurring substance abuse and mental illness;
- Partial hospitalization or intensive outpatient hospitalization;
- Psychosocial Rehabilitation (therapeutic day rehab social skill building services, such as group skill building activities that focus on development of problem solving skills, medication education, and symptom management, that allows individuals to gain necessary social and communication skills necessary to enable them to remain in or return to naturally occurring community programs) and
- Therapeutic Living Supports (services covered in settings such as group living arrangements or therapeutic foster homes. Covered therapeutic supports are only available when the identified individual resides in a licensed group

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

Health plans must have a process in place to identify adults with SPMI who are in need of additional behavioral health services according to criteria listed below. The process to identify adults with SPMI in need of additional behavioral health services must be based on the criteria listed in this section. This definition is also utilized by the Adult Mental Health Division (AMHD) in order to assure consistency in benefit management. Eligibility for additional behavioral health services includes:

- The member is eligible for the QUEST program and not in QUEST-ACE or QUEST-Net; and

- The member falls under one of the qualifying diagnoses (see Appendix J); and
- The member demonstrates presence of qualifying diagnosis for at least twelve (12) months or is expected to demonstrate the qualifying diagnosis for the next twelve (12) months; and
- The member meets at least one of the criteria below demonstrating instability and/or functional impairment:
    - Global Assessment of Functioning (GAF) < 50; or
    - Clinical records demonstrate that the member is currently unstable under current treatment or plan of care (ex. multiple hospitalizations in the last year and currently unstable, substantial history of crises and currently unstable to include but not limited to consistently noncompliant with medications and follow-up, unengaged with providers, significant and consistent isolation, resource deficit causing instability, significant co-occurring medical illness causing instability, poor coping/independent living/problem solving skills causing instability, at risk for hospitalization); or
    - Member is under Protective Services or requires intervention by housing or law enforcement officials.
- Members that do not meet the requirements listed above, but based upon an assessment by the health plan's medical director that additional services are medically necessary for the member's health and safety should be evaluated on a case by case basis for provisional eligibility.

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

- The member is unable to engage or demonstrate benefit or maintenance of benefit from additional services despite maximum intervention for at least six (6) months, OR
- Completion of assessment by the health plan's medical director who determines that the additional behavioral health services are no longer medically necessary for the member's health and safety, OR
- All of the following:
    - GAF > 50 (adults), and
    - Stable for at least 3 months with no anticipated change, and
    - Able to remain stable without additional intensive services.
- Members that meet criteria to end or suspend additional services, but are assessed by the health plan's medical director to need additional medically necessary services for the member's health and safety, should be evaluated on a case-by-case basis for extension of additional services for a specified length of time.

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

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

Children

The health plan shall provide all medically necessary behavioral health services. These services include:

- Inpatient Hospitalizations, including day and partial hospitalizations - room/board, nursing care, medical supplies, equipment, drugs, diagnostic services, psychiatric and other practitioner services, ancillary services, other medically necessary services;
- Ambulatory Mental Health Services, including crisis and response stabilization;
- Diagnostic and Treatment Services - psychological screening, testing, treatment, including individual and group counseling, and monitoring;
- Medications and Medication Management - evaluation, prescription, maintenance of psychotropic medications,

medication management/counseling/education, promotion of algorithms and guidelines; and

- Medically necessary alcohol and chemical dependency services.

For children who require the Support for Emotional and Behavioral Development (SEBD) program based on criteria listed below, the health plan should contract with the Child and Adolescent Mental Health Division (CAMHD) to allow continuity of care for the full array of intensive services at fees that do not exceed the current Medicaid fee schedule with an effective date as identified in Section 30.770. Acute hospitalizations, medications, and enabling services (interpretive services, travel/meals/lodging) are not in the CAMHD service array and must still be provided by the health plan for these members. The CAMHD SEBD services include:

- Crisis management, including twenty-four (24) hour crisis telephone stabilization, mobile outreach services, and crisis stabilization services;
- Intensive Case Management, including comprehensive case assessment, planning, coordination, and monitoring;
- Outpatient Assessment, therapy, and medication management, including psychiatric evaluation, mental health assessments (comprehensive, focused, summary, and psychosexual), therapy (individual, group, and family), treatment service planning, school consultation, and case consultation;

- Family supports, including family therapy, functional family therapy, parent skills training, and respite homes;
- Intensive Home and Community-based Intervention, including in-home intervention, and independent living programs;
- Multisystemic Therapy - time limited, intensive family and community-based treatment addressing multiple determinants of serious conduct disorder behaviors in juvenile offenders;
- Therapeutic Foster and Group Homes;
- Multidimensional Treatment Foster Care - intensive family-based services in foster family settings for youth with delinquent/disruptive behaviors and emotional challenges;
- Community Mental Health Shelters;
- Community-based Residential Programs;
- Hospital-based Residential Services and Partial Hospitalization; and
- Tele-health.

Health plans must have a process in place to identify children/youth that are unstable, of moderate-high risk, and in need of the SEBD program. Eligibility for additional services includes:

- The member is age three through twenty (3-20) years; and
- The member falls under one of the qualifying diagnoses (see Appendix J); and

- The member demonstrates presence of a qualifying diagnosis for at least six (6) months or is expected to demonstrate the qualifying diagnosis for the next six (6) months; and
- The member's Child and Adolescent Functional Assessment Scale (CAFAS) score is > 80.
- Members that do not meet the eligibility criteria, but based upon assessment by the health plan's medical director that additional services are medically necessary for the member's health and safety, should be evaluated on a case by case basis for provisional eligibility.

The health plan must also have a process in place to regularly re-assess children/youth who are receiving additional behavioral health services and re-evaluate continued need for additional behavioral health services. Criteria to end or suspend additional behavioral health services are based on the client's stabilization and clinical indication to be able to be maintained by behavioral health services available to all health plan members. The clinical criteria used include:

- The member is unable to engage or demonstrate benefit or maintenance of benefit from additional services despite maximum intervention for at least twelve (12) months, OR
- All of the following:
    - CAFAS < 80; and
    - Stable for at least six (6) months with no anticipated change; and
    - Able to remain stable without intensive additional services.

- Members that meet the discharge criteria, but are assessed by CAMHD's medical director to need additional medically necessary services for the member's health and safety, may continue to stay in the CAMHD program for a specified additional length of time with approval by the health plan's medical director.

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

Contracting with CAMHD shall occur for eligible members at fees that do not exceed the current Medicaid fee schedule. For eligible members serviced by CAMHD, the health plan is responsible for the regular assessments for continued stay or discharge from CAMHD.

<u>For Both Adults and Children</u>

The health plan may utilize a full array of effective interventions and qualified professionals such as psychiatrists, psychologists, counselors, social workers, licensed mental health counselor, registered nurses and others. Substance abuse counselors shall be certified by the State of Hawaii Department of Health Alcohol and Drug Abuse Division (ADAD). Additionally, substance abuse services, which can only have limits or prior authorization requirements that are co-extensive with physical treatments,

shall be provided in a treatment setting accredited according to the standards established by ADAD. The health plan is encouraged to utilize currently existing publicly funded community-based substance abuse treatment programs, which have received ADAD oversight, through accreditation and monitoring.

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

The health plan shall be responsible for providing behavioral health services to persons who have been involuntarily committed for evaluation and treatment under the provisions of Chapter 334, HRS to the extent that these services are deemed medically necessary by the health plan's utilization review procedures and are within the established limits.
The health plan is not obligated to provide behavioral health services to those *adult* members whose diagnostic, treatment or rehabilitative services are determined to not be medically necessary by the health plan.

The health plan is not obligated to provide behavioral health services to those *adults and children*:

- Who have been criminally committed for evaluation or treatment in an inpatient setting under the provisions of Section 706-607, HRS. These individuals will be dis-

enrolled from the program and will become the clinical and financial responsibility of the appropriate State agency. The psychiatric evaluation and treatment of members who have been criminally committed to ambulatory mental health care settings will be the clinical and financial responsibility of the appropriate State agency. The health plan shall remain responsible for providing medical services to these criminally committed members.

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

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

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

- Placing the member into other appropriate substance abuse treatment programs following discharge from the residential treatment program.

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

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

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

responsible for medical services related to dental needs as described in Sections 40.300 and 40.321.

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

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

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

The health plan's outreach and informing process shall:

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

fourteen (14) days after birth that EPSDT services are available.

The health plan's informing shall:

- Be done orally (on the telephone, face-to-face or films/tapes) or in writing. Informing may be done by health plan personnel or health care providers. The health plan shall follow-up with families with EPSDT-eligible members who, after six (6) months of enrollment, have failed to access EPSDT screens and services;
- Be done in non-technical language at or below a 6th (6.9 grade level or below) grade reading level and use accepted methods for informing persons who are blind or deaf, or cannot read or understand the English language, in accordance with Section 50.320; and
- Stress the importance of preventive care; describe the periodicity schedule; provide information about where and how to receive services; inform members that transportation and scheduling assistance is available upon request; description of how to access services; state that services are provided without cost; describe what resources are available for non-plan services; and describe the scope and breadth of the health services available. Annual informing by the health plan is required for EPSDT members who have not accessed services during the prior year.

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

- Complete periodic screens according to the EPSDT periodicity schedule in Appendix P and the requirements detailed in the State Medicaid Manual. The health plan shall strive to provide periodic screens to one hundred percent (100%) of eligible members; minimum compliance is defined as providing periodic screens to eighty (80) percent of eligible members;
- Interperiodic screens; and
- Partial screens.

The health plan shall provide all medically necessary diagnostic and treatment services to correct or ameliorate a medical, dental (as defined in Section 30.730), or behavioral health problem discovered during an EPSDT screen (complete periodic, inter-periodic, or partial). This includes, but is not limited to, timely immunizations and tuberculosis screening, diagnosis and treatment of defects in vision and hearing, diagnosis and treatment of any issues found in general developmental and autism screening, and, diagnosis and treatment of acute and chronic medical, dental (as defined in Section 30.730), and behavioral health conditions. Screening for developmental delays, autism, and behavioral health conditions, should be done using standardized, validated screening tools as recommended by current national guidelines and the State's EPSDT program.

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

The health plan shall provide additional medical services determined as medically necessary to correct or ameliorate defects of physical, mental/emotional, or dental illness (as defined in Section 30.730) and conditions discovered as a result of EPSDT screens. Examples of services are: prescription drugs not on the health plan's formulary, durable medical equipment typically not covered for adults, chiropractic care, personal care services, private duty nursing services, and certain non-experimental medical and surgical procedures.

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

The health plan is responsible for behavioral health services for all children with mental and behavioral conditions. Some children who meet criteria as identified in Section 40.370 will require more intensive services, which the health plan can provide through contract with CAMHD's Support for Emotional

and Behavioral Development (SEBD) program. Children who are eligible for the SEBD program can obtain their behavioral health needs through CAMHD's SEBD program. See Section 40.370 for details on Behavioral Health Benefits. These children are complex and often need the collaboration of multiple agencies for effective intervention. The health plan must, along with CAMHD, have a process in place for collaboration with other agencies (DOE, DOH, Child Welfare) to assure coordinated care for the member. The health plan is responsible for coordinating their services for individuals determined to be eligible for the SEBD program by the health plan with the medically necessary outpatient behavioral health services that are required for the educational needs of the member provided by DOE and DOH.

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

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

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

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

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

40.385 Vaccines for Children (VFC) Program

The State of Hawaii participates in the VFC program, a federally funded program that replaces public and private vaccines for Medicaid, QUEST and QUEST-Net children. These vaccines are distributed to qualified providers who administer them to children. As a result, the health plan will not be reimbursed for any privately acquired vaccines that can be obtained through Hawaii VFC program. Although the cost of the vaccines is not included in the capitated rate to the health plans, the health plan is not prohibited from allowing privately acquired vaccines and may decide whom, if any, and how it will reimburse for vaccines. The health plan will receive the fee for the administration of the vaccine as part of the capitated rate.

40.390 Appropriate Levels of Care

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

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

40.395 Subacute Level of Care

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

40.400 Care Coordination/Case Management System

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

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

This system shall function within the health plan's QAPI program to assist the PCP and other providers in the health plan's network to provide the care needed to optimize a member's health outcome, and must therefore, be readily accessible to the PCP and member, not placing unnecessary burdens on the PCP or compromising good medical care. As part of this CC/CM, the health plan shall, at a minimum, have in place processes and protocols for meeting CC/CM standards as required in 42 CFR §438.208. These processes are:

- Providing care coordination to support the PCP and other providers in the network in providing good medical care to members;
- Providing referrals to members for care coordination or other programs or agencies;
- Coordinating with community programs that provide services to a member which are not covered by the programs;
- Providing continuity of care when members transition to other programs (e.g., behavioral health managed care plan, QExA health plan, Medicaid fee-for-service program, Medicare);

- Providing continuity of care when members are discharged on medications which are normally prior authorized or not on the plan's formulary;
- Identifying members who have the greatest need for CC/CM, particularly those members who have chronic conditions;
- Coordinating services and ensuring continuity of care with other health plans from whom the member receives services; and
- Providing the results of its identification and assessment of any member with SHCNs to other QUEST or QExA health plans so that those activities are not duplicated.

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

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

The health plan shall also educate providers on its processes and procedures for receiving and approving referrals for treatment. Finally, the health plan shall have on staff or on contract, care coordinators who can assist the PCP in coordinating care for members with more complex needs, in obtaining translation services, in arranging for transportation, and in referring

members to appropriate programs such as Zero-To-Three, Healthy Start, and Medicaid's Home and Community Based Waiver Programs.

40.500 Second Opinions

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

40.600 Craniofacial Review Panel Recommendations

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

The health plan shall aid in the coordination of treatment in cases involving coverage by more than one health plan and shall facilitate the processing of preauthorization requests and claims. If a member changes health plans (either through the annual

plan change period or moves to another island), the “old” health plan shall assist the “new” health plan by providing information on the panel recommendations, the treatment provided, and the progress to date and shall coordinate with the “new” health plan to ensure a smooth transition.

40.700 Advance Directives

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

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

The information must include a description of current State law and must reflect changes in State laws as soon as possible, but no later than ninety (90) days after the effective date of the change. The health plan’s information must inform members

that complaints concerning noncompliance with the advance directive requirements may be filed with the DHS.

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

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

40.800 Behavioral Health Managed Care (BHMC) Health Plan

The health plans shall assume for all their members in the BHMC health plan financial responsibility for behavioral health services on the effective date identified in Section 30.760 and clinical responsibility on the effective date identified in Section 40.370. Prior to July 1, 2010, adult members, as determined by the DHS to be SPMI, may be enrolled in the BHMC plan. Between July 1, 2010 and September 1, 2010, the expectation is that members who the health plan identify to be SPMI will receive behavioral

health services through the health plan's network. On a case by case basis with DHS approval, a member may be enrolled in the BHMC plan between July 1 and September 1, 2010. The DHS will provide guidance for this enrollment.

40.810 Health Plan Referral for an Evaluation

The health plan is responsible for making the initial determination of whether or not an adult member has a SMI (using the definition in Appendix J). Once the health plan has made this determination, the health plan may refer the adult member to the DHS to be evaluated for referral and enrollment to the BHMC plan until July 1, 2010. The forms and procedures to be used may be found in the Bidder's Library.

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

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

requests that the member submit to an interview, the health plan shall provide and pay for transportation to the evaluation site for child and parent/guardian.

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

Appendix R provides a more detailed description of this process.

40.820 Enrollment into BHMC

The health plan shall be responsible for providing all behavioral health services to a member determined eligible for BHMC within the established benefit limits, until the BHMC plan enrollment date unless the member is in an inpatient setting on the date of enrollment in which case the member shall remain the health plan's responsibility until discharge. The health plan shall not receive any additional compensation for maintaining the CC/CM functions as these services are included in the capitation rate. The health plan shall be relieved of its responsibility for providing all behavioral health services and coordinating all behavioral health services relating to the member's care once enrolled in the BHMC plan. Prior to July 1, 2010, adult members, as determined by the DHS to be SPMI, may be enrolled in the BHMC plan. Between July 1, 2010 and September 1, 2010, the expectation is that members who the health plan identify to be SPMI will receive behavioral health services through the health plan's network. On a case by case basis with DHS approval, a

member may be enrolled in the BHMC plan prior to September 1, 2010. The health plan shall continue to be responsible for medical services.

Upon determination by the DHS that a member no longer meets the criteria for enrollment in the BHMC plan, the DHS will disenroll the member and notify the health plan. Upon the date of disenrollment from the BHMC plan, the health plan shall provide the appropriate mental health, drug abuse or alcohol abuse services within the established benefit limits.

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

40.900 Out-of-State and Off-Island Coverage

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

providers as long as the provider is in the same geographic location as the member and the member can be transferred.

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

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

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

41.100 Other Services to be Provided

41.110 Cultural Competency Plan

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

- Identify the health practices and behaviors of the members;
- Design programs, interventions and services which effectively address cultural and language barriers to the delivery of appropriate and necessary health services;
- Describe how the health plan will ensure that services are provided in a culturally competent manner to all members so that all members including those with limited English proficiency and diverse cultural and ethnic backgrounds understand their condition(s), the recommended treatment(s) and the effect of the treatment on their condition including side effects;
- Describe how the health plan will effectively provide services to people of all cultures, races, ethnic backgrounds and religions in a manner that recognizes, affirms and respects the worth of the individual members and protects and preserves the dignity of each; and
- Comply with, and ensure that providers participating in the health plan's provider network comply with, Title VI of the Civil Rights Act of 1964, 42 U.S.C. Section 2000d, 45 CFR Part 80 and 42 CFR 438(c)(2), 42 CFR 438.100(d), 42 CFR 438.6(d)(4) and (f)..

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

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

41.120 Transportation Services

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

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

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

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

The health plan shall provide transportation for a member under the age of twenty-one (21), and their attendant, for medically necessary evaluations required by the Craniofacial Review Panel and to attend case presentations by the Panel.

41.130 WIC Coordination

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

41.140 Certification of Physical or Mental Impairment

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

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

41.150 Foster Care/Child Welfare Services (CWS) Children

In addition to providing all medically necessary services under EPSDT, the health plan shall be responsible for providing the pre-placement physicals (prior to placement) and comprehensive examinations (within forty-five (45) days after placement into a foster care home) including medication dispensed when a physical examination shows a medical need, for children with an active case with CWS. A comprehensive examination shall have all of the components of an EPSDT visit and the health plan shall reimburse the provider the same rate as for an EPSDT visit. The health plan shall have procedures in place to assist CWS workers in obtaining a necessary physical examination within the established timeframe through a provider in its network. Physical examinations may take place in either an emergency room or physician's office. However, the health plan shall be

responsible for the examination even if a network provider is unable to provide the examination. If the provider is not a network provider within the health plan the non-network provider must understand and perform all the components of the comprehensive EPSDT examinations and be a licensed provider.

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

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

41.200 Transition of Care

If the member moves to a different service area in the middle of the month and enrolls in a different health plan the former health plan shall remain responsible for the care and the cost of the inpatient services (as provided in Section 50.110) provided to the member, if hospitalized, until discharge or level of care change, whichever occurs first. Otherwise, the new health plan will be responsible for all services to the member as of member's date of enrollment. If member moves to a different service area, and remains with the same health plan the health plan shall

remain responsible for the care and cost of the services provided to the member.

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

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 assure that the DHS or the new health plan has access to the member's medical records and any other vital information that the former health plan has to facilitate transition of care.

The former health plan shall continue an existing treatment plan for at least sixty (60) days or until the member's behavioral health needs have been assessed and medically necessary behavioral health services are in place with the new health plan in accordance with timeframes provided in the first paragraph of Section 40.370.

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

SECTION 50 HEALTH PLAN ADMINISTRATIVE REQUIREMENTS

50.100 Health Plan Enrollment Responsibilities

The health plan shall accept individuals enrolled into their plan by the DHS without restriction, unless otherwise authorized by the DHS. The health plan shall not, on the basis of health status or need for health care services, religion, race, color, gender, or national origin discriminate against individuals enrolled. The health plan shall not use any policy or practice that has the effect of discriminating on the basis of race, religion, color, gender, national origin, or health care status.

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

- A confirmation of enrollment;
- A health plan member number, which does not have to be the same as the Medicaid ID number which has been assigned by the DHS;
- An explanation of the role of the PCP and the procedures to be followed to obtain needed services;
- Information explaining that the health plan will provide assistance in selecting a PCP and how the member can receive this assistance;

- Information explaining that the health plan will auto-assign a member to a PCP if the member does not select a PCP within ten (10) days;
- A Member Handbook as described in Section 50.330;
- An explanation of the member's rights, including those related to the complaint and grievance procedures;
- A description of member responsibilities, including an explanation of the information a member must provide to the health plan and the DHS upon changes in the status of the member including marriage, divorce, birth of a child, adoption of a child, death of a spouse or child, acceptance of a job, obtaining other health insurance, etc.; and
- A copy of the written policies and procedures related to advance directives to members at the time of enrollment in accordance with 42 CFR 438.6(i).

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

The health plan shall be responsible for all inpatient services, as well as any transportation, meals and lodging for one (1) attendant, if applicable, for all members who are enrolled in its health plan on the date of admission to an acute care hospital. In the event a member changes into a non-managed care MQD program, health plan, or is otherwise disenrolled during an acute hospital stay, the health plan in which the member was enrolled on admission, shall remain responsible for the inpatient services through change in level of care (subsequent to health plan change) or discharge, whichever comes first.

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

If the member changes enrollment from either QUEST to QUEST-ACE or QUEST-Net or from QUEST-ACE or QUEST-Net to QUEST, the health plan to which the member belongs should provide coverage for the hospitalization consistent with the benefits of the program in which the member is enrolled. For instance, if a QUEST member enrolls into QUEST-ACE or QUEST-Net, the health plan to which the member belongs covers the full hospitalization benefits until the date of enrollment into QUEST-ACE or QUEST-Net, upon which only 10 days is covered. Similarly, if a QUEST-ACE or QUEST-Net member enrolls into QUEST, the health plan to which the member belongs covers 10 days of hospitalization under QUEST-ACE or QUEST-Net until the enrollment into QUEST upon which full hospital benefits are covered.

The QUEST health plan, the QExA health plan, or the non-managed care MQD program into which the hospitalized member has been enrolled shall be responsible for professional fees, outpatient prescription drugs, and transportation, meals and lodging for an attendant, if applicable from the date of enrollment into the health plan.

50.120 PCP Selection

The health plan shall provide the DHS with provider information as outlined in Section 50.350 to assist MQD in compiling a Provider Directory, and information on how to obtain care during the time there is no PCP assignment and no health plan card. The health plan shall provide assistance in selecting a PCP and shall provide the member ten (10) calendar days to select a PCP. This ten (10) day period shall not include mail time. If a PCP is not selected within ten (10) days, the health plan shall assign a PCP to the member based on the geographic area in which the member resides.

50.130 Member Status Change

The health plan shall forward to the DHS, in a timely manner, any information that affects the status of members in its health plan. The health plan shall complete the required 1179 form for changes in member status and submit the information by fax, courier services or mail to the appropriate MQD eligibility office. In addition, the health plan shall notify the member that it is also his or her responsibility to provide the information to the DHS.

The following are examples of changes in the member's status, which may affect the eligibility of the member.

- Death of the member or family member (spouse or dependent);
- Birth;

- Marriage;
- Divorce;
- Adoption;
- Transfer to long term care;
- Change in health status (e.g., pregnancy or permanent disability);
- Change of address;
- Institutionalization (e.g., state mental health hospital or prison); or
- TPL coverage, including employer sponsored or Medicare.

50.140 Enrollment for Newborns

The health plan shall notify the DHS within twenty-four (24) hours of receiving notification of the birth of a newborn to one of its members. If the notification to the health plan is on a weekend or on a day preceding a holiday, notification on the next business day following the weekend will be accepted.

50.150 Enforcement of Documentation Requirements

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

50.160 Informational Brochure

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

50.200 Disenrollment

50.210 Appropriate Reasons for Health Plan Disenrollment Requests

The DHS is solely responsible for making all disenrollment determinations and decisions. The health plan shall notify the DHS in the event it becomes aware of circumstances which might affect a member's eligibility or whether there has been a status change such that a member would be disenrolled from the health plan. Appropriate reasons for the health plan to request disenrollment include, but are not limited to, the following:

- Member no longer qualifies based on the eligibility criteria or voluntarily leaves the program;
- Member is deceased;
- Member is incarcerated;
- Member enters the State Hospital;
- Member is waitlisted at an acute hospital for a long-term care bed (after sixty (60) days and has been determined disabled by the DHS);
- Member's PCP is not in the health plan's network;
- Member is a blind or disabled child under the age of twenty-one (21);
- Member is in foster care and has moved out-of-state;
- Member becomes eligible for Medicare Special Savings Program;
- Member enters a home and community based waiver program and meet the requirements for eligibility in the Medicaid fee-for-service program; or

- Member provides false information with the intent of participating in the programs under false pretenses.

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

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

If the DHS determines that the member meets nursing facility level of care, the health plan or facility shall also refer the member for an ADRC determination. If determined disabled, the DHS or its agent will notify the eligibiity worker to disenroll the member and to transfer the person to the Medicaid fee-for-service program. The member's disenrollment will become effective no later than the first day of the second month in which the individual or health plan files the request. The health plan shall coordinate and pay for the member's care until the member is disenrolled from the health plan, or if in a facility, up to sixty (60) days of waitlist care, whichever is earlier. As long as the health plan has the member enrolled, the health plan shall make all medical necessity decisions on the placement of the member. The health plan may decide to place the member in a waitlist

bed, nursing home bed or maintain the member at home with home care and other support.

The State will assume financial responsibility for the member when the member is disenrolled from the health plan and transferred to the Medicaid fee-for-service program or on the sixty-first (61st) day if the member is waitlisted for a long-term care bed and disenrollment has not been accomplished. The health plan shall notify the facility that the State has assumed financial responsibility for the waitlisted recipient. The disenrollment will be retroactively applied to become effective on the sixty-first (61st) day of waitlisted care. If a member is not approved for nursing facility level of care or approved for nursing facility care but not determined permanently disabled through the ADRC process, the member shall remain in the health plan. If the health plan transfers the member to a nursing facility or places the member on a waitlist and the DHS's agent does not agree with the placement, the member shall remain in the health plan and the health plan shall remain responsible for the cost of the long-term care or waitlisted bed. The health plan may appeal the DHS's agent's decision to the Medical Standards Branch.

50.230 Aid to Disabled Review Committee (ADRC)

If the health plan identifies a member it believes would meet the disability criteria, it shall submit a referral to the ADRC for evaluation. Specifically, the health plan shall submit to the ADRC Coordinator in the MQD Division, the following forms and documentation:

- An “ADRC Referral and Determination” Form DHS 1180;
- A medical evaluation report, providing diagnosis and prognosis of the member which has been completed by a licensed physician or authorized evaluator within ninety (90) days of the referral. This form shall be a DHS 1156 – “Physical Examination Report”, DHS 1271 – “Report of Evaluation”, or a DHS 1150 – “Patient Assessment for ICF-MR Services Prior Authorization”, the 1147 Long Term Care Evaluation is sent to the DHS's agent for nursing facility level of care requests;
- Supporting medical evidence of physical or mental disability, if available;
- A completed DHS 1127, “Medical History and Disability Statement”; and
- A completed DHS 1128 "Disability Report"

The health plan shall provide all necessary medical services to the member until the disenrollment effective date for a member who has been determined to be disabled unless the member has been waitlisted for sixty-one (61) days and the disenrollment has not been accomplished by MQD as outlined in Section 50.220. If the ADRC does not determine that a member meets the disability criteria, the health plan shall continue to provide all services to the member.

Children who are enrolled in the programs and who later become blind or disabled and newborns that are blind or disabled shall be identified by the health plan. The health plan shall follow the

ADRC process to have the child determined blind or disabled. If the health plan has supporting documentation that the child is SSI eligible, (copy of SSA letter or payment stub), said documentation shall be sent to the eligibility worker so that appropriate action can be taken. The health plan shall remain responsible for the child until the health plan receives a disenrollment from the State.

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

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

For all other non-experimental, non-investigational covered transplants, the health plan shall refer the member to the ADRC for a disability determination and submit a 1144 form to the MQD for authorization for an evaluation by SHOTT. Based on the information provided, the ADRC will 1) make a disability determination, and 2) The MQD and the SHOTT contractor will evaluate the member as a potential transplant candidate.

If the member is determined to meet the eligibility criteria for the SHOTT transplant program, then the member will be disenrolled from the health plan and placed in the SHOTT program.

If the member does not meet the criteria for a transplant, the member shall remain in the health plan.

If the recipient is determined to meet the criteria for a transplant by SHOTT, but the transplantation facility does not accept the recipient as a patient, and the recipient is not disabled, the recipient shall be re-enrolled into the same health plan they were enrolled in prior to the transplant evaluation effective the 1st day of the following month. If the member's condition changes to make him/her a better candidate for a transplant, the health plan may resubmit the member for re-consideration for the transplant program. If the member is determined permanently disabled, the member is transferred to the Medicaid fee-for-service program.

50.250 Unacceptable Reasons for Health Plan Initiated Disenrollment Requests

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

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

50.300 Member Services

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

When directed by the State, 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.

50.310 Member Education

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

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

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

The DHS will review and approve materials prior to the health plan distributing them or otherwise using them in educational programs.

50.320 Requirements for Written Materials

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

The health plan shall make all written materials available in alternative formats and in a manner that takes into consideration the member's special needs, including those who are visually

impaired or have limited reading proficiency. The health plan shall notify all members and potential members that information is available in alternative formats and how to access those formats.

The health plan shall make all written information available in English, Ilocano, Tagalog, Chinese and Korean. The health plan may provide information in other prevalent non-English languages based upon its member population as required in Title VI of the Civil Rights Act of 1964, 42 U.S.C. Section 2000d, 45 CFR Part 80.

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

The health plan shall certify that the transcription of the information into the different languages has been reviewed by a qualified individual for accuracy.

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

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

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

50.330 Member Handbook Requirements

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

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

- A table of contents;
- Information about the roles and responsibilities of the member;
- General information on managed care;
- Information about the role and selection of the PCP;
- Information about reporting changes in family status and family composition;

- Appointment procedures;
- Information on benefits and services;
- Information on how to access services, including EPSDT services, non-emergency transportation services and maternity and family planning services;
- An explanation of any service limitations or exclusions from coverage;
- Benefits provided by the health plan not covered under the contract;
- The health plan's responsibility to coordinate care;
- A notice stating that the health plan shall be liable only for those services authorized by the health plan;
- A description of all pre-certification, prior authorization or other requirements for treatments and services;
- The policy on referrals for specialty care and for other covered services not furnished by the member's PCP;
- Information on how to obtain services when the member is out-of-state or off-island;
- Information on cost-sharing and other fees and charges;
- A statement that failure to pay for non-covered services will not result in a loss of Medicaid benefits;
- Notice of all appropriate mailing addresses and telephone numbers, to be utilized by members seeking information or authorization, including the health plan's toll-free telephone line;
- A description of member rights and responsibilities as described in Section 50.340;
- Information on advance directives;

- Information on the extent to which, and how, after-hours and emergency services are provided, including the following:
    - What constitutes an urgent and emergency medical condition, emergency services, and post-stabilization services;
    - The fact that prior authorization is not required for emergency services;
    - The process and procedures for obtaining emergency services, including the use of the 911 telephone systems or its local equivalent;
    - The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered herein; and
    - The fact that a member has a right to use any hospital or other appropriate health care setting for emergency services.
- Information on the member grievance system policies and procedures, as described in Section 50.800. This description must include the following:
    - The right to file a grievance and appeal with the health plan;
    - The requirements and timeframes for filing a grievance or appeal with the health plan;
    - The availability of assistance in filing a grievance or appeal with the health plan;

- The toll-free numbers that the member can use to file a grievance or an appeal with the health plan by phone;
- The right to a state administrative hearing, the method for obtaining a hearing, and the rules that govern representation at the hearing;
- Notice that if the member files an appeal or a request for a state administrative hearing within the timeframes specified for filing, the member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member; and
- Any appeal rights that the state chooses to make available to providers to challenge the failure of the health plan to cover a service.

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

The Member Handbook shall be submitted to the DHS for review and approval within fourteen (14) days of contract award.

50.340 Member Rights

The health plan shall have written policies and procedures regarding the rights of members and shall comply with any applicable federal and state laws and regulations that pertain to member rights. These rights shall be included in the Member

Handbook. At a minimum, said policies and procedures shall specify the member's right to:

- Receive information pursuant to 42 CFR 438.100(a)(1)(2) and Sections 50.320 and 50.390 of this RFP;
- Be treated with respect and with due consideration for the member's dignity and privacy;
- Have all records and medical and personal information remain confidential;
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;
- Participate in decisions regarding his or her health care, including the right to refuse treatment;
- Be free from any form of restraint or seclusion as a means of coercion, discipline, convenience or retaliation, as specified in federal regulations on the use of restraints and seclusion;
- Request and receive a copy of his or her medical records pursuant to 45 CFR 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;
- Be furnished health care services in accordance with 42 CFR 438.206 through 438.210;
- Freely exercise his or her rights, including those related to filing a grievance or appeal, and that the exercise of these rights will not adversely affect the way the member is treated;

- Not be held liable for the health plan's debts in the event of insolvency; not be held liable for the covered services provided to the member by the health plan for which the DHS does not pay the health plan; not be held liable for covered services provided to the member for which the DHS or the health plan does not pay the health care provider that furnishes the services; and not be held liable for payments of covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount the member would owe if the health plan provided the services directly; and
- Only be responsible for cost sharing in accordance with 42 CFR 447.50 through 42 CFR 447.60.

50.350 Provider Directory

The health plan shall produce a provider directory for the DHS to provide assistance to members selecting a health plan. The health plan shall include in the provider directory information on providers by island, including the names, locations, office hours, telephone numbers and non-English languages spoken by current contracted providers (including specialists, PCPs, pharmacists, FQHCs and RHCs, mental health and substance abuse providers, and hospitals) as well as whether or not board certification has been attained and which providers are accepting new patients.

The health plan shall produce the number of copies requested by the State, in the format prescribed by the State, and in the timeframe prescribed by the State.

Annually, at the time prescribed by the State, the health plan shall produce and supply to the State up-dated provider directories in the format prescribed by the State. The health plan shall supply the number of provider directories as requested by the State. Quarterly, the health plan shall submit to the DHS provider directory up-dates which list any changes to the provider network. These up-dates shall be submitted in the format prescribed by the State.

50.360 Member Identification (ID) Card

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

- Member number;
- Member name;
- Effective date;
- PCP name and telephone number;
- Benefit or other limits (if applicable—for example, QUEST, QUEST-Net, medical only benefits if behavioral health is provided by “carve-out”, etc);
- Third Party Liability (TPL) information; and
- EPSDT eligibility indicator.

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

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

The health plan shall submit a front and back sample member ID card to the DHS for review and approval within thirty (30) days of contract award.

50.370 Toll-Free Telephone Hotline

The health plan shall operate a toll-free telephone hotline to respond to member questions, comments and inquiries. The hotline services shall be available and accessible to members from all islands which the health plan serves.

The health plan shall develop telephone hotline policies and procedures, that address staffing, personnel, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards.

The health plan shall submit these telephone hotline policies and procedures, to the DHS for review and approval within thirty (30) days of contract award.

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

The health plan's call center systems shall have the capability to track call management metrics identified by the DHS.

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

The health plan shall develop performance standards and monitor telephone hotline performance by recording calls and employing other monitoring activities. While not required to meet the following standards, the DHS is providing the following as general guidelines for developing hotline standards: 99% of calls are answered by the fourth ring, the call abandonment rate is 5% or less, the average hold time is two (2) minutes or less, and the blocked call rate does not exceed 1%.

The health plan shall have an automated answering system available between the hours of 4:30 p.m. and 7:45 a.m., Monday through Friday and during all hours on weekends and holidays. This automated system or answering service shall provide callers with operating instructions on what to do in case of an emergency and shall include, at a minimum, a voice mailbox for members to leave messages. The health plan shall ensure that the voice mailbox has adequate capacity to receive all messages. A health plan representative shall return messages within thirty (30) minutes of the time the message is left, whether the message is left on the automated system or by the answering service.

50.380 Internet Presence/Web Site

If the health plan chooses to have a web site, the section of the web site relating to programs under this contract shall comply with the marketing policies and procedures and with requirements for written materials described in this contract and must be in compliance with applicable state and federal laws.

DHS reserves the right to review and prior approve the web site's content information relating to the health plan's information covered under this contract.

50.390 Translation Services

The health plan shall provide oral translation services of information to any member who requests the service regardless of whether a member speaks a language that meets the

threshold of a prevalent non-English language. The health plan shall notify its members of the availability of oral interpretation services and to inform them of how to access oral interpretation services. There shall be no charge to the member for translation services.

50.400 Marketing and Advertising

50.410 Prohibited Activities

The health plan is prohibited from engaging in the following activities:

- Directly or indirectly engaging in door-to-door, telephone, or other cold-call marketing activities to potential members;
- Offering any favors, inducements or gifts, promotions, or other insurance products that are designed to induce enrollment in the health plan, and that are not health related and worth more than $5.00 cash;
- Distributing information and materials that contain statements that the DHS determines are inaccurate, false, or misleading. Statements considered false or misleading include, but are not limited to, any assertion or statement (whether written or oral) that the recipient must enroll in a specific health plan to obtain benefits or to not lose benefits or that any particular health plan is endorsed by the federal or state government, or similar entity;
- Distributing materials that, according to the DHS, mislead or falsely describe the health plan's provider network, the

participation or availability of network providers, the qualifications and skills of network providers (including their bilingual skills); or the hours and location of network services; and

- Attending educational sessions or presentations without the approval of the DHS.

The State may impose financial sanctions, as described in Section 71.300, up to the federal limit, on the health plan for any violations of the marketing and advertising policies.

50.420 Allowable Activities

The health plan shall be permitted to perform the following marketing activities:

- Distributing general information through mass media (i.e. newspapers, magazines and other periodicals, radio, television, the Internet, public transportation advertising, and other media outlets);
- Making telephone calls, mailings and home visits only to members currently enrolled in its health plan, for the sole purpose of educating them about services offered by or available through the health plan;
- Distributing brochures and displaying posters at provider offices and clinics that inform patients that the clinic or provider is part of the health plan's provider network, provided that all health plans in which the provider participates have an equal opportunity to be represented; and

- Attending activities that benefit the entire community such as health fairs or other health education and promotion activities which have been prior approved by the DHS.

If the health plan performs an allowable activity, the health plan shall conduct these activities in the entire region in which it is operating.

All materials shall be in compliance with the information requirements in 42 CFR 438.10 and detailed in Section 50.320 of this RFP.

50.430 State Approval of Materials

All printed materials, advertisements, video presentations and other information prepared by the health plan that pertain to or reference the programs or the health plan's program business shall be reviewed and prior approved by the DHS before use and distribution by the health plan. The health plan shall not advertise, distribute or provide any materials to its members that relate to the programs that have not been prior approved by the DHS. All materials shall be submitted to the DHS within thirty (30) days of contract award for review and approval.

The health plan shall not change any approved materials without the consent and approval of the DHS.

50.500 Quality Improvement

50.510 General Provisions

The health plan shall provide for the delivery of quality care that is accessible and efficient, provided in the appropriate setting, according to professionally accepted standards, and in a coordinated and continuous rather than episodic manner.

The health plan shall provide quality care that includes, but is not limited to:

- Providing adequate capacity and service to ensure member's timely access to appropriate needs, services/care;
- Ensuring coordination and continuity of care;
- Ensuring that member's rights are upheld and services are provided in a manner that is sensitive to the cultural needs of members, pursuant to Section 41.110;
- Encouraging members to participate in decisions regarding their care and educating them on the importance of doing so;
- Placing emphasis on health promotion and prevention as well as early diagnosis, treatment and health maintenance;
- Ensuring appropriate utilization of medically necessary services; and
- Ensuring a continuous quality improvement approach.

The health plan shall seek input from, and work with, members, providers, MQD staff and its agents and community resources and agencies to actively improve the quality of care provided to members.

50.520 Quality Assessment and Performance Improvement Program (QAPI)

The health plan shall have an ongoing QAPI Program for all services it provides to its enrollees. The QAPI Program shall be comprehensive in range and scope, covering all demographic groups, care settings, and types of services, and addressing clinical medical care, behavioral health care, member safety, and non-clinical aspects of service, including the availability, accessibility, coordination, and continuity of care. It shall consist of the systematic internal processes and mechanisms used by the health plan for its own monitoring and evaluation of the impact and effectiveness of the care/services it provides according to established standards. The principles of continuous quality improvement shall be applied throughout the process, from developing, implementing, monitoring, and evaluating the QAPI Program to identifying and addressing opportunities for improvement. The QAPI program designates and specifies the roles/responsibilities of a physician and behavioral health practitioner as well as the Quality Improvement Committee and all subcommittees.

The health plan shall submit its QAPI Program documentation for review to DHS with its RFP proposal. The health plan shall then submit its QAPI Program within thirty (30) days of contract award, annually thereafter on a date designated by the DHS, and upon request by the DHS. The health also ensures that a QAPI program work plan is developed and evaluated on an annual basis and is updated as needed.

The health plan shall comply with the following requirements set forth in 42 CFR 438.240.

1. Conducting performance improvement projects (PIPs) described in 42 CFR 438.240(d);
2. Submitting performance measurement data (HEDIS measures) described in 42 CFR 438.240(c);
3. Mechanisms for detecting both under utilization and over utilization of services; and
4. Mechanisms for assessing the quality and appropriateness of care furnished to enrollees with SHCNs.

When establishing its QAPI program standards, the health plan shall comply with applicable provisions of federal and state laws and current NCQA Standards/Guidelines for Accreditation of Managed Care Organizations.

The DHS reserves the right to require additional standards or revisions to established standards and their respective elements to ensure compliance with changes to federal or state statutes, rules, and regulations as well as for clarification and to address identified needs for improvement.

Contingent upon approval from the DHS, the health plan may be permitted to delegate certain QAPI Program activities and functions. However, the health plan shall remain responsible for the QAPI Program, even if portions are delegated to other entities. Any delegation of functions requires:

- A written delegation agreement describing the responsibilities of the delegation and the health plan; and
- Policies and procedures detailing the health plan's process for evaluating and monitoring the delegated organization's performance. At a minimum, the following shall be completed by the health plan:
    - Prior to execution of the delegation agreement there shall be provisions for a site visit and evaluation of the delegated organization's ability to perform the delegated activities; and
    - An annual on-site visit and/or documentation/record reviews to monitor/evaluate the quality of the delegated organization's assigned processes; and evaluate the content and frequency of reports from the delegated organization.

50.530 Medical Records Standards

As part of its QAPI Program, the health plan shall establish medical records standards as well as a record review system to assess and assure conformity with standards. These standards shall be consistent with the minimum standards established by the DHS identified below:

- Require that the medical record is maintained by the provider;
- Ensure that, as long as access to the records, including behavioral health and substance abuse records, is needed to perform the duties of this contract and to administer the QUEST program, approval or member consent is not

needed for access by authorized DHS personnel or personnel contracted by the DHS.;

- Provide DHS or its designee(s) with prompt access to members' medical records;
- Provide members with the right to request and receive a copy of his or her medical records, and to request they be amended, as specified in 45 CFR Part 164; and
- Allow for paper or electronic record keeping.

As part of the record standards, the health plan shall require that providers adhere to the following requirements:

- All medical records are maintained in a detailed and comprehensive manner that conforms to good professional medical practice;
- All medical records are maintained in a manner that permits effective professional medical review and medical audit processes;
- All medical records are maintained in a manner that facilitates an adequate system for follow-up treatment;
- All medical records shall be legible, signed and dated;
- Each page of the paper or electronic record includes the patient's name or ID number;
- All medical records contain patient demographic information, including age, sex, address, home and work telephone numbers, marital status and employment, if applicable;
- All medical records contain information on any adverse drug reactions and/or food or other allergies, or the

absence of known allergies, which are posted in a prominent area on the medical record;

- All forms or notes have a notation regarding follow-up care, calls or visits, when indicated;
- All medical records contain the patient's past medical history that is easily identified and includes serious accidents, hospitalizations, operations and illnesses. For children, past medical history including prenatal care and birth;
- All pediatric medical records include a completed immunization record or documentation that immunizations are up-to-date;
- All medical records include the provisional and confirmed diagnosis(es);
- All medical records contain medication information;
- All medical records contain information on the identification of current problems (e.g. significant illnesses, medical conditions and health maintenance concerns);
- All medical records contain information about consultations, referrals, and specialist reports;
- All medical records contain information about emergency care rendered with a discussion of requirements for physician follow-up;
- All medical records contain discharge summaries for: (1) all hospital admissions that occur while the member is enrolled and (2) prior admissions as appropriate;
- All medical records for members eighteen (18) years of age or older include documentation as to whether or not

the member has executed an advance directive, including an advance mental health care directive;

- All medical records shall contain written documentation of a rendered, ordered or prescribed service, including documentation of medical necessity; and
- All medical records shall contain documented patient visits, which includes, but is not limited to:
    - A history and physical exam;
    - Treatment plan, progress and changes in treatment plan;
    - Laboratory and other studies ordered, as appropriate;
    - Working diagnosis(es) consistent with findings;
    - Treatment, therapies, and other prescribed regimens;
    - Documentation concerning follow-up care, telephone calls or visits, when indicated;
    - Documentation reflecting that any unresolved concerns from previous visits are addressed in subsequent visits;
    - Documentation of any referrals and results thereof, including evidence that the ordering physician has reviewed consultation, lab, x-ray, and other diagnostic test results/reports filed in the medical records and evidence that consultations and significantly abnormal lab and imaging study results specifically note physician follow-up plans;

- Hospitalizations and/or emergency room visits, if applicable; and
- All other aspects of patient care, including ancillary services.

As part of its medical records standards, the health plan shall ensure that providers facilitate the transfer of the member's medical records (or copies) to the new PCP within seven (7) business days from receipt of the request.

As part of its medical records standards, the health plan shall comply with medical record retention requirements in Section 71.100.

50.540 Performance Improvement Projects (PIPs)

As part of its QAPI Program, the health plan shall conduct PIPs complying with 42 CFR 438.240(d) that are designed to achieve, through ongoing measurements and interventions, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. The PIPs shall include the following:

- A study topic identified by the health plan, CMS, or DHS;
- A clearly definable answerable study question;
- The use of objective, measurable, and clearly defined quality indicators to measure performance;
- A correctly identified study population;
- Valid sampling techniques;

- Accurate and complete data collection;
- The implementation of appropriate planned system interventions to achieve improvement in quality;
- An evaluation of the effectiveness of the intervention, including sufficient data and barrier analysis; and
- An achievement of real improvement that is sustained;
- A plan and activities that will increase or sustain improvement.

The health plan shall comply with the DHS's PIP Policy, (Appendix W) and shall complete each PIP in a time period determined by the DHS, to allow information on the progress of PIPs to produce new information on quality of care every year.

PIPs may be specified by the DHS and/or by CMS. In these cases, the health plan shall meet the goals and objectives specified by the DHS and/or CMS. The health plan shall submit to the DHS and the EQRO any and all data necessary to enable validation of the health plan's performance under this section, including the status and results of each project.

50.550 Practice Guidelines

The health plan shall include, as part of its QAPI Program, practice guidelines that meet the following requirements as stated in 42 CFR 438.236 and current NCQA standards. Each adopted practice guidelines shall be:

- Relevant to the health plan's membership;

- Based on valid and reliable clinical evidence or a consensus of health care professionals in a particular field;
- Adopted in consultation with in-network providers;
- Reviewed and updated periodically as appropriate;
- Disseminated to all affected providers, and upon request, to members and potential members; and
- Consistent with 42 CFR 438.6(h) and 422.208, regarding Physician Incentive Programs.

Additionally, in compliance with 42 CFR 438.236, the health plan shall ensure that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

The health plan shall develop at least three (3) clinical practice guidelines for medical conditions (such as asthma, diabetes, pregnancy/high risk pregnancy) and at least two (2) for behavioral health conditions (such as depression, ADHD), following current NCQA and BBA standards for adopting and disseminating guidelines. The health plan shall submit its policies and procedures addressing the stated requirements, a list of all current practice guidelines as well as the practice guidelines adopted specifically for three (3) medical conditions and two (2) behavioral health conditions within one-hundred eighty (180) calendar days of the supplemental agreement that modified this paragraph.

For each practice guideline adopted, and required, the health plan shall:

- Describe the clinical basis upon which the practice guideline is based;
- Describe how the practice takes into consideration the needs of the members;
- Describe how the health plan will ensure that practice guidelines are reviewed in consultation with health care providers;
- Describe the process through which the practice guidelines are reviewed and updated periodically;
- Describe how the practice guidelines are disseminated to all relevant providers and, upon request, to potential members;
- Describe how the health plan will ensure that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines; and
- Be consistent with CFR 438.6(h) regarding Physician Incentive Programs.

The health plan shall ensure that all decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply shall be consistent with the guidelines.

50.560 Performance Incentives

The health plan may be eligible for performance incentives as described in Section 60.300.

50.600 Utilization Management Program (UMP)

The health plan shall have in place a utilization management program (UMP) that is linked with and supports the health plan's QAPI Program. The UMP shall be shall be aimed at objectively and systematically monitoring and evaluating the necessity, appropriateness, efficiency, timeliness and cost-effectiveness of care and services provided to members in order to continuously promote quality clinical care and services as well as maximize appropriate use of resources.

The health plan shall have a written UMP description, a corresponding workplan, UMP policies and procedures, and mechanisms to implement all UMP activities. The UMP description and workplan may be separate documents or may be integrated as part of the written QAPI Program description and workplan. The health plan's UMP shall include structured, systematic processes employing objective evidenced-based criteria to ensure that utilization decisions regarding medical necessity and appropriateness of medical and behavioral health care/services are made in a fair, impartial and consistent manner by qualified licensed health care professionals. The health plan shall ensure that applicable evidence-based criteria are applied with consideration given to characteristics of the local delivery system available for specific members as well as member-specific factors, such as member's age, co-morbidities, complications, progress of treatment, psychosocial situation, and home environment. The health plan shall also have formal mechanisms to evaluate and address new developments in technology and new applications of existing technology for

inclusion in the benefit package to keep pace with changes and to ensure equitable access to safe and effective care.

The health plan shall review and update, on an annual basis, all UMP criteria and application procedures in conjunction with review of the health plan's clinical practice guidelines, disease management programs, and evaluation of new technologies. Practitioners with appropriate clinical expertise shall be involved in developing, adopting and reviewing the criteria used to make utilization decisions. The health plan shall provide UMP criteria to providers and shall ensure that members and providers seeking information about the UMP process and the authorization of care/services have access to UMP staff.

The health plan's utilization review/management activities shall include:

- Prior authorization/pre-certifications;
- Concurrent reviews;
- Retrospective reviews;
- Discharge planning;
- Case management; and
- Pharmacy Management.

There shall be mechanisms to detect under-utilization, over-utilization, and inappropriate utilization as well as processes to address opportunities for improvement. The health plan shall perform:

- Routine, systematic monitoring of relevant utilization data;
- Routine analysis of all data collected to identify causes of inappropriate utilization patterns;
- Implementation of appropriate interventions to correct any patterns of potential or actual under- or over-utilization; and
- Systematic measurement of the effectiveness of interventions aimed at achieving appropriate utilization.

The health plan shall evaluate and analyze practitioners' practice patterns, and at least on an annual basis, the health plan shall produce and distribute to providers, profiles comparing the average medical care utilization rates of the members of each PCP to the average utilization rates of all health plan members. Additionally, feedback shall be provided to providers when specific utilization concerns are identified, and interventions to address utilization issues shall be systematically implemented.

The health plan shall ensure that pharmaceutical management activities promote the clinically appropriate use of pharmaceuticals. There should be policies, procedures, and mechanisms to ensure that the health plan has criteria for adopting pharmaceutical management procedures and that there is clinical and scientifically-based evidence for all decisions. The policies must include an explanation of any limits or quotas and an explanation of how prescribing practitioners must provide information to support an exceptions request. The health plan shall ensure that it has processes for determining and evaluating classes of pharmaceuticals, pharmaceuticals within the classes,

and criteria for coverage and prior authorization of pharmaceuticals. The health plan shall ensure that it has processes for generic substitution, therapeutic interchange and step-therapy protocols.

The health plan shall not develop a compensation structure that creates incentives for the individuals or entities conducting UMP activities to deny, limit, or discontinue medically necessary services to any member.

The health plan shall submit its written UMP description, corresponding workplan, and UMP policies and procedures to the DHS for review and prior approval within thirty (30) days of contract award.

50.700 Authorization of Services

The health plan shall have in place written prior authorization/pre-certification policies and procedures for processing requests for initial and continuing authorization of services in a timely manner. As part of these prior authorization policies and procedures, the health plan shall have in effect mechanisms to: (1) ensure consistent application of review criteria for authorization decisions; and (2) consult with the requesting provider when appropriate.

The health plan shall ensure that all prior authorization/pre-certification decisions, including but not limited to any decisions to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested,

shall be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.

The health plan shall not require prior authorization of emergency services, but may require prior authorization of post-stabilization services and urgent care services as specified in Sections 40.340 and 40.345.

The health plan shall notify the provider of prior authorization/pre-certification determinations in accordance with the following timeframes:

- For standard authorization decisions, the health plan shall provide notice as expeditiously as the member's health condition requires but no longer than fourteen (14) calendar days following the receipt of the request for service. An extension may be granted for up to fourteen (14) additional calendar days if the member or the provider requests the extension, or if the health plan justifies a need for additional information and the extension is in the member's interest. If the health plan extends the timeframe, it shall give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision. The health plan shall issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

- In the event a provider indicates, or the health plan determines that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the health plan shall make an expedited authorization determination and provide notice as expeditiously as the member's health condition requires but no later than three (3) business days after receipt of the request for service. The health plan may extend the three (3) business day timeframe by up to fourteen (14) calendar days if the member requests an extension, or if the health plan justifies to the DHS a need for additional information and the extension is in the member's interest. If the health plan extends the timeframe, it shall give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to appeal 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.

50.800 Member Grievance System

50.805 General Requirements

The health plan shall have a formal grievance system that is consistent with the QUEST MEMO ADMN 0311 Attachment A-2, State of Hawaii Grievance System, and 42 CFR 438 Subpart F. The member grievance system shall include an inquiry process, a grievance process and appeals process. In addition, the health

plan's grievance system shall provide information to members on access to the State's administrative hearing system. The health plan shall require that members exhaust its internal grievance system prior to accessing the State's administrative hearing system. The health plan shall develop policies and procedures for its grievance system and submit these to the DHS for review and approval within thirty (30) days of contract award. The health plan shall submit an updated copy of these policies and procedures within thirty (30) days of any modification for review and approval.

The health plan shall address, log, track and trend all expressions of dissatisfaction, regardless of the degree of seriousness or regardless of whether the member or provider expressly requests filing the concern or requests remedial action. The formal grievance system must be utilized for any expression of dissatisfaction and any unresolved issue.

The health plan shall not arbitrarily deny or reduce the required scope of services solely because of the diagnosis, type of illness or condition. The health plan may place appropriate limits on a service based on criteria such as medical necessity or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose.

The health plan shall give members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and

toll-free numbers that have adequate TTY/TTD and interpreter capability.

The health plan shall acknowledge receipt of each filed grievance and appeal in writing within five (5)[1] business days of receipt of the grievance or appeal. The health plan shall have procedures in place to notify all members in their primary language of grievance and appeal resolutions.

The health plan shall ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by a health care professional that has appropriate medical knowledge and clinical expertise in treating the member's condition or disease.

The health plan shall ensure that individuals who make decisions on grievances and appeals were not involved in any previous level of review or decision-making and are health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease if deciding any of the following:

- An appeal of a denial that is based on a lack of medical necessity;

[1] The first day shall be the day after the day of receipt of a grievance or appeal. For example, and assuming there are no intervening holidays, if an appeal is received on Monday, the five (5) business day period for acknowledgment of receipt of the appeal is counted from Tuesday. Therefore, the acknowledgment must be sent to the member by the following Monday.

- A grievance regarding denial of expedited resolution of an appeal; or
- A grievance or appeal that involves clinical issues.

50.810 Recordkeeping

The health plan shall maintain records of its members' grievances and appeals in accordance with recordkeeping and confidentiality provisions.

50.815 Inquiry Process

An inquiry is when a member contacts the health plan about any aspect of the health plan's, subcontractor's or providers' operations, activities, behavior, or a request for disenrollment that does not express dissatisfaction. If, at any point during the contact the member expresses a complaint of any kind, the inquiry becomes a grievance or appeal and the health plan shall give the member, or provider acting on behalf of the member, their grievance and appeal rights.

50.820 Grievance Process

A member or a member's representative (on behalf or a member with written consent) may file a grievance orally or in writing. A grievance may be filed about any matter other than an action, as defined in Section 30.200, and when the expression of dissatisfaction is regarding some aspect of the health plan's or provider's operations, activities, behavior or denial of an expedited appeal request. Subjects for grievances include, but are not limited to: the quality of care of a provider, rudeness of a

provider or a provider's employee, or failure to respect the member's rights.

In addition to meeting all requirements detailed in Section 50.805, in fulfilling the grievance process requirements the health plan shall:

- Send a written acknowledgement of the grievance within five (5) business days of the member's expression of dissatisfaction;
- Convey a disposition, in writing, of the grievance resolution within thirty (30) calendar days of the initial expression of dissatisfaction; and
- Include information on how to access the State's grievance review process on the written disposition of the grievance.

The health plan's resolution of the grievance shall be final unless the member or member's representative wishes to file for a grievance review with the State.

50.825 Grievance Review

As part of its grievance system, the health plan shall inform members of their rights to seek a grievance review from the State, in the event the disposition of the grievance does not meet the satisfaction or expectations of the member. The health plan shall provide its members with the following information about the State grievance review process:

- Health plan members may request a State grievance review, within thirty (30) calendar days after the member receives the grievance disposition from the health plan. A State grievance review may be made by contacting the MQD office by calling the MQD Health Plan Liaison or mailing a request to:

Med-QUEST Division
Health Coverage Management Branch
PO Box 700190
Kapolei, HI 96709-0190

- The MQD Health Plan Liaison will review the grievance and contact the member with a determination within thirty (30) calendar days from the day the request for a grievance review is received; and
- The grievance review determination made by MQD is final.

50.830 Appeals Process

An appeal may be filed when the health plan issues a notice of action to a health plan member.

A member, provider, or authorized representative on behalf of the member with the member's written consent, may file an appeal within thirty (30) calendar days of the notice of action. An oral appeal may be submitted in order to establish the appeal submission date; however, this must be followed by a written request. The health plan shall assist the member, provider or authorized representative in this process.

In addition to meeting the general requirements detailed in Section 50.805, the health plan shall:

- Ensure that oral inquiries seeking to appeal an action are treated as appeals and confirmed in writing, unless the provider requests expedited resolutions;
- Send an acknowledgement of the receipt of the appeal within five (5) business days from the date of the receipt of the written or oral appeal;
- Provide the member a reasonable opportunity to present evidence, and evidence of allegations of fact or law, in person as well as in writing;
- Provide the member and his or her representative opportunity, before and during the appeals process, to examine the member's case file, including medical records, and any other documents and records considered during the appeal process; and
- Include as parties to the appeal, the member and his or her representative, or the legal representative of a deceased member's estate.

For standard resolution of an appeal, the health plan shall resolve the appeal and provide a written notice of disposition to the affected parties as expeditiously as the member's health condition requires, but no more than thirty (30) calendar days from the day the health plan receives the appeal.

The health plan may extend the resolution timeframe by up to fourteen (14) calendar days if the member requests the extension, or the health plan shows (to the satisfaction of MQD, upon its request for review) that there is need for additional information and how the delay is in the member's interest. For any extension not requested by a member, the health plan shall give the member written notice of the reason for the delay.

The health plan shall include the following in the written notice of the resolution:

- The results of the appeal process and the date it was completed; and
- For appeals not resolved wholly in favor of the member:
    - The right to request a State administrative hearing, and how to access this process;
    - The right to request an expedited State administrative hearing if applicable;
    - The right to request to receive benefits while the hearing is pending, and how to make the request; and
    - A statement that the member may be held liable for the cost of those benefits if the hearing decision upholds the health plan's action.

The health plan shall notify the provider of the resolution but it need not be in writing.

50.835 Expedited Appeal Process

The health plan shall establish and maintain an expedited review process for appeals. The member or provider may file an expedited appeal either orally or in writing. An expedited appeal is only appropriate when the health plan or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function.

The health plan shall ensure that punitive action is not taken against a provider who requests an expedited resolution or who supports a member's appeal.

For expedited resolution of an appeal, the health plan shall resolve the appeal and provide written notice to the affected parties as expeditiously as the member's health condition requires, but no more than three (3) business days from the time the health plan received the appeal. The health plan shall make reasonable efforts to provide oral notice to the member with the appeal determination.

The health plan may extend the expedited appeal resolution timeframe by up to fourteen (14) calendar days if the member requests the extension or the health plan needs additional information and demonstrates to the MQD that the extension of time is in the member's interest.

The health plan shall notify a MQD Health Plan Liaison, within twenty-four (24) hours, regarding expedited appeals if an

expedited appeal has been granted by the health plan or if an expedited appeal timeframe has been requested by the member or the health plan. The health plan shall provide the reason it is requesting a fourteen (14) day extension. The health plan shall notify the MQD Health Plan Liaison within twenty-four (24) hours (or sooner if possible) from the time, the expedited appeal is lost.

The health plan shall follow the procedures below when notifying the MQD Health Plan Liaison:

- Contact the designated Health Plan Liaison;
- If no Liaison is available, send a fax to MQD/HCMB, to the attention of the Supervising Contract Specialist, label the fax as “Urgent”, and include all applicable information.

For any extension not requested by the member, the health plan shall give the member written notice of the reason for the delay. If the health plan denies a request for expedited resolution of an appeal, it shall:

- Transfer the appeal to the timeframe for standard resolution;
- Make reasonable efforts to give the member prompt oral notice of the denial, and follow-up within two (2) calendar days of written notice; and
- Inform the member that they may file a grievance for the denial of the expedited process.

The health plan shall provide the member a reasonable opportunity to present evidence and allegation of fact or law, in person as well as in writing and inform the member of limited time available to present this information.

The health plan shall inform the member of the limited time available for this process in the case of expedited resolutions.

50.840 State Administrative Hearing for Regular Appeals

If the member is not satisfied with the health plan's written notice of disposition of the appeal, he or she may file for a state administrative hearing within thirty (30) calendar days of the receipt of the notice of disposition (denial). At the time of the denied appeal determination, the health plan shall inform the member, the provider acting on behalf of the member, or the representative of a deceased member's estate that he or she may access the state administrative hearing process. The member, or his or her representative, may access the state administrative hearing process by either calling the member's eligibility worker or submitting a letter to the Administrative Appeals Office (AAO) within thirty (30) calendar days from the receipt of the member's appeal determination.

The health plan shall provide the following address to the members:

State of Hawaii Department of Human Services
Administrative Appeals Office
PO Box 339
Honolulu, HI 96809

The State shall reach its decision within ninety (90) days of the date the member filed the request for an administrative hearing with the State.

50.845 Expedited State Administrative Hearings

The member may file for an expedited state administrative hearing only when the health plan has provided an expedited appeal and the action of the appeal was determined to be adverse to the member (Action Denied). In this situation, the health plan shall inform the member that he or she must contact a MQD Health Plan Liaison within three (3) days of the receipt of the denial from the health plan.

An expedited state administrative hearing must be heard and determined within three (3) business days 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 are in compliance with state and federal regulations.

In the event of an expedited state administrative hearing the health plan shall submit information that was used to make the determination, e.g. medical records, written documents to and from the member, provider notes, etc. The health plan shall

submit this information to the MQD within twenty-four (24) hours of the decision to deny the expedited appeal.

50.850 Continuation of Benefits During an Appeal or State Administrative Hearing

The health plan shall continue the member's benefits if:

- The member requests an extension of benefits;
- The appeal or request for state administrative hearing is filed in a timely manner, meaning on or before the later of the following:
    - Within ten (10) days of the health plan mailing the notice of adverse action; or
    - The intended effective date of the health plan's proposed adverse action.
- The appeal or request for state administrative hearing involves the termination, suspension, or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized provider; and
- The original period covered by the original authorization has not expired.

If the health plan continues or reinstates the member's benefits while the appeal or state administrative hearing is pending, the health plan shall continue all benefits until one of following occurs:

- The member withdraws the appeal;
- The member does not request an administrative hearing

within ten (10) days from when the health plan mails a notice of adverse action;

- A State administrative hearing decision adverse to the member is made; or
- The authorization expires or authorization service limits are met.

If the final resolution of the State administrative hearing is adverse to the member, that is, upholds the health plan's adverse action, the health plan may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section.

If the health plan or the state reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the health plan shall authorize or provide these disputed services promptly, and as expeditiously as the member's health condition requires.

If the health plan or the state reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the health plan shall pay for those services.

50.855 External Review Procedures

After exhausting all internal grievance and appeal procedures available with the health plan, the member, the member's provider or the member's authorized representative may file a

request for an external review of a managed care plan's final internal determination with the State of Hawaii's Insurance Commissioner.

The health plan shall inform the member, the member's provider or the member's authorized representative of the process to request an external review by the Insurance Commissioner.

50.860 Notice of Adverse Action

The health plan shall give the member and the referring provider a written notice of any action within the timeframes specified below. The notice to the member or provider shall include the following information:

- The action the health plan has taken or intends to take;
- The reasons for the action;
- The member's or provider's right to an appeal with the health plan;
- The member's or provider's right to request an appeal;
- Procedures for filing an appeal with the health plan;
- The circumstances under which an expedited resolution is available and how to request it; and
- The member's right to have benefits continue pending resolution of an appeal, how to request that the benefits be continued, and the circumstances under which a member may be required to pay the costs of these services.

The notice of action to the member shall be written pursuant to the requirements in Section 50.320 of this RFP.

The health plan shall mail the notice within the following timeframes:

- For termination, suspension, or reduction of previously authorized Medicaid-covered services: at least ten (10) calendar days prior to the date the adverse action is to start except:
    - By the date of action for the following reasons:
        - The health plan has factual information confirming the death of a member;
        - The health plan receives a clear written statement signed by the member that he or she no longer wishes services or gives information that requires termination or reduction of services and indicates that he or she understands that this must be the result of supplying that information;
        - The member has been admitted to an institution that makes him or her ineligible for further services;
        - The member's address is unknown and the post office returns health plan mail directed to the member indicating no forwarding address;
        - The member has been accepted for Medicaid services by another local jurisdiction;

- The member's provider prescribes a change in the level of medical care;
- There has been an adverse determination made with regard to the preadmission screening requirements for nursing facility admissions on or after January 1, 1989; or
- In the case of adverse actions for nursing facility transfers, the safety or health of individuals in the facility would be endangered, the member's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the member's urgent medical needs, or the member has not resided in the nursing facility for thirty (30) days.

- The period of advanced notice is shortened to five (5) days if there is alleged fraud by the recipient and the facts have been verified, if possible, through secondary sources.
- For denial of payment: at the time of any action affecting the claim.
- For standard service authorization decisions that deny or limit services: as expeditiously as the member's health condition requires, but not more than fourteen (14) calendar days following receipt of request for service, with a possible extension of up to fourteen (14) additional calendar days (total timeframe allowed with extension is twenty-eight (28) calendar days from the date of the request for services) if (1) the recipient or provider requests an extension and (2) the health plan justifies a

need for additional information and how the extension is in the member's interest. If the health plan extends the timeframe it must (1) 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 and (2) issue and carry out its determination as expeditiously as the member's health condition requires but no later than the date the extension expires.

- For expedited authorization decisions: as expeditiously as the member's health condition requires but no later than three (3) business days after receipt of the request for service.

Service authorization decisions not reached within the timeframes specified above shall be considered a denial and therefore considered an action.

50.900 Information Systems

50.910 Health Plan Information System

The health plan shall have information management systems that enable it to meet the DHS requirements, state and federal reporting requirements, all other contract requirements and any other applicable state and federal laws, rules and regulations, including HIPAA.

Specifically, the DHS requires that the health plan install the DHS approved Virtual Private Network (VPN) software that is

provided free of charge to the health plans. The VPN software allows the MQD and the health plan to securely transfer member, provider, and encounter data via the internet.

50.920 Compliance with the Health Insurance Portability and Accountability Act

The health plan shall implement the electronic transaction standards and other "Administrative Simplification" provisions, privacy and security provisions of the Health Insurance Portability and Accountability Act (HIPAA), Public Law 104-191, as specified by CMS.

50.930 Possible Audits of Health Plan Information System

The health plan shall institute processes to insure the validity and completeness of the data submitted to the DHS. The DHS or its contractors may conduct general data validity and completeness audits using industry standard sampling techniques. The DHS reserves the right to have access to the health plan's system at any time when deemed necessary under this contract.

50.940 Health Plan Information System Changes

The health plan shall notify the DHS and obtain prior approval for any proposed changes to its information system which could impact any process or program under this contract.

50.950 Disaster Planning and Recovery Operations

The health plan shall have in place disaster planning and recovery operations appropriate for the health plan industry, and comply with all applicable federal and state laws relating to security and recovery of confidential information and electronic data. The health plan shall provide the DHS with a copy of its documentation describing its disaster planning and recovery operations within thirty (30) days of contract award.

51.100 Fraud & Abuse

The health plan shall comply with Program Integrity Requirements, as outlined in 42 CFR Part 438, Subpart H. The health plan shall have a written compliance program which shall have stated program goals and objectives, stated program scope, and stated methodology (refer to CMS publications: "Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care", A product of the National Medical Fraud and Abuse Initiative, October 2000) as well as the CMS publication: "Guidelines for Constructing a Compliance Program for Medicaid and Prepaid Health Plans", a product of the Medicaid Alliance for Program Safeguards, May 2002.

The health plan shall have a monitoring program and identify providers or members who may be committing fraud or abuse. The health plan's fraud and abuse monitoring program shall include the following activities, but not be limited to:

A. Monitoring the billings of its providers to ensure members receive services for which the health plan is billed;
B. Investigating all reports of suspected fraud and over billings (upcoding, unbundling, billing for services furnished by others and other overfilling practices);
C. Reviewing providers for over or underutilization;
D. Verifying with members the delivery of services as claimed; and
E. Reviewing and trending consumer complaints on providers.

The health plan shall have administrative and management fraud and abuse policies and procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse. The health plan shall submit these procedures to MQD for review and approval within thirty (30) days of contract award. The health plan's fraud and abuse policies and procedures shall include the following:

A. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable federal and state standards;
B. The designation of a compliance officer and a compliance committee that are accountable to senior management;
C. Effective training and education for the compliance officer and the organization's employees;
D. Education about fraud and abuse identification and reporting in provider and member material;
E. Effective lines of communication between the compliance officer and the organization's employees;

F. Enforcement of standards through well-publicized guidelines; and

G. Provision of internal monitoring and auditing with provisions for prompt response to potential offenses, and for the development of corrective action initiatives relating to the health plan's fraud and abuse efforts.

Within thirty (30) days of discovering instances of suspected fraud or abuse, the health plan shall submit a report it to the Med-QUEST Division, Medical Standards Branch and the Medicaid Fraud Control Unit of the Attorney General's Office. The health plan shall use the report form in Appendix X to report or refer suspected cases of Medicaid fraud or abuse that includes, at a minimum:

- Name
- ID Number
- Source of complaint
- Type of provider
- Nature of complaint
- Approximate dollars involved
- Legal and administrative disposition of the case

The health plan shall provide any evidence it has on the member's services or providers' billing practices (unusual billing patterns, services not rendered as billed and same services billed differently or separately).

The health plan and all subcontractors shall cooperate fully with federal and state agencies in investigations and subsequent legal actions.

If the provider is not billing appropriately, but the health plan has found no evidence of fraud (defined as intention to defraud) or abuse, the health plan shall provide education and training to the provider in question.

The DHS may impose sanctions on the health plan for fraud and abuse. Refer to Section 71.300 for more information on sanctions.

51.110 Child Abuse Reporting Requirements

The health plan shall report all cases of suspected child abuse to the Child Protective Services Section of the DHS, and all suspected dependent adult abuse to the Adult Protective Services Section of the DHS as required by state and federal statutes. The health plan shall ensure that its network providers report all cases of suspected child abuse to the Child Protective Services Section of the DHS, and all suspected dependent adult abuse to the Adult Protective Services Section of the DHS as required by state and federal statutes.

51.200 Health Plan Personnel

51.210 Medical Director

The health plan shall have on staff a locally based Medical Director licensed to practice medicine in the State of Hawaii, to

oversee the quality of care furnished by the plan and to ensure care is provided by qualified medical personnel. The Medical Director shall address any potential quality of care problems and direct QAPI activities. The Medical Director shall work closely with the MQD Medical Director and participate in quarterly DHS Medical Director meetings, Provider Advisory Board meetings and any committee meetings relating to the programs when requested by the DHS.

51.220 Support Staff and Systems

The health plan shall have in place adequate organizational and administrative systems that are capable of implementing contractual obligations. The staff and associated functions shall include, but not be limited to:

- QUEST Coordinator to serve as the health plan's key contact for the contract;
- Behavioral health practitioner involved in behavioral health care aspects of the QAPI Program;
- Care Coordination/Case Management staff to ensure timely access to medically necessary services and to assist the member in understanding and following his/her treatment plan;
- Pharmacist either on staff with the health plan or on contract who is physically located in the State of Hawaii to address pharmacy needs of members;
- Quality Improvement Program Director and staff capable of undertaking all Quality Improvement activities;

- Utilization Management Coordinator and sufficient staff to handle all UM activities;
- EPSDT Coordinator (must be an R.N. and minimum 0.5 FTE);
- Member Services Director and representatives located in the State of Hawaii to address member needs or coordinate services;
- Provider Services Director and representatives located in the State of Hawaii to confirm eligibility, interpret/explain plan policies and guidelines and resolve provider complaints;
- Grievance Coordinator to investigate member and provider complaints;
- Catastrophic Claims Coordinator;
- Fraud and Abuse Compliance Officer;
- Administrator to oversee the business processes;
- Designated Financial Officer to oversee the budget and accounting system and to ensure timely and accurate submission of financial reports;
- Information Systems Director and staff capable of processing rosters, and ensuring the timely and accurate submission of encounter data and other required information and reports;
- Support Services staff to ensure the timely and accurate processing of other reports; and
- Clerical staff to conduct daily business.

The health plan shall ensure that all staff have the necessary qualifications (i.e. education, skills and experience) to fulfill the

requirements of their respective positions. The health plan shall conduct initial and on-going training of all staff to ensure they have the education, knowledge and experience to fulfill the requirements of this contract. A specific number of staff or FTEs are not required; only that adequate staff is available and assigned to appropriate areas to fulfill the required functions specified in this contract. The health plan shall submit a staffing plan to DHS for review and approval within thirty (30) days of contract award.

51.300 Reporting Requirements

51.310 Purpose for Collection of Data

The health plan shall submit all requested data to the DHS or its designee (i.e. EQRO) so that periodic reviews, including validation studies, can be performed. The State is required to have in its contracts with the health plan, the requirement for the provision of the data and is authorized to impose financial penalties if the data is not provided timely and accurately.

The health plan shall comply with all additional requests from the DHS, or its designee, for additional data, information and reports.

Data received from the health plan on quality, performance, patient satisfaction, or other measures will be used for monitoring, public reporting, and financial incentives. DHS will also share information among health plans to promote transparency and sharing of benchmarks/best practices. DHS

will begin publicly reporting measures in formats such as a consumer guide, public report, or otherwise on MQD's website. Financial incentives are described in Section 60.300.

All reporting data shall be submitted to the DHS in electronic format of either Word 2003 or lower (.doc), or Excel 2003 or lower (.xls). Reporting data shall not be submitted with read only or protected formatting. All reporting data shall be provided to the Health Care Services Branch within the Med-QUEST Division who will distribute internally as required.

51.400 Provider Network Reports

51.410 Provider Network Adequacy and Capacity Report

The health plan shall submit a *Provider Network Adequacy and Capacity Report* that demonstrates that the health plan offers an appropriate range of preventive, primary care and specialty services that is adequate for the anticipated number of members for the service and that the network of providers is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area.

The health plan shall submit these reports on electronic media in the format specified by the DHS. The information shall, at a minimum, include:

- A listing of all providers and include the specialty or type of practice of the provider;
- The provider's location;
- Mailing address including the zip code;

- Telephone number;
- Professional license number and expiration date;
- Number of members from its plan that are currently assigned to the provider (PCPs only);
- Indication as to whether the provider has a limit on the number of the program patients he/she will accept
- Indication as to whether the provider is accepting new patients;
- Foreign language spoken (if applicable);
- Verification of valid license for in-state and out-or-state providers; and
- Verification that provider or affiliated provider is not on the federal or state exclusions list.

These reports shall be submitted to the DHS at the following times:

- Prior to implementation of the contract (the DHS reserves the right to delay implementation of the contract or cap enrollment due to an inadequate provider network);
- Monthly;
- Upon the DHS request;
- Upon enrollment of a new population in the health plan;
- Upon changes in services, benefits, geographic service area or payments; and
- Any time there has been a significant change in the health plan's operations that would impact adequate capacity and services. A significant change is defined as any of the following:

- A decrease in the total number of PCPs by more than 5% per island;
- A loss of providers in a specific specialty where another provider in that specialty is not available on the island; or
- A loss of a hospital.

51.420 PCP Report

The health plan shall submit a monthly *PCP Assignment Report* which lists each member's name and the name of the PCP to which they are assigned. This report shall be provided in the format to be prescribed by the DHS.

51.430 Timely Access Report

The health plan shall submit a quarterly *Timely Access Report* that monitors the time lapsed between a member's initial request for an office appointment and the date of the appointment. The data for the Timely Access Reports may be collected using statistical sampling methods (including periodic member or provider surveys). The report shall include:

- Total number of appointment requests;
- Total number of requests that meet the waiting time standards (for each provider type/class);
- Total number of requests that exceed the waiting standards (for each provider type/class); and
- Average waiting time for those requests that exceed the waiting time standards (for each provider type/class).

The reports shall be submitted November 30 for the quarter July-September, February 28 for the quarter October-December, May 31 for the quarter January-March, and August 31 for the quarter April-June.

51.440 Annual Report of Services Rendered to Members by an FQHC or RHC

The health plan shall submit an *Annual Report of Services Rendered to Members by an FQHC or RHC* by June 30 of each year, for the prior calendar year (January through December). The report shall include the following information:

- The total dollar amount of payments made to an FQHC/RHC, listed by FQHC/RHC;
- All visits and payments (including capitated payments) made to any FQHC/RHC, regardless of whether the FQHC/RHC is included in the health plan's contracted provider network; and
- The number of unduplicated visits provided to the health plan's members.

51.450 Provider Suspensions and Termination Report

The health plan shall submit a *Provider Suspensions and Terminations Report* listing by name, all provider suspensions or terminations on a quarterly basis. This report shall include all providers, each provider's specialty, their primary city and island of services, reason(s) for the action taken as well as the effective

date of the suspension or termination. If the health plan has taken no action against providers during the quarter this should be documented in the *Provider Suspensions and Terminations Report*. The health plan shall utilize the report format provided by the DHS.

The reports shall be submitted November 30 for the quarter July-September, February 28 for the quarter October-December, May 31 for the quarter January-March, and August 31 for the quarter April-June.

51.460 Provider Complaints Report

The health plan shall submit to DHS the following Provider Complaints Reports for each of the quarters identified in Section 51.740. Due dates are also the same as specified in Section 51.740. Reports shall be submitted using the matrix provided by the DHS on the same due dates specified in Section 51.740 in hard copy and in electronic file copy.

- A quarterly report which totals the number of complaints by category (benefits and limits; eligibility and enrollment; member issues; health plan issues) which were resolved during the reporting quarter;
- A quarterly report which totals the number of complaints by category (benefits and limits; eligibility and enrollment; member issues; health plan issues) and by unresolved provider complaint reason code (complaint is expected to be resolved by the reporting date and complaint is unlikely to be resolved by the reporting date);

- A quarterly follow-up report consisting of data elements specified by DHS for provider complaints unresolved in previous quarter(s).
- A quarterly report of delays in claims payment, denials of claims payment, and claims not paid correctly which includes the following:
    - The number of claims processed for each month in the reporting quarter;
    - The number of claims paid for each month in the reporting quarter;
    - The percentage of claims processed (at 14, 30, 60, and 90 days) after date of service for each month of the reporting quarter;
    - The number of claims denied for each month in the reporting quarter;
    - The percentage of claims denied for each of the following reasons: 1) prior authorization/referral requirements were not met for each month in the reporting quarter, 2) submitted past the filing deadline for each month in the reporting quarter, 3) provider not eligible on date of service for each month in the reporting quarter, 4) member not eligible on date of service, and 5) member has another health insurer which should be billed first.

51.500 Covered Benefits and Services Reports

51.510 CMS 416 Report

The health plan shall submit an annual CMS 416 Report to the DHS no later than March 1 of every year to measure and document screening and participation rates in the EPSDT program so opportunities for improvement can be identified and addressed.

51.600 Quality Assessment and Performance Improvement (QAPI) Program Reports

51.610 QAPI Program Report

The health plan shall provide an annual *QAPI Program Report*. This report shall be submitted by the date specified by MQD in the Annual Reporting and Monitoring Activities Memorandum that is issued to the health plans every year. The health plan's medical director shall review these reports prior to submittal to the DHS. The *Report* shall include the following:

- Any changes to the QAPI Program;
- A detailed set of QAPI Program goals and objectives that are developed annually and includes timetables for implementation and accomplishments;
- A copy of the health plan's organizational chart including vacancies of required staff, changes in scope of responsibilities, changes in delegated activities and additions or deletions of positions;
- A current list of the required staff as detailed in Section 51.200 including name, title, location, phone number and fax number;
- An executive summary outlining the changes from the prior QAPI;
- A copy of the current approved QAPI Program description, the QAPI Program work plan and, if issued as a separate document, the health plan's current utilization management program description with signatures and dates;

- A copy of the previous year's QAPI Program and utilization management program evaluation reports; and
- Written notification of any delegation of QAPI Program activities to contractors.

51.620 Health Plan Employer Data and Information Set (HEDIS) Report

The health plan shall submit *Health Plan Employer Data and Information Set (HEDIS) Reports* in the format required by the DHS. This report shall cover the period from January 1 to December 31 and shall be reviewed by the health plan's Medical Director prior to submittal to the DHS by June 30 of each year.

The EQRO shall annually perform a HEDIS Report Validation to at least three (3) of the State-selected HEDIS measures to ensure health plan compliance with HEDIS methodology.

51.630 Performance Improvement Projects Report

Annually, the health plan shall submit, on the DHS designated reporting form, two (2) *Performance Improvement Projects Report*s to the DHS and its EQRO. Each report shall document a clearly defined study question and, well-defined indicators (both of which may be selected by the DHS). The reports shall also address the following elements: a correctly identified study population, valid sampling techniques, accurate/complete data collection, appropriate improvements strategies, data analysis and interpretation, reported improvements (if any), and sustained improvement over time (if any). These reports shall

be independently validated by the EQRO, on an annual basis, to ensure compliance with CMS protocols, and DHS policy, including timeline requirements. Status reports on performance improvement projects may be requested more frequently by the DHS.

This report shall be submitted on the same date the QAPI Program Report required in Section 51.610 is submitted.

51.700 Member Services Reports

51.710 Call Center Report

By the 15th of each month starting in March 2010, the health plan shall submit a report on the utilization rate of the call center for members during the previous month that shall include, at a minimum, the following:

- Number of customer service call center calls (actual number and number reported per 1,000 members);
- Call abandonment rate;
- Longest wait in queue;
- Average talk time; and
- Type of call.

If approved by the DHS, the health plan may submit call center utilization using alternative methods.

51.720 Translation/Interpretation Services Report

By the end of the month following the end of each quarter, starting in January 2010 for the quarter ending in December 31, 2009, the health plan shall submit *Translation/Interpretation Services Reports* that include the following information on activities during that quarter:

- The name and Medicaid identification number for each member to whom translation/interpretation service was provided;
- The date of the request;
- The date provided;
- The type of service including the language requested; and
- The identification of the translator/interpreter or translator/interpreter agency.

51.730 Requests for Documents in Alternate Languages Report

By the end of the second month following the end of each quarter starting in February 2010 for the quarter ending December 31, 2009, the health plan shall submit *Requests for Documents in Alternative Languages Reports* that include the following information on activities during that quarter:

- The name and Medicaid identification number for each member requesting documents in an alternative language;

- The language requested;
- The data of the request; and
- The date the documents were mailed or provided.

51.740 CAHPS® Consumer Survey

The health plan shall report the results of any CAHPS® Consumer Survey conducted by the health plan on Medicaid members, if applicable. The health plan shall provide a copy of the overall report of survey results to the DHS. This report is separate from any CAHPS® Consumer Survey that is conducted by the DHS.

51.750 Member Grievance and Appeals Report

The health plan shall submit to the DHS a *Member Grievance and Appeals Report* on a quarterly basis. Reports shall be submitted November 30 for the quarter July-September, February 28 for the quarter October-December, May 31 for the quarter January-March, and August 31 for the quarter April-June. Reports shall meet the formatting and content requirements outlined in Section 50.805, and shall be submitted in the format provided by the DHS.

At a minimum the reports shall include:

- The number of grievances and appeals by type;
- Type of assistance provided;
- Administrative disposition of the case;
- Overturn rates;
- Percentage of grievances and appeals that did not meet timeliness requirements;
- Ratio of grievances and appeals per 1,000 members; and
- Listing of unresolved appeals originally filed in previous quarters.

51.760 Case Management Report

The health plan shall submit to the DHS a *Case Management Report* by the end of the second month following the end of each quarter starting from December 31, 2009 (the first report is due on February 28, 2010). Reports shall include a list of all clients who received case management services over the past quarter, their pertinent diagnosis, start and end date of case management services, estimated length of continued services if still occurring and a total of the number of clients who received case management services (excludes disease management services) for the quarter.

51.770 Behavioral Health Services Report

The health plan shall submit to the DHS a *Behavioral Health Services report* on a quarterly basis with monthly reports being submitted for the first six (6) months of the transition of behavioral health services for members with a diagnosis of SPMI. Monthly reports shall be submitted on the fifteenth (15th) of the following month for which the report is submitted starting with July 2010 through December 2010 (reports will be due on August 15, 2010 for the month of July 2010 and on the fifteenth of each month thereafter until January 15, 2011 for the month of December 2010). Reports shall be submitted April 30 for the quarter January-March 2011, and July 31 for the quarter April-June 2011. Reports shall include information on transition of care, services provided by acuity of member, incident reporting related to SPMI diagnosis, and any other quality measure that the DHS deems necessary. Both monthly and quarterly report formats will be provided to health plans at least sixty (60) days prior to due date of the initial report.

51.800 Utilization Management Reports

51.810 Prior Authorization Requests Denied/Deferred

The health plan shall submit on a semi-annual basis, a *Prior Authorization Requests that have been Denied or Deferred Report*. The specific reporting period, types of services and due dates will be designated by the DHS. The quality improvement objective of this report is to ensure that health plans are correctly interpreting the QUEST program benefits and appropriately applying the program's medical necessity criteria. The report shall include the following data:

- Date of the request;
- Name of the requesting provider;
- Member's name and ID number;
- Date of birth;
- Diagnoses and service/medication being requested;
- Justification given by the provider for the member's need for the service/medication;
- Justification of the health plan's denial or the reason(s) for deferral of the request; and
- The date and method of notification of the provider and the member of the health plan's determination.

51.820 Report of Over- and Under Utilization of Drugs

The health plan shall submit a *Report of Over- and Under Utilization of Drugs* which consists of the following four (4) reports two (2) times per year on a schedule designated by the DHS:

A. Listings of the top fifty (50) high cost drugs and the top fifty (50) highly utilized drugs, the criteria that is used/developed to evaluate their appropriate, safe and effective use, and the outcomes/results of the evaluations
B. Listings of the top fifty (50) highest utilized non-formulary drugs paid for by the plan including the charges and allowances for each drug as well as the criteria used/developed to evaluate the appropriate, safe and effective use of these medications and the outcomes/results of the evaluations.

C. Listing of members who are high users of controlled substances but have no medical condition (i.e. malignancies, acute injuries, etc.) which would justify the high usage. Additionally, the health plan shall submit: 1) its procedures for referring these members for care coordination/case management (CC/CM) for monitoring and controlling their over-utilization, and 2) the results of the CC/CM services provided.

D. Results of pharmacy audits, including who performed the audits, what areas were audited, and if problems were found, the action(s) taken to address the issue(s), and the outcome of the corrective action(s).

These reports shall be submitted twice per year according to the schedule prescribed by the DHS.

51.830 Report of Over- and Under-Utilization of Services

The health plan shall submit a *Report of Over- and Under Utilization of Services*, consisting of the following six (6) measures.

All measures, with the exception of item "C. QI Investigations for Delay in Treatment" shall be measured twice per year with reports due on September 30 (for the period January to June), and March 31 (for the period July to December). Item "C." shall be measured on an annual basis (for the period January to December) and shall be due on March 31.

A. PCP Visit Rates: The percent of PCPs that are at the top three percent (3%) and bottom three percent (3%) in utilization compared to the health plan's specialty. The health plan shall include only those PCPs that have at least one hundred (100) members assigned to them.

B. Approved Authorization/1000 Member Months: Percent of PCPs that are at the top three percent (3%) and bottom three percent (3%) in utilization compared to the health plan's specialty norm. The health plan shall include only those PCPs that have at least one hundred (100) members assigned to them.

C. QI Investigations for Delay in Treatment: The measure to be reported is the rate (20% or more) of QI investigations conducted by the health plan in a 12 month period relating to a delay in treatment by a PCP with more than 100 members.

D. The over-utilization measure to be reported is the percent of hospitals and other providers delegated to perform concurrent reviews that have one hundred fifty percent (150%) or higher of service utilization exceeding the health plan average. The under-utilization measure shall reflect the percent of hospitals and other providers delegated to perform concurrent reviews that have utilization of twenty-five percent (25%) or less of the recommended services in the clinical decision criteria adopted by the health plan e.g. Milliman or InterQual guidelines.

E. Selected Specialty Visit Rates: The percent of individual providers within the specialties of cardiology, general

surgery and orthopedics with fifty (50) or more approved prior authorizations in a six (6) month period that are at the top and bottom three percent (3%) in utilization compared to the health plan's specialty norm.

F. Selected Chronic Conditions: The follow-up utilization variance per clinical practice guidelines or disease management guidelines adopted by the health plan for two (2) relevant chronic conditions selected by the health plan.

For each measure, the health plan shall identify the threshold designated by the health plan's Medical Director that triggers further investigation for over- and/or under-utilization.

51.900 Fraud and Abuse Reports

The health plan shall submit a Fraud and Abuse Report that shall include, at a minimum, the following information on all alleged fraud and abuse cases:

- Source of complaint;
- Alleged persons or entities involved;
- Nature of complaint;
- Approximate dollars involved;
- Date of the complaint;
- Disciplinary action imposed;
- Administrative dispostion of the case;
- Investigative activities, corrective actions, prevention efforts, and results; and

- Trending and analysis as it applies to: utilization management, claims management, post-processing review of claims, and provider profiling.

52.100 Financial Reports

52.110 QUEST Financial Reporting Guide

The health plan shall submit financial information on a regular basis in accordance with the QUEST Financial Reporting Guide in Appendix AA. The health plan shall comply by submitting all quarterly and annual reports and data in the formats prescribed in the QUEST Financial Reporting Guide. The DHS reserves the right to increase the frequency of financial reporting by the health plan. The financial information shall be analyzed and compared to industry standards and standards established by the DHS to ensure the financial solvency of the health plan. The DHS may also monitor the financial performance of the health plan with on-site inspections and audits.

The health plan shall, in accordance with generally accepted accounting practices prepare financial reports that adequately reflect all direct and indirect expenditures and management and fiscal practices related to the health plan's performance of services under this contract.

52.120 Third Party Liability (TPL) Cost Avoidance Report

The health plan shall submit a monthly *Third Party Liability (TPL) Cost Avoidance Report*, using the format received by the DHS, which identifies all cost-avoided claims for members with third

party coverage from private insurance carriers and other responsible third parties.

52.130 Disclosure of Information on Annual Business Transaction Report

The health plan shall submit to the DHS a *Disclosure of Information on Annual Business Transactions Report* that discloses information on the following types of transactions:

- Any sale, exchange, or lease of any property between the health plan and a party in interest;
- Any lending of money or other extension of credit between the health plan and a party in interest; and
- Any furnishing for consideration of goods, services (including management services) or facilities between the health plan and the party in interest. This does not include salaries paid to employees for services provided in the normal course of their employment.

The health plan shall include the following information in the transactions listed above:

- The name of the party in interest for each transaction;
- A description of each transaction and the quantity or units involved;
- The accrued dollar value of each transaction during the fiscal year; and
- Justification of the reasonableness of each transaction.

For the purposes of this section, a party in interest, as defined in Section 1318(b) of the Public Health Service Act, is:

- Any director, officer, partner, or employee responsible for management or administration of an HMO; any person who is directly or indirectly the beneficial owner of more than five percent (5%) of the equity of the HMO; any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than five percent (5%) of the HMO; or, in the case of an HMO organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law;
- Any organization in which a person described above is director, officer or partner; has directly or indirectly a beneficial interest of more than five percent (5%) of the equity of the HMO; or has a mortgage, deed of trust, note, or other interest valuing more than five percent (5%) of the assets of the HMO;
- Any person directly or indirectly controlling, controlled by, or under common control with a HMO; or
- Any spouse, child, or parent of an individual described in the foregoing bullets.

52.140 Encounter Data/Financial Summary Reconciliation Report

The health plan shall submit quarterly Encounter Data/Financial Summary Reconciliation Reports to MQD. These reports shall be submitted within ninety (90) calendar days of the last day of the quarter. The health plan shall submit these reports using the

instructions and format provided in Appendix B. In addition, the health plan shall provide any additional summaries, data or explanations as to differences between the summary report, and encounter data and financial summaries (for example, this analysis could include a detailed discussion of reserves and any items included in the claim cost portion of the financial statements that are not included in the encounter data).

52.150 Medicaid Contracting Report

The health plan shall submit an annual Medicaid contracting report to DHS, the State of Hawaii Department of Commerce and Consumer Affairs Insurance Division, and the Hawaii State Legislature, no later than one-hundred eighty (180) days following the end of the State Fiscal Year (SFY) or December 31. The content of the Medicaid contracting report will include the information required by Act 12, First Special Session 2009. The health plan shall submit the report using the format provided by the DHS.

52.200 Encounter Data Reporting

The health plan shall submit encounters to MQD once per month in accordance with the requirements and specifications defined by the State and included in the Health Plan Manual. Encounters shall be certified and submitted by the health plans as required in 42 CFR 438.606 and as specified in Section 52.400.

52.210 Accuracy, Completeness and Timeliness of Encounter Data Submissions

The State will impose financial penalties or sanctions on the health plan for inaccurate, incomplete and late submissions of required data, information and reports. All requested data and information shall be complete with no material omissions. Encounter data is not complete if the data has missing or incomplete field information. The State shall impose financial penalties on the health plan for failure to submit accurate encounter data on a timely basis. Any financial penalty imposed on the health plan shall be deducted from the subsequent month's capitation payment to the health plan. The amount of the total financial penalty for the month shall not exceed ten percent (10%) of the monthly capitation payment.

The following encounter data submission requirements apply:

- Timeliness –eighty percent (80%) of the encounter data shall be received by the DHS no more than one-hundred twenty (120) days from the date that services were rendered and one-hundred percent (100%) within fifteen (15) months from the date of services. Adjustments and resubmitted encounters will not be subject to the one-hundred twenty (120) day submission requirement. In addition, TPL related encounters will not be subject to the one-hundred twenty (120) day submission deadline.
- Accuracy and Completeness – The data and information provided to the DHS shall be accurate and complete. Data and reports shall be mathematically correct and present

accurate information. An accurate encounter is one that reports a complete and accurate description of the service provided.

The health plan will be notified by the DHS within thirty (30) days from the receipt date of the initial encounter submission of all encounters that have failed the accuracy and completeness edits. The health plan shall be granted a thirty (30) day error resolution period from the date of notification. If, at the end of the thirty (30) day error resolution period, fifteen percent (15%) of the initial encounter submission continues to fail the accuracy and completeness edits, a penalty amounting up to ten percent (10%) of the monthly (initial month's submission) capitation payment shall be assessed against the health plan for failing to submit accurate and timely encounter data.

The health plan may file a written challenge to the financial penalty with the DHS not more than thirty (30) days after the health plan receives written notice of the financial penalty. Challenges will be considered and decisions made by the DHS no more than sixty (60) days after the challenge is submitted.

Financial penalties are not refundable unless challenged and decided in favor of the health plan.

The health plan shall continue reporting encounter data once per month beyond the term of the contract as processing and reporting of the data is likely to continue due to lags in time in filing source documents by subcontractors and providers.

52.300 Financial Penalties for Failure to File Reports, Information and Data Requests

All information, data, reports and medical records, including behavioral health and substance abuse records, shall be provided to the DHS or its designee by the specified deadlines. The health plan shall be assessed a penalty of $200.00 per day until the required information, accurate data, reports or medical records are received by the DHS or its designee**.**

52.400 Health Plan Certification

The health plan shall certify the accuracy, completeness, and truthfulness of any data, including but not limited to, encounter data, data upon which payment is based, and other information required by the State, that may be submitted to determine the basis for payment from the State agency. Health plan representation shall certify that it is in substantial compliance with the contract and provide a letter of certification attesting to the accuracy, completeness, and truthfulness of the data submitted based on best knowledge, information, and belief. The health plan shall submit the letter of certification to its MQD plan liaison concurrent with the certified data and document submission. In the case of two (2) submissions in one month, the health plan shall submit two (2) letters of certification. The certifications are to be based on best knowledge, information, and belief of the following health plan personnel.

The data shall be certified by:

- The health plan's Chief Executive Officer (CEO);
- The health plan's Chief Financial Officer (CFO); or
- An individual who has delegated authority to sign for, and who reports directly to, the health plan's CEO or CFO.

The health plan shall require claim certification from each provider submitting data to the health plan.

52.500 Follow-Up by Health Plans/Corrective Action Plans/Policies and Procedures

The DHS shall provide a report of findings to the health plan after completion of each review, monitoring activity, etc. Unless otherwise stated, the health plan shall have thirty (30) days from the date of receipt of a DHS report to respond to the MQD's request for follow-up, actions, information, etc. The health plan's response shall be in writing and address how the health plan resolved the issue(s). If the 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 MQD. In certain circumstances (i.e., concerns or issues that remain unresolved or repeated from previous reviews or urgent quality issues), MQD may request a ten (10) day plan of correction as opposed to the thirty (30) day response time.

For all medical record reviews, the health plan shall submit information prior to the scheduled review and arrange for MQD and the EQRO to access medical records through on-site review and provision of a copy of the requested records. The health

plan shall submit this information within sixty (60) days of notification or sooner should circumstances dictate an expedited production of records.

The health plan shall submit the most current copy of any policies and procedures requested. In the event the health plan has previously submitted a copy of a specific policy or procedure and there have been no changes, the health plan shall state so in writing and include information as to when and to whom the policy and procedure was submitted. If there are no policies or procedures for a specific area, the health plan may submit other written documentation such as workflow charts or other documents that accurately document the actions the health plan has or will take.

53.000 Readiness Review for Behavioral Health Transition

The health plan shall comply with all readiness review activities required by the DHS. This includes, but is not limited to, submitting all required documents for review as identified below by the required due date, participating in any on-site review activities conducted by the DHS, and submitting updates on implementation activities. The DHS reserves the right to request additional documents for review and approval during readiness review.

Document	RFP Reference	Due Date
Provider Contracting Summary using format provided by the DHS	Section 40.210 Required Providers	Every two weeks after April 1, 2010

GeoAccess reports	Section 40.210 Required Providers	Every two weeks after April 1, 2010
Behavioral Health Policies and Procedures to include at a minimum: • Assessment process for identifying SPMI members who need additional services as well as for identifying members who no longer need additional services • Process for developing plans of care based on assessments • Acuity system-process for evaluating and re-evaluating SPMI members' acuity and risk • Process for starting additional services for members with SPMI diagnosis • Process for ending additional services for members with SPMI diagnosis • Description of services offered to include but not limited to provider type, location(s), and time frame • Internal quality monitoring of program	Section 40.370 Behavioral Health	February 1, 2010

Description of internal Transition of Care process	Section 41.200	February 1, 2010
Provider/subcontractor agreement with CAMHD	Section 40.372	May 15, 2010
Provider/subcontractor agreement with AMHD	Section 40.370	May 15, 2010

The health plans must meet behavioral health provider network requirements outlined in Section 40.210 to meet their members' needs as outlined in Section 40.370 no later than June 15, 2010. Failure to obtain an adequate network for provision of behavioral health services may result in sanctions as described in Section 71.320.

The health plan must develop a behavioral health program that is approved by the DHS to meet their members' needs as outlined in Section 40.370 no later than June 15, 2010. Failure to develop a behavioral health program that is adequate to provide behavioral health services for members with a SPMI diagnosis may result in sanctions as described in Section 71.320.

SECTION 60 FINANCIAL RESPONSIBILITIES

60.100 The DHS Responsibilities

60.110 Reimbursement

The only reimbursement to be made to the health plan is the monthly capitation payments stated in the health plan's contract with the State. The DHS will make monthly capitation payments to the health plan for each enrolled member in the health plan beginning on February 1, 2007.

The DHS will pay the established capitation rate to the health plan for members enrolled for the entire month.

The DHS will make additional capitation payments or recover capitation payments from the health plan as a result of retroactive enrollments and disenrollments. Changes in the capitation amount/rate code paid shall become effective when the DHS notifies the health plan.

The DHS will provide to the health plan a Monthly Payment Summary Report which summarizes capitation payments and recoveries made to the health plan.

60.120 Collection of Premium Shares for Members

The DHS or its agent will bill and collect the members' premium share, for members with a required premium share, as stated in the HAR.

60.130 Risk Share Program

The DHS will implement and manage a risk share arrangement and will share in any significant costs or savings. Additional information about the risk share program is available in Appendix T.

60.200 Daily Rosters/Capitation Payments

The DHS will enroll and disenroll members through daily files. The health plan agrees to accept daily and monthly transaction files from the DHS as the official enrollment record. The daily membership rosters identify the capitated fee amounts associated with mid-month enrollment and disenrollment transactions. Capitation payment will be paid on rate codes, which reflect the risk factor adjustments. Capitation payments for members enrolled/disenrolled on dates other than the first or last day of the month will be prorated on a daily basis based on the number of days in a month.

The health plan shall not change any of the information provided by the DHS on the daily or monthly transaction files. Any inconsistencies between the health plan and the DHS information shall be reported to the DHS for investigation and resolution. All payments and recoveries will be detailed on the daily file and also summarized on the Monthly Payment Summary Report.

The Monthly Payment Summary Report shall be used to invoice MQD. This report includes the capitation payment amounts from

all the daily adjustments incurred during the month and the monthly capitation amounts for the subsequent month.

60.210 Capitation Payments for Changes in Rate Codes

There are several situations in which a member may change eligibility categories, and therefore rate codes, which will result in a different capitation payment amount or a disenrollment from the health plan. Examples of these changes include members moving:

- From QUEST to QUEST-Net
- From General Assistance (GA) to QUEST

The DHS will change rate codes for QUEST-Net members who are retroactively determined eligible for QUEST, to be effective as of the retroactive eligibility date. The rate code will be changed to the QUEST rate and the difference will be paid to the health plan.

No changes in rate code will be implemented retroactively with the exception of QUEST-Net members moving to QUEST. Changes in the capitation payment amount/rate code paid shall become effective the next day after the enrollment call center processes the change.

60.300 Incentives for Health Plan Performance

The health plan shall be eligible for financial performance incentives or Pay for Performance (P4P) as long as the health plan is fully compliant with all terms of the contract. All

incentives shall be in compliance with the federal managed care incentive arrangement requirements set forth in 42 CFR §438.6 and the State Health Plan Manual.

To qualify for receipt of a financial incentive that uses either HEDIS or CAHPS measurements as a performance indicator demonstrating improvement, an NCQA licensed audit organization must have audited the reported HEDIS rate and an NCQA-certified survey vendor must have administered the CAHPS survey. This is to ensure that both NCQA and CAHPS performance measures followed the CMS protocol for validation. The validation of HEDIS measures and CAHPS survey administration will be performed by the DHS through the EQRO. The total of all payments paid to the health plan under this contract shall be pursuant to 42 CFR §438.6.

To receive the incentive payment, the health plan must either meet a minimum threshold of achievement or meet a minimum level of improvement. Funding for the incentive payments would come from a $1.00 per member per month (PMPM) withhold amount taken from the administrative allowance in the capitation rates starting on January 1, 2010. The health plans rates are actuarially sound with or without the refund of the $1.00 PMPM P4P withhold. The DHS will weigh each of the five (5) measures described in Sections 60.310 to 60.350 equally. For the successful outcome of each of the five (5) measures, one-fifth of the withhold amount will be returned to the health plan. The DHS will not award partial incentives. If DHS fails to validate the HEDIS measures in accordance with timeframes

established in 42 CFR §438.240(c) or conduct the CAHPS survey, the withhold amount for that measure will be returned to the health plan.

The performance measures to be used for calendar year 2010, as measured by HEDIS 2011 specifications for 2010 data, are described in Sections 60.310 to 60.350. Earned incentives will be paid within sixty (60) days after the validated HEDIS and CAHPS results are available. The timeframe for validation of results will be in accordance with timeframes established in 42 CFR §438.240(c) for annual validation of performance measures. The minimum threshold of achievement and the minimum level of improvement are listed below for each of the measures; however, these measures and targets are subject to change in subsequent years. DHS will inform the health plan of the change in measures no less than fourteen (14) days prior to the beginning of the time period from which the data is being measured.

The source for the measures will be the NCQA HEDIS data and CAHPS survey data as described above. For HEDIS measures, the percentile thresholds used will be the HEDIS percentiles identified in the NCQA HEDIS Audit Means and Percentiles for Medicaid HMOs for the measurement year that NCQA publishes yearly in the spring. For CAHPS measures, the percentile thresholds used will be the National Accreditation Benchmarks for Medicaid CAHPS measures. For HEDIS measures, NCQA specifications for the measures must have been followed. For

the CAHPS measure, the CAHPS specification must have been followed.

60.310 Childhood Immunizations

For calendar year 2010, a health plan shall be eligible for a performance incentive payment if the health plan's performance:

- Is at or exceeds the HEDIS 2010 Medicaid 75th percentile rate for the measure of Combination 2 under the Childhood Immunization Status measures; or
- Meets or exceeds the rate that is an improvement, of 25% of the difference between the health plan's rate in calendar year 2009 and the HEDIS 2010 Medicaid 75th percentile rate, above the health plan's rate in calendar year 2009.

60.320 Emergency Department Visits/1000

For calendar year 2010, a health plan shall be eligible for a performance incentive payment if the health plan's performance:

- Meets or falls below the HEDIS 2010 Medicaid 10th percentile rate for the measure of Emergency Department Visits/1000 under the Ambulatory Care Measures; or
- Meets or falls below the rate that is an improvement, of 50% of the difference between the health plan's rate in calendar year 2009 and the HEDIS 2010 Medicaid 10th percentile rate, below the health plan's rate in calendar year 2009.

60.330 LDL Control in Diabetes

For calendar year 2010, a health plan shall be eligible for a performance incentive payment if the health plan's performance:

- Meets or exceeds the HEDIS 2010 Medicaid 75th percentile rate for the measure of LDL-C Control under the Comprehensive Diabetes Care Measures; or
- Meets or exceeds the rate that is an improvement, of 50% of the difference between the health plan's rate in calendar year 2009 and the HEDIS 2010 Medicaid 75th percentile rate, above the health plan's rate in calendar year 2009.

60.340 Chlamydia Screening

For calendar year 2010, a health plan shall be eligible for a performance incentive payment if the health plan's performance:

- Meets or exceeds the HEDIS 2010 Medicaid 75th percentile rate for the measure of Chlamydia Screening; or
- Meets or exceeds the rate that is an improvement, of 50% of the difference between the health plan's rate in calendar year 2009 and the HEDIS 2010 Medicaid 75th percentile rate, above the health plan's rate in calendar year 2009.

60.350 Getting Needed Care

For calendar year 2010, a health plan shall be eligible for a performance incentive payment if the health plan's performance:

- Meets or exceeds the CAHPS 2010 Adult Medicaid 75th percentile rate for the measure of 'Getting Needed Care' in the 2010 Adult CAHPS Survey; or

- Meets or exceeds the rate that is an improvement, of 50% of the difference between the health plan's rate in calendar year 2008 and the CAHPS 2010 Adult Medicaid 75th percentile rate, above the health plan's rate in calendar year 2008.

60.400 Health Plan Responsibilities

60.410 Provider and Subcontractor Reimbursement

With the exception of hospice providers, FQHCs, and RHCs, the health plan may reimburse its providers and subcontractors in any manner, subject to federal rules. The reimbursement by the health plan to its providers and subcontractors, for example, may be a capitated rate or discounted Medicaid fee-for-service amount. Regardless of the payment methodology, the health plan shall require that all providers submit detailed encounter data.

The health plan shall make monthly supplemental payments to the Hawaii Health Systems Corporation (HHSC). This amount will be based on the health plan's percentage of total QUEST enrollees during that month. DHS will notify the health plans of their contribution each month.

The health plan shall reimburse non-contracted FQHCs and RHCs no less than the level and amount of payment which the health

plan would make for like services if the services were furnished by a provider which is not an FQHC or RHC. The health plan will reimburse contracted FQHCs or RHCs at the PPS rate provided annually by the DHS.

The DHS will calculate and reimburse FQHC/RHC's for any retroactive settlements involving a change in scope of services. The health plan shall report this information to the DHS quarterly and in the format required by MQD.

The health plan shall pay hospice providers Medicare hospice rates as calculated by the DHS and CMS. The health plan shall implement these rates on October 1 of each year.

The health plan shall not pay out-of-network providers who deliver emergency services more than they would have been paid if the emergency services had been provided to an individual in the Medicaid fee-for-service program.

The health plan shall pay its subcontractors and providers on a timely basis, consistent with the claims payment procedures described in Section 1902(a)(37)(A) of the Social Security Act.

This section requires that ninety percent (90%) of claims for payment (for which no further written information or substantiation is required in order to make payment) are paid within thirty (30) days of the date of receipt of such claims and that ninety-nine percent (99%) of claims are paid within ninety (90) days of the date of receipt of such claims. The health plan

and the provider may, however, agree to an alternative payment schedule provided this alternative payment schedule is reviewed and approved by the DHS.

In no event shall the health plan's subcontractors and providers look directly to the State for payment.

The State and the health plan's members shall bear no liability for the health plan's failure or refusal to pay valid claims of subcontractors or providers. The health plan shall include in all subcontractor and provider contracts a statement that the State and plan members bear no liability for the health plan's failure or refusal to pay valid claims of subcontractors or providers for covered services. Further, the State and health plan members shall bear no liability for services provided to a member for which the State does not pay the health plan; or for which the plan or State does not pay the individual or health care provider that furnishes the services under a contractual, referral, or other arrangement; or for payment for covered services furnished under a contract, referral, or other arrangement, to the extent that these payments are in excess of the amount that the member would owe if the health plan provided the services directly.

The health plan shall indemnify and hold the State and the members harmless from any and all liability arising from such claims and shall bear all costs in defense of any action over such liability, including attorney's fees.

60.420 Non-Covered Services

The health plan may collect fees directly from members for non-covered services or for services from unauthorized non-plan providers. If a member self-refers to a specialist or other provider within the health plan's network without following procedures (e.g. obtaining prior authorization), the health plan may deny payment to the service provider.

The health plan shall educate providers about the processes which must be followed for billing a member when non-covered or unauthorized services are provided. This education shall include at a minimum the following:

- If a member self-refers to a specialist or other provider within the network without following health plan procedures (e.g. obtaining prior authorization) and the health plan does deny payment to the provider, the provider may bill the member;
- If a provider fails to follow plan procedures which results in nonpayment, the provider may not bill the member; and
- If a provider bills the member for non-covered services or for self-referrals, he or she shall inform the member and obtain prior agreement from the member regarding the cost of the procedure and the payment terms at time of service.

If the health plan later determines that a member has been billed for health plan-covered services, the plan shall refund the member directly.

60.430 Physician Incentives

The health plan may establish physician incentive plans pursuant to federal and state regulations, including 42 CFR 422.208, 422.210, and 42 CFR 438.6.

The health plan shall disclose any and all such arrangements to the DHS for review and approval prior to implementing physician incentives, and upon request, to members. Such disclosure shall include:

- Whether services not furnished by the physician or group are covered by the incentive plan;
- The type of incentive arrangement;
- The percent of withhold or bonus; and
- The panel size and if patients are pooled, the method used.

Upon request, the health plan shall report adequate information specified by applicable regulations to the DHS so that the DHS can adequately monitor the health plan.

If the health plan's physician incentive plan includes services not furnished by the physician/group, the health plan shall: (1) ensure adequate stop loss protection to individual physicians, and must provide to the DHS proof of such stop loss coverage, including the amount and type of stop loss; and (2) conduct annual member surveys, with results disclosed to the DHS, and to members, upon request.

Such physician incentive plans may not provide for payment, either directly or indirectly, to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual.

60.440 Payment to PCPs

The health plan shall coordinate with other health plans and the State to provide a one-time payment to a PCP for one visit for a member who was auto-assigned to a new health plan during the positive enrollment period who receives services from the PCP to which they were assigned under the old health plan, provided that the PCP is not in the network of the new health plan.

60.500 Third Party Liability (TPL)

60.510 Background

TPL refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded, or commercial carrier, automobile insurance and worker's compensation) or program, that is, or may be, liable to pay all or part of the health care expenses of the member.

Pursuant to Section 1902(a) (25) of the Social Security Act, the DHS authorizes the health plan as its agent to identify legally liable third parties and treat verified TPL as a resource of the member.

Reimbursement from the third party shall be sought unless the health plan determines that recovery would not be cost effective. For example, the health plan may determine that the amount it reasonably expects to recover will be less than the cost of recovery. In such situations, the health plan shall document the situation and provide adequate documentation to the DHS.

60.520 Responsibilities of the DHS

The DHS will:

- Be responsible for coordination and recovery of accident and workers' compensation subrogation benefits;
- Collect and provide member TPL information to the health plan. TPL information will be provided to the health plan via the daily TPL roster; and
- Conduct TPL audits every six (6) months to ensure TPL responsibilities are being completed by the health plan.

60.530 Responsibilities of the Health Plan

The health plan shall coordinate health care benefits with other coverages, both public and private, which are or may be available to pay medical expenses on behalf of any member.

The health plan shall seek reimbursement from all other liable third parties to the limit of legal liability for the health services rendered. The health plan shall retain all health insurance benefits collected, including cost avoidance.

The health plan shall follow the mandatory pay and chase provisions described in 42 CFR. 433.139(b)(3)(i)(ii).

In addition, the health plan shall:

- Continue cost avoidance of the health insurance plans accident and workers' compensation benefits;
- Report all accident cases incurring medical and medically related dental expenses in excess of five-hundred dollars ($500) to the DHS;
- Provide a list of medical and medically related dental expenses, in the format requested by the DHS, for recovery purposes. (See Appendix U for required data). "RUSH" requests shall be reported within three (3) business days of receipt and "ROUTINE" requests within seven (7) business days of receipt. Listings shall also include claims received but not processed for payments or rejected;
- Provide copies of claim forms with similar response time as the above;
- Provide listings of medical and medically related dental expenses (including adjustments, e.g., payment corrections, refunds, etc.) according to the payment period or "as of" date. Adjustments shall be recorded on the date of adjustment and not on the date of service;
- Inform the DHS of TPL information uncovered during the course of normal business operations;
- Provide the DHS with monthly reports of the total cost avoidance and amounts collected from TPLs within thirty (30) days of the end of the month;

- Develop procedures for determining when to pursue TPL recovery; and
- Provide health care services for members receiving motor vehicle insurance liability coverage at no cost through the Hawaii Joint Underwriting Plan (HJUP) in accordance with Section 431-10C-103, HRS.

60.600 Catastrophic Care

60.610 Introduction

The State has contracted with a catastrophic reinsurer that will provide the participating health plan with reimbursement for eligible medical costs incurred by members beyond a specified dollar threshold. The purpose of this reimbursement program is to share the financial risks associated with catastrophic care and protect participating plans from significant, long-term, or unanticipated costs for specific cases.

The catastrophic reimbursement program is available to the health plan for QUEST members, and QUEST-Net and QUEST-ACE children.

60.620 The DHS Responsibilities Regarding Catastrophic Care

The DHS or its designee (Catastrophic Claims Manager) will manage, administer and provide reimbursement to the QUEST Plans for the State's share of eligible medical catastrophic medical expenses. Reimbursement for catastrophic care shall be

for eligible members and services. Experimental or investigational services are excluded from catastrophic care.

The catastrophic claims manager will provide a policy and procedure manual which outline the processes and requirements of the program, i.e. notification requirements, conducting concurrent reviews.

60.630 Health Plan Responsibilities Regarding Catastrophic Care

Effective January 1, 2010, the health plan shall be held solely responsible for incurred costs for eligible services for each member up to three hundred thousand dollars ($300,000) in a benefit year. The DHS shall reimburse for eligible costs according to the following:

	Health Plan Share	State Share
Up to $300,000	100%	0%
$300,000.01 - $1,000,000.00	25%	75%
$1,000,000.01 and up	0%	100%

Any and all available TPL shall be exhausted before reimbursement through the DHS' catastrophic care program is initiated.

The health plan shall notify the Catastrophic Claims Manager within five (5) business days, whenever a case has incurred costs equal to sixty percent (60%) of the minimum or a member is expected to have the minimum cost or more. The health plan shall utilize the listing of the diagnostic codes on which the

catastrophic claims manager expects notification and the specific forms for transmittal of information provided by the catastrophic claims manager.

The following information shall be submitted to the Catastrophic Claims Manager after incurred costs have reached the threshold described above:

- Reports showing the charges and incurred costs of the services provided;
- All medical authorizations for services and level of care determinations, as requested;
- Pertinent information relative to the collection or cost avoidance due to other insurance coverage; and
- Case management reports or other relevant documentation.

In accordance with HRS section 346-10(a)(3), the health plan shall release medical records to the catastrophic reinsurer.

The plan shall designate one individual within its organization to be responsible for the coordination and communication of catastrophic care information to the catastrophic claims manager.

If a health plan establishes a capitation payment methodology with a hospital, the catastrophic claims manager shall be notified of the payment arrangements. The health plan shall provide the

DHS with a copy of the portion of the hospital contract which outlines the payment terms.

SECTION 70 TERMS AND CONDITIONS

70.100 General

This RFP, appendices, any amendments to the RFP and/or appendices, and the health plan's technical and business proposals submitted in response to this RFP form an integral part of the contract between the health plan and the DHS (see Section 100.700). In exchange for payment from the DHS of monthly capitated rates, the health plan agrees to provide health care benefits as described in this RFP. The health plan shall perform all of the services and shall develop, produce and deliver to the DHS all of the data requirements described in this RFP. The DHS shall make payment as described in this RFP.

QUEST Policy Memoranda are issued primarily to clarify process or operational issues with the plans. The health plan shall comply with the requirements of the memoranda and sign each memorandum as it is issued to acknowledge receipt and intention to implement.

The health plan shall comply with all applicable laws, ordinances, codes, rules and regulations of the federal, state and local governments that in any way affect its performance under the contract. The standard State General Conditions found in Appendix C shall be incorporated into and become part of the contract between the health plan and the State.

In the event of a conflict between the language of the contract, and applicable statutes and regulations, the latter shall prevail.

In the event of a conflict among the contract documents, the order of precedence shall be as follows: (1) Agreement (form AG3-Comp (4/99)), including all general conditions, special conditions, attachments, and addenda; (2) the RFP, including all attachments and addenda; and (3) Offeror's proposal. In the event of a conflict between the General Conditions and the Special Conditions, the Special Conditions shall control. The sections of the rules and regulations cited in this RFP may change as the rules and regulations are amended for MQD. No changes shall be made to this RFP due to changes in the section numbers. The documents in the documentation library shall be changed as needed. The availability and extent of the materials in the documentation library shall have no effect on the requirements stated in this RFP.

The contract shall be construed in accordance with the laws of the State of Hawaii.

Time is of the essence in the contract. As such, any reference to "days" shall be deemed calendar days unless otherwise specifically stated.

The health plan shall pay all taxes lawfully imposed upon it with respect to the contract or any product delivered in accordance herewith. The DHS makes no representations whatsoever as to the liability or exemption from liability of the health plan to any tax imposed by any governmental entity.

The contract shall be executed by the Hawaii DHS in accordance with the Chapter 103F, HRS.

The head of the purchasing agency (which includes the designee of the head of the purchasing agency), shall coordinate the services to be provided by the health plan in order to complete the performance required in this RFP. The health plan shall maintain communications with the head of the purchasing agency at all stages of the health plan's work, and submit to the head of the purchasing agency for resolution any questions which may arise as to the performance of the contract.

70.110 Compliance with other Federal Laws

Contractor shall agree to conform with such federal laws as affect the delivery of services under the Contract, including but not limited to the Titles VI, VII, XIX, XXI of the Social Security Act, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Federal Rehabilitation Act of 1973, the Davis Bacon Act (40 U.S.C. Section 276a et seq.), the Copeland Anti-Kickback Act (40 U.S.C. Section 276c), the Clean Air Act (42 U.S.C. 7401 et seq.) and the Federal Water Pollution Control Act as Amended (33 U.S.C. 1251 et seq.); the Byrd Anti-Lobbying Amendment (31 U.S.C. 1352); the Debarment and Suspension (45 CFR 74 Appendix A (8) and Executive Order 12549 and 12689); Education programs and activities: Title IX of the Education Amendment of 1972; EEO provisions; and Contract Work Hours and Safety Standards.

The Contractor shall recognize mandatory standards and policies relating to energy efficiency which are contained in the State energy conservation plan issues in compliance with the Energy Policy and Conservation Act (Pub. L. 94-165).

The Contractor 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.

70.200 Term of the Contract

This is a multi-term contract solicitation that has been deemed to be in the best interest of the State by the Director of the DHS. The contract is for the initial period of September 12, 2006 to June 30, 2009. Unless terminated, the contract shall be extended without the necessity of re-bidding, for not more than one (1) additional twelve (12) month period or parts thereof, upon mutual agreement in writing, at least sixty (60) days prior to expiration of the contract, provided that the contract price for the extended period shall remain the same or lower than the initial bid price or as adjusted in accordance with the contract price adjustment provision herein. Funds are available for only the initial term of the contract, and the contractual obligation of both parties in each fiscal period succeeding the first initial term is subject to the appropriation and availability of funds to DHS.

The contract will be cancelled only if funds are not appropriated or otherwise made available to support continuation of performance in any fiscal period succeeding the initial term 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 must notify the health plan, in writing, at least sixty (60) days prior to the expiration of the contract whether funds are available or not available for the continuation of the contract for each succeeding contract extension period. In the event of cancellation, as provided in this paragraph, the health plan will be reimbursed for the unamortized, reasonably incurred, nonrecurring costs.

The health plan acknowledges that other unanticipated uncertainties may arise that may require an increase or decrease in the original scope of services to be performed, in which event the health plan agrees to enter into a supplemental agreement upon request by the State. The supplemental agreement may also include an extension of the period of performance and a respective modification of the compensation.

70.210 Availability of Funds

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

70.300 Contract Changes

Any modification, alteration, amendment, change or extension of any term, provision, or condition of the contract shall be made by written amendment signed by the health plan and the State. No oral modification, alteration, amendment, change or extension of any term, provision or condition shall be permitted, except as otherwise provided within this RFP.

All changes to the scope of services for medical services to be provided by the health plan shall be negotiated and accompanying capitated rates established. If the parties reach an agreement, the contract terms shall be modified accordingly by a written amendment signed by the Director of the DHS and an authorized representative of the health plan. If the parties are unable to reach an agreement within thirty (30) days of the health plan's receipt of a contract change, the MQD Administrator shall make a determination as to the revised price, and the health plan shall proceed with the work according to a schedule approved by the DHS, subject to the health plan's right to appeal the MQD Administrator's determination of the price.

The health plan has up to fourteen (14) business days after receipt of the initial capitation rates established for the inclusion of behavioral health services for members with a diagnosis of SPMI or SEBD to determine if the health plan will accept or decline the capitation rates. These rates will be based on a specified health plan total enrollment, and the rates may be later adjusted to account for change in total enrollment. If the health plan decides to decline the capitation rates, they must inform the

DHS in writing within fourteen (14) business days of receipt of the rates. If a health plan declines the rates, the DHS may terminate the health plan's contract, giving no less than thirty (30) days written notice prior to the termination date of the contract. The DHS will determine the duration of the health plan contract based upon a coordinated transition of their members to other health plans. In the event of a plan termination, the State and the terminated plan will be in compliance with the 42 CFR 438.10 beneficiary notification requirements.

The State may, at its discretion, require the health plan to submit to the State, prior to the State's approval of any modification, alteration, amendment, change or extension of any term, provision, or condition of the contract, a tax clearance from the Director of DOTAX, State of Hawaii, showing that all delinquent taxes, if any, levied or accrued under State law against the health plan have been paid.

70.400 Health Plan Progress

70.410 Progress Reporting

The DHS will conduct on-site readiness reviews to verify the accuracy and appropriateness of information provided by the health plan in its proposal. The health plan shall submit a plan for implementation of the program and shall provide progress/performance reports every two (2) weeks beginning two (2) weeks after the notification of contract award in order to ensure that the health plan will be ready to enroll members as of February 1, 2007 and that all required elements such as the

QAPI program are in place. The implementation plan format to be used by the health plan shall be approved by the DHS.

70.420 Inspection of Work Performed

The DHS, the State Auditor of Hawaii, the U.S. Department of Health and Human Services (DHHS), the General Accounting Office (GAO), the Comptroller General of the United States, the Office of the Inspector General (OIG), Medicaid Fraud Control Unit of the Department of the Attorney General, or their authorized representatives shall, during normal business hours, have the right to enter into the premises of the health plan, all subcontractors and providers, or such other places where duties under the contract are being performed, to inspect, monitor, or otherwise evaluate the work being performed. All inspections and evaluations shall be performed in such a manner to not unduly delay work. All records and files pertaining to the health plan must be located in 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.

70.500 Subcontractor Agreements

The health plan may negotiate and contract or enter into contracts or agreements with subcontractors to the benefit of the health plan and the State as long as the following conditions are met:

- The health plan obtains the prior written consent of the State;

- The health plans' subcontractor submits to the health plan 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;
- The subcontractors meet all established criteria prescribed and provide the services in a manner consistent with the minimum standards specified in the health plan's contract with the State; and
- All subcontracts fulfill the requirements of 42 CFR 438.6 that are appropriate to the service delegated under the subcontract.

Additionally, no assignment by the health plan of the health plan's right to compensation under the contract shall be effective unless and until the assignment is approved by the Comptroller of the State of Hawaii, as provided in Section 40-58, HRS, or its successor provision.

All such agreements shall be in writing and shall specify the activities and responsibilities delegated to the subcontractor. The contracts must also include provisions for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate. The DHS reserves the right to inspect all subcontractor agreements at any time during the contract period. Any subcontract may be subject to the DHS's prior review and approval.

No subcontract that the health plan enters into with respect to the performance under the contract shall in any way relieve the health plan of any responsibility for any performance required of it by the contract. The health plan shall provide the DHS immediate notice in writing by registered or certified mail of any action or suit filed against it by any subcontractor, and prompt notice of any claim made against the health plan by any subcontractor which in the opinion of the health plan may result in litigation related in any way to the contract with the State of Hawaii. The health plan shall designate itself as the sole point of recovery for any subcontractor.

All contracts between the health plan and subcontractors must ensure that the health plan evaluates the subcontractor's ability to perform the activities to be delegated; monitors the subcontractor's performance on an ongoing basis and subjects it to formal review according to a periodic schedule established by the DHS and consistent with industry standards or State laws and regulations; and identifies deficiencies or areas for improvement and that corrective action is taken.

The health plan shall notify the DHS at least fifteen (15) days prior to adding or deleting subcontractor agreements or making any change to any subcontractor agreements which may materially affect the health plan's ability to fulfill the terms of the contract.

All subcontracts shall be finalized and fully executed within thirty (30) days of the contract award. DHS reserves the right to

review any contractor or subcontractor agreements prior to the implementation of the contract. The health plan shall ensure that each contract with a subcontractor states that the State and health plan members shall bear no liability of the health plan's failure or refusal to pay valid claims of subcontractors.

All subcontracts shall require that the subcontractors agree to comply with the confidentiality requirements imposed by this RFP, to the extent subcontractors render services or perform functions that make such provisions applicable to such agreements.

70.600 Reinsurance

The health plan may obtain reinsurance for its costs for program members.

70.700 Applicability of Hawaii Revised Statutes

70.710 Licensed as a Health Plan

The health plan shall be properly licensed as a health plan in the State of Hawaii as described in 431, 432, or 432D, HRS. The health plan shall comply with all applicable requirements set forth in the above mentioned statutes. In the event of any conflict between the requirements of the contract and the requirements of any applicable statute, the statute shall prevail and the health plan shall not be deemed to be in default for compliance with any mandatory statutory requirement.

70.720 Wages, Hours and Working Conditions of Employees Providing Services

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 laws of federal and state government relative to workers compensation, unemployment compensation, payment of wages, prepaid healthcare, and safety standards. The health plan shall complete and submit the Wage Certification provided in Appendix D pursuant to Section 103-55, HRS.

70.730 Standards of Conduct

The health plan shall execute the Provider's Standards of Conduct Declaration, a copy of which is found in Appendix F, and

which shall become part of the contract between the health plan and the State.

70.740 Campaign Contributions by State and County Contractors

Contractors are hereby notified of the applicability of Section 11-205.5, HRS, which states that 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, Act 203/2005 FAQs are available at the Campaign Spending Commission webpage. See www.hawaii.gov/campaign.

70.800 Disputes

Any dispute concerning a question of fact arising under the contract which is not disposed of by agreement shall be decided by the Director of the DHS or his/her duly authorized representative who shall reduce his/her decision to writing and mail or otherwise furnish a copy to the health plan within ninety (90) days after written request for a final decision by certified mail, return receipt requested. The decision shall be final and conclusive unless determined by a court of competent jurisdiction to have been fraudulent, or capricious or arbitrary, or so grossly erroneous as necessarily to imply bad faith. In connection with any dispute proceeding under this clause, the health plan shall be afforded an opportunity to be heard and to offer evidence in support of his/her dispute. The health plan shall proceed diligently with the performance of the contract in

accordance with the disputed decision pending final resolution by a circuit court of this State.

Any legal proceedings against the State of Hawaii regarding this RFP or any resultant contract shall be brought in a court of competent jurisdiction in the City and County of Honolulu, State of Hawaii.

70.900 Audit Requirements

The state and federal standards for audits of the DHS agents, contractors and programs conducted under contract are applicable to this subsection and are incorporated by reference into the contract. The DHS may inspect and audit any records of the health plan and its subcontractors or providers.

70.910 Accounting Records Requirements

The health plan shall, in accordance with generally accepted accounting practices, maintain fiscal records and supporting documents and related files, papers and reports that adequately reflect all direct and indirect expenditures and management and fiscal practices related to the health plan's performance of services under the contract.

The health plan's accounting procedures and practices shall conform to generally accepted accounting principles and the costs properly applicable to the contract shall be readily ascertainable from the records.

70.920 Inclusion of Audit Requirements in Subcontracts

The provisions of Section 70.900 and its associated subsections shall be incorporated in any subcontract/provider agreement.

71.100 Retention of Medical Records

The health plan shall ensure that all medical records are maintained, in accordance with Sections 622-51 and 622-58, HRS, for a minimum of seven (7) years from the last date of entry in the records. For minors, the health plan shall preserve and maintain all medical records during the period of minority plus a minimum of seven (7) years after the age of majority. All providers shall maintain and retain records of members according to the standards stated in the contract and the HRS.

During the period that records are retained under this section, the health plan and any subcontractor shall allow the state and federal governments full access to such records, to the extent allowed by law.

71.200 Confidentiality of Information

The health plan understands that the use and disclosure of information concerning applicants, recipients or members is restricted to purposes directly connected with the administration of the Hawaii Medicaid program, and agrees to guard the confidentiality of an applicant's, recipient's or member's information as required by law. The health plan shall not disclose confidential information to any individual or entity except in compliance with

- 42 CFR Part 431, Subpart F;
- The Administrative Simplification provisions of HIPAA and the regulations promulgated thereunder, including but not limited to the Security and Privacy requirements set forth in 45 C.F.R. Parts 160 and 164, and the Administrative Requirements set forth in 45 C.F.R. Part 162 (if applicable);
- HRS Section 346-10; and
- All other applicable Hawaii statutes and administrative rules.

Access to member identifying information shall be limited by the health plan to persons or agencies that require the information in order to perform their duties in accordance with this contract, including the DHHS, the DHS and other individuals or entities as may be required by the DHS. (See 42 CFR 431.300 et seq. and 45 CFR parts 160 and 164)

Any other party shall be granted access to confidential information only after complying with the requirements of state and federal laws, including HIPAA, and regulations pertaining to such access. The health plan is responsible for knowing and understanding the confidentiality laws specific to certain groups (i.e., Chapter 577A, HRS, for minor females for pregnancy and family planning services, Section 325-101, HRS for persons with HIV/AIDS, Section 334-5, HRS for persons receiving mental health services and 42 CFR Part 2 for persons receiving substance abuse services. The health plan, if it reports services

to its members, shall comply with confidentiality laws. The DHS and the health plan shall determine if and when any other party has properly obtained the right to have access to this confidential information. Nothing herein shall prohibit the disclosure of information in summary, statistical or other form that does not identify particular individuals, provided that deidentification of protected health information is performed in compliance with the HIPAA Privacy Rule.

The health plan is cautioned that federal and state Medicaid rules, and some other federal and state statutes and rules, including but not limited to those listed in the previous paragraph, 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 MQD.

The health plan shall implement a secure electronic mail (email) encryption solution to ensure confidentiality, integrity, and authenticity of email communications.

71.300 Liquidated Damages, Sanctions and Financial Penalties

71.310 Liquidated Damages

In the event of any breach of the terms of the contract by the health plan, liquidated damages shall be assessed against the health plan in an amount equal to the costs of obtaining alternative medical benefits for its members. The damages shall

include the difference in the capitated rates paid to the health plan and the rates paid to a replacement health plan.

Notwithstanding the above, the health plan shall not be relieved of liability to the State for any damages sustained by the State due to the health plan's breach of the contract.

The DHS may withhold from payments to the health plan, amounts for liquidated damages until such damages are paid in full.

71.320 Sanctions

The DHS may impose civil or administrative monetary penalties not to exceed the maximum amount established by federal statutes and regulations on the health plan, if the health plan:

- Fails substantially to provide medically necessary services that are required under law or under contract, to a member covered by the contract;
- Imposes upon members premiums and charges that are in excess of the premiums or charges permitted under the program;
- Acts to discriminate among members on the basis of the health status or need for health care services;
- Fails to comply with the requirements for physician incentive plans, as set forth in 42 CFR 422.208 and 422.210;

- Misrepresents or falsifies information that it furnishes to the state, CMS, a member, a potential enrollee, or health care provider;
- 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;
- Has violated any requirements of the contract;
- Has violated any of the other applicable requirements of Sections 1903(m) or 1932 of the Social Security Act and any implementing regulations;
- Has violated any of the other applicable requirements of 1932 or 1905(t)(3) of the Social Security Act and any implementing regulations.

Sanctions will be determined by the State and may include civil monetary penalties, suspending enrollment of new members with the health plan, suspending payment, notifying and allowing members to change plans without cause, temporary management or contract termination. The State will give the health plan timely written notice that explains the basis and nature of the sanction as outlined in 42 CFR 438 subpart I.

The following civil monetary penalties may be imposed on the health plan by the State:

- A maximum of one-hundred thousand dollars ($100,000) for each determination of discrimination or misrepresentation or false statements to CMS or the State.

- A maximum of twenty-five thousand dollars ($25,000) for:
    - each determination of failure to provide services;
    - misrepresentations or false statements to members, potential members or health care providers;
    - failure to comply with physician incentive plan requirements; or marketing violations;
- A maximum of twenty-five thousand dollars ($25,000) or double the amount of the excess charges (whichever is greater) for charging premiums or charges in excess of the amounts permitted under the Medicaid program. The State shall deduct from the penalty the amount of overcharge and return it to the affected member(s).
- A maximum of fifteen thousand dollars ($15,000) for each member the State determines was not enrolled because of a discriminatory practice (subject to the one-hundred thousand dollars ($100,000) overall limit above).

Payments provided for under the contract will 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.

The DHS may impose financial penalties or sanctions for inaccurate, incomplete and untimely data for reports submitted to the DHS. The financial penalties or sanctions determined for the month shall be deducted from the upcoming month's capitated payment for covered members. The health plan may follow appeal procedures as outlined in this RFP to contest the penalties or sanctions.

71.330 Special Rules for Temporary Management

The sanction of temporary management may be imposed by the State if it finds that:

- There is continued egregious behavior by the health plan, including, but not limited to, behavior that is described in 42 CFR 438.700, or that is contrary to any requirements of Section 1903(m) and 1932 of the Social Security Act;
- There is substantial risk to the member's health;
- 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.

The State will impose temporary management if it finds that the health plan has repeatedly failed to meet substantive requirements in Section 1903(m) and 1932 of the Social Security Act. The State will not provide the health plan with a pre-termination hearing before the appointment of temporary management.

In the event the State imposes the sanction of temporary management, members shall be allowed to disenroll from the health plan without cause.

71.400 Use of Funds

The health plan shall not use any public funds for purposes of entertainment 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 Legislature or by administrative rules adopted pursuant to law.

71.500 Performance Bond

The health plan shall obtain a performance bond issued by a reputable surety company authorized to do business in the State of Hawaii in the amount of one-million dollars ($1,000,000) or more, conditioned upon the prompt, proper, and efficient performance of the contract, and shall submit same to the DHS prior to or at the time of the execution of the contract. The performance bond shall be liable to forfeit by the health plan in the event the health plan is unable to properly, promptly and efficiently perform the contract terms and conditions or the contract is terminated by default or bankruptcy of the health plan.

The amount of the performance bond shall be adjusted at the time members begin enrolling in the plan. At that time, the amount of the performance bond shall approximate one month's capitation payments. The health plan may, in place of the performance bond, provide for the following in the same amount as the performance bond:

- Certificate of deposit; share certificate; or cashier's, treasurer's, teller's or official check drawn by, or a certified check and made payable to the Department of Human Services, State of Hawaii, issued by a bank, a savings institution, or credit union that is insured by the Federal Deposit Insurance Corporation (FDIC) or the National Credit Union Administration, and payable at sight or unconditionally assigned to the procurement officer advertising for offers. These instruments may be utilized only to a maximum of one-hundred thousand dollars ($100,000) each and must be issued by different financial institutions.
- Letter of credit with a bank insured by the FDIC with the Department of Human Services, State of Hawaii, designated as the sole payee.

Upon termination of the contract, for any reason, including expiration of the contract term, the health plan shall ensure that the performance bond is in place until such time that all of the terms of the contract have been satisfied. The performance bond shall be liable for, and the DHS shall have the authority to retain funds for additional costs, including but not limited to:

- Any costs for a special plan change period necessitated by the termination of the contract;
- Any costs for services provided prior to the date of termination that are paid by MQD;
- Any additional costs incurred by the State due to the termination; and

- Any sanctions or penalties owed to the DHS.

71.600 Acceptance

The health plan shall comply with all of the requirements of the contract and the DHS shall have no obligation to enroll any members in the health plan until such time as all of said requirements have been met (See Section 70.410).

71.700 Employment of Department Personnel

The health plan shall not knowingly engage any persons who are or have been employed within the past twelve (12) months by the State of Hawaii to assist or represent the health plan for consideration in matters which he/she participated as an employee or on matters involving official action by the State agency or subdivision, thereof, where the employee had served.

71.800 Warranty of Fiscal Integrity

The health plan warrants that it is of sufficient financial solvency to assure the DHS of its ability to perform the requirements of the contract. The health plan shall provide sufficient financial data and information to prove its financial solvency and 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.

71.900 Full Disclosure

The health plan warrants that it has fully disclosed all business relationships, joint ventures, subsidiaries, holding companies, or any other related entity in its proposal and that any new relationships shall be brought to the attention of the DHS as soon as such a relationship is consummated. The terms and conditions of CMS require full disclosure on the part of all contracting health plans and providers.

The health plan shall not knowingly have a director, officer, partner, or person with more than five percent (5%) of the health plan's equity, or have an employment, consulting, or other agreement with such a person for the provision of items and services that are significant and material to the entity's contractual obligation with the State, who has been debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. The health plan shall not, without prior approval of the DHS, lend money or extend credit to any related party. The health plan shall fully disclose such proposed transactions and submit a formal written request for review and approval.

The health plan shall include the provisions of this section in any subcontract or provider agreement.

The health plan shall complete and provide all information required in the Disclosure Statement in Appendix S.

The health plan shall comply with General Condition 1.4 and submit to the DHS the insurance information requested in Appendix C.

71.910 Litigation

The health plan shall disclose any pending litigation to which they are a party, including the disclosure of any outstanding judgment. If applicable, please explain.

72.100 Termination of the Contract

The contract may terminate or may be terminated by DHS for any or all of the following reasons in addition to the General Conditions in Appendix C:

- Termination for Default;
- Termination for Expiration of the Programs by CMS; or
- Termination for Bankruptcy or Insolvency

72.110 Termination for Default

The failure of the health plan to comply with any term, condition, or provision of the contract shall constitute default by the health plan. In the event of default, the DHS shall notify the health plan by certified or registered mail, with return receipt requested, of the specific act or omission of the health plan, which constitutes default. The health plan shall have fifteen (15)

days from the date of receipt of such notification to cure such default. In the event of default, and during the above-specified grace period, performance under the contract shall continue as though the default had never occurred. In the event the default is not cured in fifteen (15) days, the DHS may, at its sole option, terminate the contract for default. Such termination shall be accomplished by written notice of termination forwarded to the health plan by certified or registered mail and shall be effective as of the date specified in the notice. If it is determined, after notice of termination for default, that the health plan's failure was due to causes beyond the control of and without error or negligence of the health plan, the termination shall be deemed a termination for convenience under General Condition 4.3 in Appendix C.

The DHS' decision not to declare default shall not be deemed a waiver of such default for the purpose of any other remedy the health plan may have.

72.120 Termination for Expiration of the Programs by CMS

The DHS may terminate performance of work under the contract in whole or in part whenever, for any reason, CMS terminates or modifies the programs. In the event that CMS elects to terminate its agreement with the DHS, the DHS shall so notify the health plan by certified or registered mail, return receipt requested. The termination shall be effective as of the date specified in the notice.

72.130 Termination for Bankruptcy or Insolvency

In the event that the health plan ceases conducting business in the normal course, become insolvent, make a general assignment for the benefit of creditors, suffer or permit the appointment of a receiver for its business or its assets or shall avail itself of, or become subject to, any proceeding under the Federal Bankruptcy Act or any other statute of any State relating to insolvency or the protection of the rights or creditors, the DHS may, at its option, terminate the contract. In the event the DHS elects to terminate the contract under this provision it shall do so by sending notice of termination to the health plan by registered or certified mail, return receipt requested. The termination shall be effective as of the date specified in the notice.

In the event of insolvency of the health plan, the health plan must cover continuation of services to members for the duration of period for which payment has been made, as well as for inpatient admissions up until discharge. Members shall not be liable for the debts of the health plan. In addition, in the event of insolvency of the health plan, members may not be held liable for the covered services provided to the member, for which the State does not pay the health plan.

72.140 Procedure for Termination

In the event the State decides to terminate the contract, it will provide the health plan with a pre-termination hearing. The State will:

- Give the health plan written notice of its intent to terminate, the reason(s) for termination, and the time and place of the pre-termination hearing;
- Give the health plan's members written notice of the intent to terminate the contract, notify members of the hearing, and allow them to disenroll immediately without cause.

Following the termination hearing, the State will provide written notice to the health plan of the termination decision affirming or reversing the proposed termination. If the State decides to terminate the contract, the notice shall include the effective date of termination. In addition, if the contract is to be terminated, the State shall notify the health plan's members in writing of their options for receiving Medicaid services following the effective date of termination.

In the event of any termination, the health plan shall:

- Stop work under the contract on the date and to the extent specified in the notice of termination.
- Notify the members of the termination and arrange for the orderly transition to the new health plan(s).
- Place no further orders or subcontracts for materials, services, or facilities, except as may be necessary for completion of the work under the portion of the contract that is not terminated.
- Terminate all orders and subcontracts to the extent that they relate to the performance of work terminated by the notice of termination.

- Assign to the DHS in the manner and to the extent directed by the MQD Administrator of the right, title, and interest of the health plan under the orders or subcontracts so terminated, in which case the DHS shall have the right, in its discretion, to settle or pay any or all claims arising out of the termination of such orders and subcontracts.
- With the approval of the MQD Administrator, settle all outstanding liabilities and all claims arising out of such termination of orders and subcontracts, the cost of which would be reimbursable in whole or in part, in accordance with the provisions of the contract.
- Complete the performance of such part of the work as shall not have been terminated by the notice of the termination.
- Take such action as may be necessary, or as the MQD administrator may direct, for the protection and preservation of any and all property or information related to the contract which is in the possession of the health plan and in which the DHS has or may acquire an interest.
- Within thirty (30) business days from the effective date of the termination, deliver to the DHS copies of all current data files, program documentation, and other documentation and procedures used in the performance of the contract at no cost to the DHS. The health plan agrees that the DHS or its agent shall have a non-exclusive, royalty-free right to the use of any such documentation.

The health plan shall create written procedures for the orderly termination of services to any members receiving the required services under the contract, and for the transition to services

supplied by another health plan upon termination of the contract, regardless of the circumstances of such termination. These procedures shall include, at the minimum, timely notice to the health plan's members of the termination of the contract, and appropriate counseling. The health plan shall submit these procedures to the DHS for approval upon their completion, but no later than one-hundred eighty (180) days after the effective date of the contract.

72.150 Termination Claims

After receipt of a notice of termination, the health plan shall submit to the MQD Administrator any termination claim in the form and with the certification prescribed by the MQD Administrator. Such claim shall be submitted promptly but no later than six (6) months from the effective date of termination. Upon failure of the health plan to submit its termination claims within the time allowed, the MQD Administrator may, subject to any review required by the State procedures in effect as of the date of execution of the contract, determine, on the basis of information available to him/her, the amount, if any, due to the health plan by reason of the termination and shall thereupon cause to be paid to the health plan the amount to be determined.

Upon receipt of notice of termination, the health plan shall have no entitlement to receive any amount for lost revenues or anticipated profits or for expenditures associated with this or any other contract. The health plan shall be paid only the following upon termination:

- At the contract price(s) for the number of members enrolled in the health plan at the time of termination; and
- At a price mutually agreed to by the health plan and the DHS.

In the event the health plan and the DHS fail to agree, in whole or in part, on the amount of costs to be paid to the health plan in connection with the total or partial termination of work pursuant to this section, the DHS shall determine, on the basis of information available to the DHS, the amount, if any, due to the health plan by reason of the termination and shall pay to the health plan the amount so determined.

The health plan shall have the right to appeal any such determination made by the DHS as stated in Section 70.800, Disputes.

72.200 Conformance with Federal Regulations

Any provision of the contract which is in conflict with federal Medicaid statutes, regulations, or CMS policy guidance is hereby amended to conform to the provisions of those laws, regulations, and federal policy. Such amendment of the contract will be effective on the effective date of the statutes or regulations necessitating it, and will be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

72.300 Force Majeure

If the health plan is prevented from performing any of its obligations hereunder in whole or in part as a result of major epidemic, act of God, war, civil disturbance, court order or any other cause beyond its control, the health plan shall make a good faith effort to perform such obligations through its then-existing facilities and personnel; and such non-performance shall not be grounds for termination for default.

Neither party to the contract shall be responsible for delays or failures in performance resulting from acts beyond the control of such party.

Nothing in this section shall be construed to prevent the DHS from terminating the contract for reasons other than default during the period of events set forth above, or for default if such default occurred prior to such event.

72.400 Conflict of Interest

The health plan covenants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with its performance hereunder. The health plan further covenants that in the performance of the contract no person having any such interest is presently employed or shall be employed in the future.

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.

In light of the federal rules intended to encourage contracting between health plans and FQHCs and RHCs, and in order to implement the federal mandate to promote open and free competition to the maximum extent practical, the DHS requires the health plan to covenant (in the form set forth in Appendix Y) that at all times during which the contract is in effect, any FQHC or RHC with an ownership or control interest in the health plan shall, if requested, participate in the network of any other health plan participating in the programs, so long as the requesting health plan has offered payment terms that comply with the requirements of Section 60.410. Pursuant to 42 U.S.C. § 1396b(aa)(5), the DHS shall, if necessary, supplement payments from a health plan to an FQHC or RHC in order to ensure payment of the reasonable costs of the FQHC or RHC as established by the prospective payment system.

For purposes of this section, an “ownership or control interest” in an entity means that an FQHC or RHC:

> (A)(i) has a direct or indirect ownership interest of 5 per centum or more in the entity, or in the case of a nonprofit corporation, is a member; or

(ii) is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the entity or any of the property or assets thereof, which whole or part interest is equal to or exceeds 5 per centum of the total property and assets of the entity; or

(B) has the ability to appoint or is otherwise represented by an officer or director of the entity, if the entity is organized as a corporation; or

(C) is a partner in the entity, if the entity is organized as a partnership.

72.500 Prohibition of Gratuities

Neither the health plan nor any person, firm or corporation employed by the health plan in the performance of the contract shall offer or give, directly or indirectly, to any employee or agent of the State of Hawaii, any gift, money or anything of value, or any promise, obligation, or contract for future reward or compensation at any time during the term of the contract.

72.600 Publicity

General Condition 6.2.1 is amended to read as follows: Acknowledgment of State Support. The health plan shall not use the State's or the DHS's name, logo or other identifying marks on any materials produced or issued without the prior written consent of the DHS. The health plan also agrees not to represent that it was supported by or affiliated with the State of Hawaii without the prior written consent of the DHS.

72.700 Notices

All notices under the contract shall be deemed duly given upon delivery, if delivered by hand (against receipt); or three (3) days after posting, if sent by registered or certified mail, return receipt requested, to a party hereto at the address set forth below or to such other address as a party may designate by notice pursuant hereto:

Ms. Leslie Tawata
Med-QUEST Division
Department of Human Services
State of Hawaii
601 Kamokila Boulevard, Suite 518
Kapolei, Hawaii 96707

The same provisions apply to notices delivered to or sent to the health plan. The health plan shall specify the notice address in its proposal. Both parties shall immediately inform the other in writing of any changes to its notice address.

72.800 Attorney's Fees

In addition to General Condition 5.2, in the event that the DHS should prevail in any legal action arising out of the performance or non-performance of the contract, the health plan shall pay, in addition to any damages, all expenses of such action including reasonable attorney's fees and costs. The term 'legal action'

shall be deemed to include administrative proceedings of all kinds, as well as all actions at law or equity.

72.900 Authority

Each party has full power and authority to enter into and perform the contract, and the person signing the contract on behalf of each party certifies that such person has been properly authorized and empowered to enter into the contract. Each party further acknowledges that it has read the contract, understands it, and agrees to be bound by it.

73.100 Personnel Requirements

The health plan shall secure, at its own expense, all personnel required to perform the contract, unless otherwise specified in the contract. The health plan shall ensure that its employees or agents are experienced and fully qualified to engage in the activities and perform the services required under the contract, and that all applicable licensing and operating requirements imposed or required under federal, state, and local law and all applicable accreditation and other standards of quality generally accepted in the field of the activities of such employees and agents are complied with and satisfied.

SECTION 80 TECHNICAL PROPOSAL

80.100 Introduction

This section describes the required content and format for the technical proposal. It is essential that all questions which are to be answered as part of the narrative are answered in the order in which they appear in each sub-section and that the question is repeated above the response. The questions related to any attachment do not need to be repeated, so long as it is clear from the heading of the document which attachment it is. Attachments may be placed, in the order in which they are requested, behind the narrative responses for that section. Attachments do not count toward the maximum page limits.

Neither narrative in excess of the maximum page limits nor any documentation not specifically requested will be reviewed. Likewise, providing the actual policies and procedures in lieu of a description of the policies and procedures may result in the health plan receiving a non-responsive score for that question.

80.200 Transmittal Letter, Company Background Narrative, Other Documentation, Financial Statements, and Per Member Financial Data

80.210 Attachment: Transmittal Letter

The transmittal letter shall be on official business letterhead and shall be signed by an individual authorized to legally bind the offeror. It shall include:

A. A statement indicating that the offeror is a corporation or other legal entity and is a properly licensed health plan or has a pending application for licensure in the State of Hawaii. All subcontractors shall be identified and a statement included indicating the percentage of work to be performed by the prime offeror and each subcontractor, as measured by percentage of total contract price;
B. A statement that the offeror is or will be registered to do business in Hawaii and has or will obtain a State of Hawaii General Excise Tax License, if applicable, by the start of work;
C. A statement identifying all amendments and addenda to this RFP issued by the issuing office. If no amendments or addenda have been issued, a statement to that effect shall be included;
D. A statement of affirmative action that the offeror does not discriminate in its employment practices with regard to race, color, religion, creed, age, sex, national origin or mental or physical handicap, except as provided by law;
E. A statement that neither cost nor pricing is included in this letter or the technical proposal;
F. A statement that no attempt has been made or will be made by the offeror to induce any other party to submit or refrain from submitting a proposal;
G. A statement that the offeror has read, understands and agrees to all provisions of this RFP;
H. A statement that it is understood that if awarded the contract, the offeror's organization will deliver the goods

and services meeting or exceeding the specifications in the RFP and amendments;

I. The offeror's Hawaii excise tax number (if applicable);

J. A list of the islands for which the health plan is bidding; and

K. A statement that the person signing this proposal certifies that he/she is the person in the offeror's organization responsible for, or authorized to make, decisions as to the prices quoted, that the offer is firm and binding, and that he/she has not participated and will not participate in any action contrary to the above conditions.

L. A statement of independent price determination as described in Section 21.600.

80.220 Company Background Narrative

The offeror shall provide a description of the company and the health plan including:

A. The legal name and any names under which the offeror has done business;

B. Address, telephone number and e-mail address of the offeror's headquarter office;

C. Date company was established;

D. Date company began operations;

E. Names and addresses of officers and directors; and

F. The size and resources, including the gross revenues and number of employees.

The information required above shall be supplied for each affiliated company that serves Medicaid members and any subcontractors the offeror intends to use.

80.230 Attachment: Other Documentation

The offeror shall attach:

A. The State of Hawaii DHS Proposal Letter provided in Appendix S;
B. The Certification for Contracts, Grants, Loans and Cooperative Agreements form in Appendix S;
C. The Disclosure Statement (CMS required) form provided in Appendix S;
D. The Disclosure Statement (Ownership) form provided in Appendix S;
E. The Organization Structure and Financial Planning Form provided in Appendix S;
F. The Financial Planning Form provided in Appendix S;
G. The Financial Performance Form provided in Appendix S;
H. The Controlling Interest Form provided in Appendix S;
I. The Background Check Information provided in Appendix S;
J. The Operational Certification Submission Form provided in Appendix S;
K. The Grievance System Form provided in Appendix S.
L. The State and Federal Tax Clearance certificates as assurance that all federal and state tax liabilities have been paid and that there are no significant outstanding balances owing (a statement shall be included if

certificates are not available at time of submission of proposal that the certificates will be submitted in compliance with Section 20.500.);

M. Proof of its license to serve as health plan in the State of Hawaii. A letter from the Insurance Division notifying the health plan of its license will be acceptable "proof." If the offeror does not have a Hawaii license, the offeror shall include a copy of its filed application to operate as a health plan in the State;

N. Its liability insurance certificate (Appendix E); and

80.240 Attachment: Financial Statements

The offeror shall attach financial statements for the applicable legal entity or each partner if a joint venture shall be provided for each of the last three (3) years. These statements shall include:

A. Balance Sheets
B. Statements of Income
C. Statements of Cash flow
D. Auditor's reports
E. Amounts associated with related party transactions
F. Management letters
G. Federal Income Tax returns

If an offeror seeks confidentiality on a part of a submission, the section of that submission which is sought to be protected must be marked as "Proprietary" and an explanation of how substantial competitive harm would occur if that information was

released upon request. If the explanation is sufficient, then, to the extent permitted by the exemptions in Section 92F-13, HRS, State of Hawaii Office of Information Practices, or a Court, the affected section may be deemed confidential. Blanket labeling of the entire document as "Proprietary," however, will result in none of the document being considered proprietary.

80.250 Attachment: Per Member Financial Data

The following data shall be provided for each of the past three (3) years for each of the offeror's Medicaid line of business:

A. Cost per member (reported for hospital, professional services, pharmacy and other);
B. Average Monthly per member premiums charged by category (i.e., individual, couple, family);
C. Per member per month administration costs;
D. Per member profit; and
E. Annual member month count.

80.260 Attachment: Risk Based Capital

The offeror shall provide the most recent completed risk based capital (RBC) amount. Where applicable, separate RBC amounts shall be submitted for all parent companies and subsidiaries.

80.270 Attachment: Appendix Y: Elimination of Barriers to Contracting Between FQHCs/RHCs and Health Plans (is applicable to Health Plans) and Appendix Z: Elimination of Barriers to Contracting Between FQHCs/RHCs and Health Plans (applicable to

FQHCs/RHCs) or Explanation of Why These Forms Have Not Been Submitted

The offeror shall attach the Elimination of Barriers to Contracting Between FQHCs/RHCs and Health Plans form(s) provided in Appendix Y and, if applicable, Appendix Z, or an appropriate explanation of why these forms have not been attached. Appendix Y shall be submitted by each offeror. Appendix Z shall be submitted by any FQHC or RHC that has an ownership or control interest in the offeror, as defined in Section 72.400.

80.300 Prior Contract Activity Narrative

The offeror shall provide:

A. A listing of contacts for all state Medicaid program clients (including those served by an affiliated company), past and present. This listing shall include the name, title, address, telephone number and e-mail address of the client and/or contract manager, the number of lives the health plan has or had broken down by the type of membership (e.g. TANF, foster children, aged, blind, disabled, etc.); and

B. Information on whether or not any contract (including those for an affiliate of the company) has been terminated or not renewed for non-performance or poor performance within the past five (5) years. In this instance include information on the details of termination or non-renewal.

80.400 Provider Network (30 pages maximum)

80.410 Provider Network Narrative

The offeror shall provide a narrative describing:

A. How it will provide services for which there are either no contracted providers or the number of providers fails to meet the minimum requirement; and
B. How it will recruit and retain providers in rural and other historically under-served areas to ensure access to care and services in these areas.
C. Its PCP policies and procedures that includes information on choosing and selecting a PCP (including the PCP assignment process), describes who may serve as a PCP and describes who may serve as a PCP to members with chronic conditions;
D. Specialist referral policies and procedures to be provided to providers and members;
E. The procedures it will have in place to monitor and analyze network adequacy;
F. Provider network analysis for its QUEST business or for a Medicaid program in another state. This analysis shall include:
    1. The percent of PCPs who are Board certified; and
    2. The percent of specialists who are Board certified in the specialty of their predominant practice.

80.420 Attachment: Required Providers

The offeror shall provide a separate listing of its providers for each island for which it is bidding. Use the form—*Provider Network Matrix*—provided in Appendix V for these listings.

Offerors may include in this listing both providers who have signed a contract and those who have signed a letter of intent. Providers who have not signed a contract but have signed a letter of intent shall be identified with an asterisk. Attach a sample of the letter of intent to the back of the *Provider Network Matrix*.

The offeror shall separate the providers by provider type as follows:

A. PCP providers;
B. Certified nurse midwives, pediatric nurse practitioners, and family nurse practitioners;
C. Specialists;
D. Hospitals (the DHS will assume the hospital is on contract for acute services, outpatient and emergency room unless otherwise noted in the speciality column);
E. Urgent care providers;
F. Emergency transport (including ground and air ambulance) providers;
G. Pharmacies;
H. Laboratories;
I. Radiology providers;

J. Physical, occupational, audiology and speech and language therapy providers;
K. Behavioral health providers;
L. Home health agencies and hospices;
M. Durable medical equipment and medical suppliers;
N. Non-Emergency transportation providers; and
O. Translation service providers.

The offeror shall list each provider once. For example, if an OB/GYN is serving both as a PCP and a specialist, he or she shall be listed as either a PCP or a specialist, not both.

For provider types which may include a variety of providers the provider listing should be ordered by specialty. As an example, for the PCP matrix, sort providers by pediatricians, physician assistants, family practitioners, general practitioners, internists, and OB/GYNs.

List nurse midwives, pediatric nurse practitioners, family nurse practitioners and behavioral health practitioners who are in independent practice separately. If the nurse midwife, pediatric nurse practitioner or family nurse practitioner practice in a physician's office or clinic, he/she should be listed under the clinic or physician's office as described below.

For clinics serving in the capacity of a PCP, list the clinic and under the clinic name, identify each specific provider (i.e., physician, nurse practitioner, etc.). The address of the clinic should be placed in the address field. If applicable, the number

of QUEST plan members assigned to the clinic should be noted. Clinics may be listed on different provider type network matrices, but the individual provider of the service is listed only once. As an example, the clinic may be listed as a PCP with the clinic's pediatrician. Other physicians serving as specialists should be listed on the specialty care matrix with the clinic's name. If the clinic also provides translation, it should be listed on the translation services matrix.

The specialists list shall include all physicians (e.g. cardiologists, neurologists, ophthalmologists, pulmonologists, etc) and non-physician services (e.g. optometrists, opticians, podiatrists, etc.) that provide medical services, but are not in the behavioral health service providers.

All behavioral health providers shall be listed on the behavioral health service provider lists and not the specialists list. This includes psychiatrists, psychologists, psychiatric social workers, residential treatment providers etc.

In addition to a hard copy of the provider listings, the offeror shall include with its proposal an electronic file of providers in Excel version 5.0 or higher.

80.430 Attachment: Map of PCPs and Hospitals

The offeror shall include in its proposal a map of the island indicating the locations of its PCPs and acute hospitals. PCPs and acute hospitals which are not contracted but have signed LOIs shall be designated with an asterisk.

80.440 Availability of Providers Narrative

The offeror shall describe:

A. How it will ensure that network providers are in compliance with timely access appointment standards and what corrective actions will be taken if they are not; and
B. How it will ensure that PCPs fulfill their responsibilities for supervising and coordinating care for all assigned members. As part of this the offeror shall describe how it will monitor the performance of specialists or other health care providers who are permitted to serve as PCP to members with chronic conditions.

80.450 Moral or Religious Objection Narrative

The offeror shall describe whether there are any services it objects to based on moral or religious grounds as described in Section 40.280. The offeror shall include a description of the grounds for the objection and information on how it will provide the required services.

80.460 Provider Services Narrative

The offeror shall provide the following:

A. A description of its provider education and training activities to ensure that providers are aware of the health plan's processes and policies;

B. Details on its provider grievance system, including the policies and procedures guiding the provider grievance system;

C. A description of how it will up-date providers of major changes in the program.

80.500 Covered Benefits and Services (40 pages maximum)

80.510 Covered Benefits and Services Narrative

The offeror shall describe:

A. Its experience providing, on a capitated basis, the covered benefits and services as described in Section 40.300. This description shall indicate:

1. The extent to which this experience is for a population comparable to that in the programs;
2. Which covered benefits and services the offeror does not have experience providing; and
3. The proposal for providing the covered benefits and services required in this RFP, including whether or not the offeror intends to use a subcontractor and, if so, how the subcontractor will be monitored.

B. Whether the offeror intends to provide additional services not required but allowed for in Section 40.310 and how it intends to provide these services; and

C. Its experience in providing services to members with special health care needs, including how it has identified such individuals and how it has provided needed services. In addition, the offeror shall describe how it intends to provide these services to its members in Hawaii.

80.520 Prescription Drug Narrative

The offeror shall detail how it intends to track, monitor and manage over and under utilization of prescription drugs.

80.530 Behavioral Health Narrative

The offeror shall describe its planned approach to providing mental health and substance abuse services as required in Section 40.370. As part of this description, the offeror shall detail whether or not it intends to subcontract these services and how it will coordinate with the Alcohol and Drug Abuse Division as required in Section 40.375. Specifically address how the services will be provided to each of the following populations:

A. Pregnant and parenting substance abusers;
B. Children and adolescents; and
C. Native Hawaiians.

80.540 Children's Medical and Behavioral Health Services (EPSDT) Narrative

The offeror shall describe:

A. Its outreach and informing process as required in Section 40.380;
B. How it intends to coordinate with the DHS contractor providing dental care coordination services and what its procedures for referrals will be;

C. How it will train providers and monitor their compliance with EPSDT program requirements;

D. How it will coordinate with the Department of Education and DOH in providing services for individuals determined to be SEBD; and

E. The procedures it will follow to address the following situations:

    1. A parent who is not adhering to periodicity schedules; and
    2. A parent who is not following up with the children's referrals for diagnostic treatment services.

F. The offeror shall provide specific data from its largest Medicaid contract and documentation to verify the statistics, on the:

    1. Percentage of children who receive all screenings pursuant to the pediatric periodicity schedule;
    2. Percentage of children idenfited for referral to follow-up services; and
    3. Percentage of children so identified who actually receive follow-up services.

80.600 Care Coordination/Case Management (CC/CM) System/Services Narrative (20 pages maximum)

The offeror shall provide a comprehensive description of its CC/CM system/services (either in Hawaii, another state, or its proposed CCM/CM system/services for Hawaii), including policies and procedures as well as mechanisms developed for providing CC/CM system/services. The offeror shall address the

requirements in RFP section 40.400 - Care Coordination/Case Management System, RFP section 40.325 - Services for Members with Special Health Care Needs (SHCNs) as well as each requirement outlined in QAPI Standard VIII - Continuity of Care (Appendix K).

At a minimum, the offeror shall describe and address:

A. The organizational structure of its CC/CM system and services including the staff to caseload ratios;
B. How the CC/CM system ensures that members, family/designated representatives, providers and health plan staff are informed about the availability of CC/CM services, how to make a referral for services, and how to access these services during and after regular working hours;
C. The needs assessment process including the criteria used to screen/identify members in need of CC/CM services;
D. If the offeror elects to develop differing levels of CC/CM services, a description of the levels of services, the criteria to be used in determining what level of service a member will receive and how cases are prioritized;
E. How the CC/CM system addresses coordination and follow up of outpatient and inpatient care/service needs as well as referrals to, and coordination with, community-based resources/services that provide services that are not covered by the programs;
F. The processes for receiving and sharing pertinent information, and interfacing with the member, the

member's PCP and other relevant providers, and as appropriate, the member's family, other relevant providers and offeror departments, to promote continuity of care and coordination of services. In addition, discuss how you involved the member and/or the member's family in decisions regarding care;

G. The mechanisms to ensure that the implementation of the member's ICP is monitored/evaluated for effectiveness, and is revised as frequently as the member's condition warrants;

H. The requirements for documentation of all CC/CM activities,;

I. The criteria for discontinuing CC/CM services; and

J. How the CC/CM system is linked to the offeror's information system. Description shall include how the information system will track CC/CM activities, support evaluation of the CC/CM system and generate reports.

80.700 Behavioral Health Managed Care (BHMC) Health Plan Narrative (10 pages maximum)

The offeror shall describe how it will coordinate transfers of its members, either into or out of the BHMC plan, to ensure smooth transfers and to minimize disruptions**.**

The Offeror shall describe the processes for receiving and sharing pertinent information relating to their behavioral health needs, and interfacing with the member, the member's PCP, and as appropriate, the member's family, other relevant providers

and behavioral health providers, to promote continuity of care and coordination of services.

80.800 Transportation Narrative (3 pages maximum)

The offeror shall describe how it will provide transportation to and from medically necessary medical appointments.

80.900 Foster Care/Child Welfare Services (CWS) Children Narrative (10 pages maximum)

Please provide a narrative explaining how you intend to fulfill all requirements in Section 41.150.

81.000 Transition of Care Narrative (8 pages maximum)

The offeror shall describe how it will ensure that members transitioning into its health plan receive appropriate care, including how it will honor prior authorizations from a different health plan. The offeror shall also describe how it will coordinate with a new health plan when one of its members transitions out of its health plan. As part of this narrative please provide specific examples.

81.100 Health Plan Administrative Requirements (30 pages maximum)

81.110 Enrollment Narrative

The offeror shall describe:

A. How it will ensure that new member enrollment packets are mailed within ten (10) days of enrollment;
B. How it will provide assistance to members in selecting a PCP and the auto-assignment process it will employ in the event the member does not select a PCP in the required time period; and
C. How it will ensure that the timely notification requirements are met as it relates to notifying the DHS about the birth of a newborn and about circumstances which might effect a member's eligibilty.

81.120 Enforcement of Documetation Requirements Narrative

The offeror shall describe the specific steps it will take to provide assistance to the DHS in meeting all citizen documentation requirements required by the DRA.

81.130 Disenrollment Narrative

The health plan is responsible for referring to the DHS members who may qualify for LTC services, may meet the disability criteria, or may be eligible for the SHOTT program. The offeror shall explain the procedures it underakes before making a decirion to refer a member.

81.140 Member Services Narrative

A. The offeror shall describe how it will educate members about:

1. Their rights and responsibilities;
2. The benefits provided and protocols and processes for obtaining care;
3. The role of PCPs;
4. How to obtain care;
5. What to do in an emergent or urgent medical situation;
6. How to request a grievance or appeal;
7. How to report suspected fraud and abuse; and
8. The importance of good health and the use of preventive care, including a description of the specific activities it will undertake.

B. The offeror shall describe how it will ensure that all written materials meet the language requirements detailed in Section 50.320 and which reference material will be used to ensure that the 6th (6.9 or below) grade reading level requirement is met.

81.150 Toll-free Telephone Hotline Requirements Narrative

The offeror shall describe/provide:

A. How it will route calls among hotline staff to ensure timely and accurate response to member inquiries;
B. What the after-hours procedures are;
C. How it will ensure that the telephone hotline can handle calls from non-English speaking callers and from members who are hearing impaired, including the number of hotline

staff that are fluent in one of the State-identified prevalent non-English languages; and

D. How it will monitor compliance with performance standards and what it will do in the event the minimums are not being met.

81.160 Translation Services Narrative

The offeror shall describe how it will notify members of the availability of oral translation services as required in Section 50.390.

81.170 Marketing and Advertising Narrative

The offeror shall describe the marketing activities in which it will engage if selected.

The offeror shall explain whether it has ever been sanctioned or placed under corrective action by CMS or another state for prohibited marketing practices related to managed care products, describe the basis for each sanction or corrective action and the current status with CMS or the affected state.

81.200 Quality Assessment and Performance Improvement (50 pages maximum)

81.210 Attachment: EQRO Evaluations

The offeror shall provide its most recent EQRO evaluations from all states in which it has previously or is currently operating.

81.220 QAPI Program Narrative

The offeror shall provide the following information relative to its QAPI program

A. The governing body accountable for providing organizational governance of the offeror's QAPI Program, a description of the governing body's responsibilities, a description of how it exercises these responsibilities, and the frequency of meetings;
B. The committee/group responsible for developing, implementing and overseeing QAPI Program activities/operations including;
    1. A description of the committee's specific functions/ responsibilities, how it exercises these responsibilities, and the frequency of its meetings;
    2. A description of the composition/membership of this committee, , including information on:
        - The chairperson(s) – including title(s), and for physicians, provide specialty;
        - Physician membership - including the total number and types of specialties represented;
        - The physician designated to have substantial involvement in the QAPI Program; and
        - The licensed behavioral health care practitioner designated to be involved in the behavioral health care aspects of the QAPI Program.
    3. The offeror's staff membership – including names and position titles.

C. A description of how the offeror ensures that practitioners participate in the QAPI Program through planning, design, implementation and/or review;

D. A description of how the offeror makes information about the QAPI program available to its practitioners and members, including a description of the QAPI program and a report on the organization's progress in meeting its goals;

81.230 Systematic Process for Monitoring Quality – QAPI Standard III – General Requirements Narrative

The offeror shall describe:

A. How it will address, evaluate, and review both the quality of clinical care and the quality of non-clinical aspects of service such as availability, accessibility, coordination and continuity of care;

B. The methodology which will be used to review the entire range of care provided to all demographic groups, care settings (inpatient, ambulatory, home) and types of services (preventive, primary, specialty care, including behavioral health care) to ensure quality, member safety, and appropriateness of care/services in pursuit of opportunities for improvement on an ongoing basis; and

C. The methodology and mechanisms to implement corrective actions as well as monitor and evaluate the effectiveness of the corrective action plans.

81.240 Systematic Process for Monitoring Quality _QAPI Standard III. - Performance Improvement Projects (PIPs) Narrative

A. The Offeror shall desribe the methodology for determination of PIP topic selection; and the methodology and organizational arrangements used to implement studies/activities; and
B. The offeror shall provide copies of at least two (2) evaluations of PIPs (newly initiated, ongoing or past studies) conducted in the past twenty-four (24) months that have been validated by an EQRO.

81.250 Systematic Process for Monitoring Quality QAPI Standard III. - Disease Management (DM) Programs Narrative

The Offeror shall provide:

A. A description of its disease management (DM) program policies and procedures that address the components in QAPI Standard III;
B. A description of how the offeror will operate the required disease management programs for two of the conditions listed in Section 40.330;
C. Quantitative data on health improvement of members in two disease management programs your plan is currently operating in Hawaii or another state.

81.260 Systematic Process for Monitoring Quality - QAPI Standard III. - Performance Measures Narrative

The Offeror shall:

A. Describe its policies and procedures relating to meeting HEDIS performance measures requirements; and
B. Provide HEDIS measures for the last two (2), twelve (12) month periods. The offeror shall indicate which measures were validated by an EQRO and provide the EQRO validation reports.

81.270 QAPI Standard XII, - Credentialing and Re-credentialing of Providers Narrative

The offeror shall describe its credentialing and re-credentialing policies and procedures, including:

A. The quality of care deficiencies which result in providers' suspension or termination;
B. Its mechanisms to suspend or terminate providers including a copy of a Provider Suspension or Termination letter;
C. The mechanisms used to monitor providers on an ongoing basis (during the interval between formal re-credentialing) to identify quality of care and safety issues, and to initiate appropriate interventions when quality issues are identified; and

D. A description of how the offeror tracks credentialing and re-credentialing activities from application through disposition.

81.280 Delegation of QAPI Program Activities Narrative

The offeror shall provide a narrative describing the functions of all activities it intends to delegate, a list of proposed delegates and its plan to monitor the delegated functions.

81.290 Medical Records Standards Narrative

The offeror shall provide a narrative explaining how it maintains medical records and assures appropriate record retention and how it monitors provider compliance with its policies.

81.300 Utilization Management Program and Authorization of Services Narrative (20 pages maximum)

The offeror shall provide a narrative describing its:

A. Utilization Management Program (UMP) including:
   1. A description of the committee responsible for the UMP as well as its functions and responsibilities, and how it exercises these responsibilities;
   2. How it notifies providers and other practitioners about prior authorization request decisions;
   3. A description of how the offeror will ensure that its prior authorization and referral policies do not preclude members from receiving necessary services; and

4. A description of how it detects, monitors and evaluates under-utilization, over-utilization and inappropriate utilization of services.

B. UMP policies and procedures and a description of the mechanisms that will or have been developed to address the components of QAPI Standard X. Utilization Management Program;

81.400 Member Grievance System Narrative (10 pages maximum)

The offeror shall provide a narrative describing the member grievance system it is currently using in Hawaii or another state. In your narrative please provide:

A. A description of how member grievances and appeals are tracked;
B. An explanation of how member grievances and appeals are trended;
C. A description of the training provided to staff who handle member grievances and appeals;
D. A description of how staff performance and operational processes are monitored to ensure compliance with member grievance system requirements.

81.500 Information Systems Narrative (15 pages maximum)

The offeror shall provide:

A. A description of its information systems, including an explanation of how it will ensure that its systems can

interface with the DHS systems and how it will institute processes to insure the validity and completeness of the data submitted to the DHS;

B. A description of how it will ensure confidentiality of member information in accordance with professional ethics, state and federal laws, including HIPAA compliance provisions; and

C. A description of its disaster planning and recovery operations policies and procedures.

81.600 Compliance Program Narrative (10 pages maximum)

A. The offeror shall describe its overall Compliance Program, including the health plans' Standards of Conduct that articulate its commitment to comply with all applicable federal and state standards, rules and regulations.

B. The offeror shall provide a narrative on how it will address the components of QAPI Standard XIII. Program Integrity. This description shall include but not be limited to:

1. The overall strategies and mechanisms established to prevent, coordinate, detect, enforce, and report fraud and abuse;
2. The designation of a compliance officer and a compliance committee that are accountable to senior management;
3. Effective training and education for the compliance officer and the organization's employees;
4. Education about fraud and abuse identification and reporting in provider and member materials;

5. Effective lines of communication between the compliance officer and the organization's employees;
6. Enforcement of standards through well-publicized guidelines;
7. Provision of internal monitoring and auditing with provisions for prompt response to potential offenses, and for the development of corrective action initiatives relating to the health plan's fraud and abuse efforts; and
8. How to report suspected cases of fraud or abuse to MQD and the Medicaid Fraud Contraol Unit with the State's Department of Attorney General.

81.700 Organization and Staffing(20 pages maximum)

81.710 Attachment: Organization Charts

The offeror shall attach organization charts that show:

A. The relationships of the offeror to related entities;
B. The organization structure, lines of authority, functions and staffing of the health plan;
C. The geographic location of the health plan personnel

81.720 Organization Charts Narrative

The offeror shall provide a brief narrative explaining the organization charts submitted and whether it intends to use subcontractors and how it will manage and monitor subcontractors.

81.730 Staffing Requirements Narrative

The offeror shall describe its current or proposed staffing that includes the number of positions per type (reported as full-time equivalents) for the following functions:

A. Credentialing Program
B. Member Services
C. Provider Services
D. Member Grievance System
E. Quality Improvement Program
F. Utilization Management Program, including a list of any additional practitioners who may be consulted with, if necessary.
G. Care Coordination/Case Management Services
H. Compliance Program
I. Information Systems

81.800 Reporting Requirements Narrative (10 pages maximum)

A. The offeror shall describe how it will ensure that all encounter data requirements are met and that encounter data is submitted to the State in a timely and accurate manner as described in Section 52.200. As part of this description, please provide a narrative of how you prepare encounter data reports and how you assure accuracy.
B. Please provide a narrative on what trend analysis you perform on your encounter data.

81.900 Financial Responsibilities (5 pages maximum)

81.910 Attachment: Provider Contracts

The offeror shall include a copy of the following types of provider contracts:

A. Primary Care Provider;
B. Specialist;
C. Hospital; and
D. A sub-capitation contract if one is used by your plan.

81.920 Third Party Liability Narrative

The offeror shall describe how it will coordinate health care benefits with other coverages, its methods for obtaining reimbursement from other liable third parties, and how it will fulfill all requirements as detailed in Section 60.530.

SECTION 90 BUSINESS PROPOSAL

Information regarding the Business Proposal will be published at a later date under separate cover.

SECTION 100 EVALUATION AND SELECTION

100.100 Introduction

The DHS shall conduct a comprehensive, fair and impartial evaluation of proposals received in response to this RFP. The DHS shall be the sole judge in the selection of the health plan(s). The evaluation of the proposals shall be conducted as follows:

- Review of the proposals to ensure that all mandatory requirements are met;
- Review of the technical proposals to determine whether the health plan meets the minimum criteria and requirements;
- Review of the business proposals to determine whether the capitated rates are within the range acceptable to the DHS;
- Compilation of technical and business proposal scores; and
- Award of the contract to the selected health plans.

100.200 Evaluation Committee(s)

The DHS shall establish evaluation committee(s) that will evaluate designated sections of the proposal. The committee(s) shall consist of members who are familiar with the programs and the minimum standards or criteria for the particular area. Additionally, the DHS may, at its discretion, designate additional representatives to assist in the evaluation process. The committee(s) shall evaluate the assigned section of each

qualifying proposal and document their comments, concerns and questions.

100.300 Mandatory Requirements

Each proposal shall be evaluated to determine whether the requirements as specified in this RFP have been met. The proposal will first be evaluated against the following criteria:

1. Proposal was submitted within the closing date and time for proposals (refer to Section 21.900).
2. Bid rates and technical proposal are in separate envelopes (refer to Section 21.900).
3. The proper number of separately bound copies are in sealed envelopes (refer to Section 21.900).
4. Proposal contains the necessary information in the proper order.
5. Certified statement as specified in Section 21.600 regarding Independent Price Determination is included.

Failure of the health plan to comply with the instructions of this RFP or failure to submit a complete proposal shall be grounds for deeming the proposal non-responsive to the RFP. However, the DHS reserves the right to waive minor irregularities in proposals provided such action is in the best interest of the State. Where the DHS may waive minor irregularities, such waiver shall in no way modify the RFP requirements or excuse the health plan from full compliance with the RFP specifications and other contract requirements if the health plan is awarded the contract.

Proposals deemed by the evaluation committee(s) to be incomplete or not in accordance with the specified requirements shall be disqualified and the proposal returned to the health plan with a letter of explanation.

100.400 Technical Evaluation Criteria

The technical proposals shall be evaluated first in order to identify those health plans that meet the minimum requirements. Each health plan must obtain a minimum of seventy-five percent (75%) of the total points for each of the required review sections. For those health plans that meet all minimum requirements, the business proposal shall then be opened at the public opening.

For those health plans that cannot demonstrate compliance with all minimum requirements, the proposals shall be returned with a letter of explanation. The business proposals shall not be opened.

The listing of criteria is not all-inclusive and the DHS reserves the right to add, delete or modify any criteria.

Section/Title	Section Number	Total Points Possible for Section	Points Needed to Pass
80.210, 80.220, 80.230, 80.240, 80.250, 80.260 – Transmittal Letter, Company Background, Other Documentation, Financial Statements, Per Member Financial Data, Risk Based Capital	80.210 80.220 80.230 80.240 80.250 80.260	Pass/Fail (part of the mandatory reqs,)	
80.270 - Appendix Y: Elimination of Barriers to Contracting Between FQHCs/RHCs and Health Plans (applicable to Health Plans) and Appendix Z: Elimination of Barriers to Contracting Between FQHCs/RHCs and Health Plans (applicable to FQHCs/RHCs, or Explanation of Why These Forms Have Not Been Submitted	80.270	The State is not assigning points to this required attachment (or narrative), however the State reserves the right to evaluate the impact of a health plan's failure to attach the required document(s) and/or provide a reasonable explanation for its failure, against the State's desire to assure an open and competitive procurement. The State will evaluate the health plan's	

Section/Title	Section Number	Total Points Possible for Section	Points Needed to Pass
		response to this attachment for its impact on the ability of all health plans to assure access to necessary care for the State's QUEST population. Remedies imposed by the State may include, but not be limited to, limitation on enrollment into the non-responsive health plan or refusal to contract with the non-responsive health plan.	
80.300 - Prior Contract Activity Narrative	80.300	70	52
80.400 - Provider Network	80.410 80.420 80.430 80.440 80.450 80.460	130	97
80.500 - Covered Benefits and Services	80.510 80.520 80.530 80.540	120	90
80.600 - Care Coordination/ Case Management	80.600	60	45

Section/Title	Section Number	Total Points Possible for Section	Points Needed to Pass
System/Services Narrative			
80.700- Behavioral Health Managed Care Narrative	80.700	20	15
80.800 - Transportation Narrative	80.800	10	7
80.900 - Foster Care/Child Welfare Services Narrative	80.900	30	22
81.000 - Transition of Care	81.000	40	30
81.100 - Health Plan Administrative Requirements	81.110 81.120 81.130 81.140 81.150 81.160 81.170	80	60
81.200 - Quality Assessment and Performance Improvement	81.210 81.220 81.230 81.240 81.250 81.260 81.270 81.280 81.290	170	127
81.300 - Utilization Management Programs and Authorization of Services Narrative	81.300	50	37
81.400 - Member Grievance System	81.400	20	15
81.500 - Information Systems Narrative	81.500	40	30
81.600 - Compliance Program Narrative	81.600	40	30
81.700 - Organization and Staffing	81.710 81.720	40	30

Section/Title	Section Number	Total Points Possible for Section	Points Needed to Pass
	81.730		
81.800 - Reporting Requirements Narrative	81.800	40	30
81.900 - Financial Responsibilities	81.910 81.920	40	30

100.500 Business Evaluation

To be published with Section 90 and the Data Book.

100.600 Selection of Health Plans

Upon completion of the Technical and Business Proposal evaluations, the DHS shall tally the scores from both evaluations to determine the health plans that will receive contracts from the State. The DHS will select up to the following number of health plans per island:

Oahu	Up to 4 health plans
Maui, Kauai, and Hawaii	Up to 3 health plans per island
Molokai and Lanai	1 health plan per island

A health plan will not be selected for Oahu unless it has also been selected for either Hawaii, Maui or Kauai.

100.700 Contract Award

Upon selection of the health plans that will receive contracts the DHS shall initiate the contracting process. The health plan shall be notified in writing that the RFP proposal has been accepted and that the DHS intends to contract with the health plan. This

letter shall serve as notification that the health plan should begin to develop its programs, materials, policies and procedures for the programs.

The contracts will be awarded no later than September 18, 2006. If an awarded health plan requests to withdraw its bid from all or specified islands without incurring penalties, it must be requested in writing to the MQD before the close of business (4:30 p.m. H.S.T.) on September 20, 2006. After that date, the State will expect to enter into a contract with the health plan.

This RFP and the health plan's technical and business proposals shall become part of the contract.

APPENDIX A – PROPOSAL APPLICATION ID FORM (SPO-H-200)

APPENDIX B – ENCOUNTER DATA/FINANCIAL SUMMARY RECONCILIATION REPORT

APPENDIX C – GENERAL CONDITIONS

APPENDIX D – WAGE CERTIFICATION

APPENDIX E – INSURANCE

APPENDIX F – STANDARDS OF CONDUCT DECLARATION

APPENDIX G – WRITTEN QUESTIONS FORMAT

APPENDIX H – AUTO-ASSIGNMENT ALGORITHM

APPENDIX I – LONG TERM CARE FACILITY SERVICES

APPENDIX J – PERSONS W/SERIOUS MENTAL ILLNESS

APPENDIX K – QAPI PROGRAM STANDARDS/GUIDELINES

APPENDIX L – COVERED PREVENTIVE SERVICES FOR ADULTS AND CHILDREN

APPENDIX M – DENTAL PROCEDURES

APPENDIX N – GUIDELINES FOR ONE MONTH WAITING PERIOD

APPENDIX O – SERVICES & MISC. ITEMS NOT COVERED BY THE HAWAII QUEST PROGRAM

APPENDIX P – EPSDT PERIODIC SCREENING GUIDELINES

APPENDIX Q – LOC EVALUATION (FORM 1147)

APPENDIX R – EVALUATION PROCESS FOR BHMC PLAN FOR SMI ADULTS OR SED CHILDREN

APPENDIX S – FINANCIAL REPORTING GUIDE FORMS

APPENDIX T – RISK SHARE PROGRAM

APPENDIX U – TPL MEDICAL/DENTAL EXPENSE REPORT

APPENDIX V – PROVIDER NETWORK MATRIX

APPENDIX W - PIPS

APPENDIX X – FRAUD AND/OR ABUSE REPORT/REFERRAL

APPENDIX Y – ELIMINATION OF BARRIERS TO CONTRACTING BETWEEN FQHC/RHCS AND HEALTH PLANS (HEALTH PLANS)

APPENDIX Z - ELIMINATION OF BARRIERS TO CONTRACTING BETWEEN FQHC/RHCS AND HEALTH PLANS (FQHC OR RHC)